

Missouri Department of Mental Health  
**Housing Toolkit**



*Blazing New Trails in Services and Funding*  
September 2011



Missouri's Mental Health Transformation Initiative and this publication are supported by grant number 6 U79 SM57474-01-1 from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Mental Health Transformation State Incentive Grant (MHT SIG) program. The contents are solely the responsibility of the authors and do not necessarily represent the official views of SAMHSA. When referencing this document, please use:

*Cooperative Agreements for Mental Health Transformation State Incentive Grants*. Request for Applications No. SM-05-009. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. *Missouri Department of Mental Health Housing Toolkit, September 2011*


# foreword

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Safe and supportive housing is one of the linchpins of recovery for individuals with mental health challenges. As Missouri’s Mental Health Transformation initiative has taken shape over the past five years, this issue was recognized early on, and led to the formation of the Transformation Housing Workgroup. This document is the result of one of many recommendations made by the workgroup, which issued its final report in March 2010 (for the full report, go to the Transformation web site at [www.motransformation.com](http://www.motransformation.com) and click the **Housing** link under “Work Groups”).

We were very pleased when Francie Broderick consented to develop this toolkit for the Community Mental Health Center (CMHC) Community. For 22 years, Francie served as executive director of St. Louis’ *Places for People* – recognized as a leader for many years in providing housing for people with mental illnesses – and we wanted to provide a platform for her to share her knowledge. This toolkit provides context and history, and gives specific examples that exist here in Missouri. The focus on the use of Medicaid service dollars is particularly needed in order for the CMHC community to undertake supported housing, and this toolkit provides a roadmap.

If you are reading this material, you are likely to be well aware of the changeable nature of funding streams and policies in the mental health world. The field has evolved from heavy reliance on institutional care, to a community program focus, and now, hopefully, to a focus on individualized services and supports for recovery, driven by consumer choice and participation. We expect this to be a living document, and will update it and revise it as policies and funding streams evolve.



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# table of contents

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## introduction

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Foreword.....	iii
From the Author.....	1
Missouri’s History: Deinstitutionalization and National Leadership .....	3

## part 1 – The How and Why of Housing Creation and Management

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Chapter 1 – Getting Started.....	12
Chapter 2 – The Building: Design and Modifications .....	20
Chapter 3 – Housing Philosophy and Management Policies .....	26
Chapter 4 – How Do I Pay For It? .....	32
Chapter 5 – Putting It All Together .....	66

## part 2 – Missouri Models in Housing Design and Services

---

SRO With On-Site Supports   2 models.....	78
SRO Without On-Site Supports .....	87
An Array of Choices and a Process of “Decongregating” .....	89
Ownership Partnership and Collaboration   Master Lease Arrangement.....	92
Flexibility, Transitions.....	94
Mixed Use and Financing .....	98
Transitioning from RCF to Independence .....	101
Partnering with Private Landlords and Developers .....	104
An Array of Housing Options.....	106
Partnership with Community Action Agency.....	110
“PATH” to Independence for Young Adults .....	111
Community Housing Network.....	113

## appendix A

---

Glossary of Housing and Financing Terms .....	115
---	-----

## appendix B

---

Key Websites .....	121
--------------------	-----

## appendix C

---

Working with Landlords .....	123
------------------------------	-----

## appendix D

---

Entitlement Cities, Counties in Missouri .....	127
--	-----

## appendix E

---

Service Descriptions for Intensive CPR in Specific Residential Settings .....	131
---	-----

## appendix F

---

Client Statements .....	137
-------------------------	-----

## addenda

---

.....	139
-------	-----

# introduction

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## From the Author

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The creation of this Housing Manual has provided me with a wonderful opportunity to visit colleagues, programs, and consumers from one end of Missouri to the other. I have met people who are changing lives and people whose lives are changing because of the recovery partnerships they have engaged in with our mental health providers.

I have been impressed by the creativity shown by our community mental health providers in blazing new paths in services and funding. I am enormously grateful for their generosity in sharing their time and resource information in this effort to learn from each other and ultimately create more opportunities for people we serve.

This manual is not meant to be an exhaustive or complete list of all mental health supported housing or residential programs in Missouri. Rather, I have attempted to describe different models and different approaches used by providers across the state.

There are several themes that recurred as I met with my colleagues and learned about their experiences in housing development. These are the messages I heard:

1. **Creativity and Resourcefulness**—The process of developing a range of housing options for people we serve is not a simple matter of looking up the instructions in a manual. Each region, each political subdivision, each funding stream, each service focus are all different, and, frankly, none of them are easy or obvious. Generally, there is no single funder that will pay for everything you will need through predevelopment to construction and operations. You will have to package together a variety of different funding streams both for development and for operations. The process is similar to a treasure hunt where you are given clues that lead to more clues that lead to the final prize! But the message is don't give up! It can be and has been done all over the state.
2. **Go to the Experts**—Especially if you have never done this before and even if you have, housing development can be complicated and the landscape is changing significantly. Unless you do this full time, it is hard to keep up. The good news, however, is that there are a number of people who can help you—from nonprofit organizations to for-profit consultants, and the Department of Mental Health (DMH) Housing Unit staff can provide a list of those resources.
3. **Perseverance**— Building on the themes above, this process may not go as quickly or as smoothly as you hoped. There may be false starts and start-overs. You may assemble land to build on and then find you have a zoning problem or an environmental problem. You may have been told you are eligible for a certain funding option and then find out it was bad information and you need to find another source to fill the gap. I am not saying

this to discourage you but rather to *encourage* you. You should expect these bumps as part of the process and know that it gets easier as you go along. You're not doing anything wrong; this is just the way the process works.

4. **Risk**—When you are hiking on a trail that has not been taken in a while or even marking a new trail, you sometimes get spider webs on your face. That's part of the price you pay for making something new and wonderful. But you brush them off and you keep going.
5. **A compelling need**—This is why you do it. There is a compelling need for opportunities for people to live hopeful lives in housing that supports choice, dignity and recovery.



Francie Broderick  
Past Director  
Places for People, St. Louis

*Francie Broderick worked as a case manager for three years in the old St. Louis State Hospital until 1975, when she became the first full-time employee of Places for People, the first community-based psychiatric rehabilitation center in Missouri. She served as its executive director from 1989 until 2011.*

*Broderick led the agency in the development of Missouri's largest independent living program for people with serious and persistent mental illnesses. Under Broderick's direction, Places for People became a recognized leader in affordable housing and outreach to people who are homeless, living mental illness, and diagnosed with multiple disorders – including addiction and HIV/AIDS.*

## Missouri's History: Deinstitutionalization and National Leadership

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Deinstitutionalization was a national movement that began in the late 1950s and continued through the early '70s to move people with serious mental illness out of large state institutions into the community with part or all of those institutions then closing. That policy has continued in various forms up to today.

Many reasons have been cited as driving this movement, including:

- Introduction in late '50s and early '60s of psychotropic medications, making it possible to consider treating people outside of hospitals.
- In the '70s a number of court cases established rights for people in institutions. Wyatt v. Stickney established a right-to-treatment in hospitals, not just custodial care. The court case that had the biggest impact was Donaldson v. O'Connor in 1975, which established rights to not be held without due cause and changed commitment laws all over the country. (Ken Donaldson actually visited housing programs in St. Louis in the late 1970s and wrote a very laudatory piece, saying that he had "seen the answer" in St. Louis.)



St. Louis State Hospital

In Missouri, the census of State Hospitals decreased from 12,021 in 1955 to 1,109 in 1994, the peak decades of deinstitutionalization.

The real driving force for deinstitutionalization, however, was the introduction of federal dollars in the form of Medicare and Medicaid, allowing states to move people into the community and shift costs away from the states to the federal government.

To this day, people are debating the pros and cons of deinstitutionalization. What is not debatable is this:

- Most people, even people with the most serious of psychiatric disorders, want to and can live in independent, community housing with access to appropriate support and affordable housing.
- No state or community was prepared with the appropriate and needed community based system of care (including access to housing) to adequately support these discharged “patients.”

## The Missouri Model

Different states approached this shift in different ways. In Missouri, parallel movements were taking place within the community and within the Department of Mental Health.

With a lack of available housing and supports in those early days of deinstitutionalization, thousands of former patients were “placed” in nursing homes and then in newly created “boarding homes” which quickly rose up to accept these large numbers of people being moved into the community. In an effort to track and monitor care for these former patients, the Missouri Department of Mental Health created the Community Placement Program (CPP, forerunner of the Supported Community Living Program) and provided staff to visit individuals and facilities. Caseloads were high, however, and resources and alternatives limited.

It should be noted, however, that Missouri was very unusual and even exemplary in its efforts to maintain contact with former state hospital patients who were placed into nursing homes and boarding homes. Many states just discharged people and they disappeared, left to fend for themselves. The funding that went along with the original CPP was even more unusual—few states appropriated extra dollars to support improved services beyond Medicaid funding.

Outpatient clinics attached to the large state hospitals were expanded to treat the large number of discharged patients. The old St. Louis State Hospital Outpatient Clinic initiated the Prolixin Social Club offering former patients coffee and doughnuts as an incentive to come into clinic for scheduled Prolixin shots, an early recognition that people needed a community or support network in addition to medication!

In 1963, the Kennedy Administration passed the Community Mental Health Act. This legislation spurred the development of Community Mental Health Centers, which later became the basis of the Administrative Agent system. This was the beginning of a community effort to build a system of care.

It quickly became apparent, however, that there was more to building a system of care than visits for therapy and medication. People needed lives. They needed housing and jobs and friends.

## St. Louis Community Homes Program

It was in this climate that Dr. Hilary Sandall, a psychiatrist at the St. Louis State Hospital, along with her “head nurse” Mildred Dunn, began an effort that was to be recognized as an early national model of independent living, the St. Louis Community Homes Program. In an article published in the *American Journal of Psychiatry* in 1975, Sandall described how, in 1971, with no special funding, staff and volunteers of the state hospital helped rent apartments in the community and furnished them with donated and old hospital furniture. Patients and former patients then living in nursing homes formed small groups of friends who would like to live together to move into these apartment settings.

Eventually, a nonprofit organization was created to rent and lease apartments and accept donations. Aides from the hospital participated in special training and were transferred to this new Community Homes Program to help support people in the community. This demonstration program was eventually incorporated into the Community Placement Program and became a new option in the continuum of residential care and placement.

The National Institute of Mental Health Community Support Program designated Missouri as a training site and model program in providing independent supported housing.

It is worth noting, too, that even in those early days of creating supported housing, Sandall and her colleagues made some important observations:

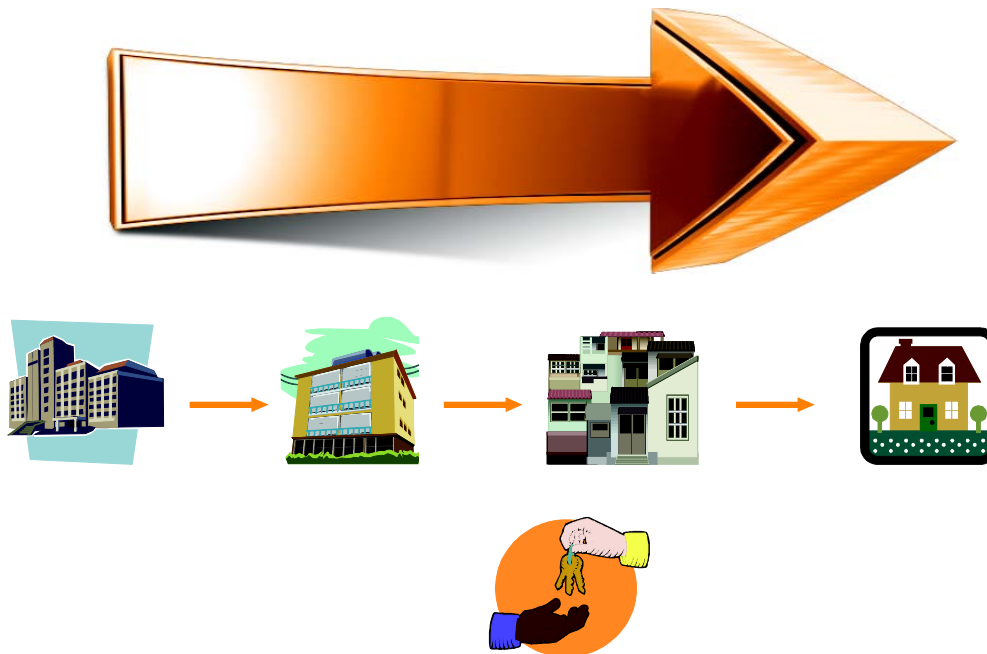
1. The length of previous hospitalization (defined in the article as “chronicity”) was a predictor of successful exit or graduation from the program. In other words, the less time spent in hospital, the more likely the person was to graduate from the Community Homes (supported housing) program. Chronicity or length of institutionalization *was not*, however, a predictor of successful participation in the program; in other words, even those people with very long histories of institutionalization could succeed in supported housing. The length of previous hospital stay was almost exactly the same for those who were returned to more restrictive settings as for those who were successful in the supported apartment setting. (Sandall, 1975, p. 619)
2. Findings stated above led Sandall to conclude that trying to predict ahead of time who was or who was not a good candidate for independent living was not realistic. “In terms of traditional prognostic indicators, many successful community homes residents showed little potential for success. We feel that because the benefits accruing to those who succeed in their adjustment so outweigh the bad effects of possible failure, it is unwise for programs to be overly cautious in placing patients. Gambles on poor-risk patients can often pay off if the support and supervision are flexible enough...” (Sandall, 1975, p. 621)

Timothy Hawley, PhD, a psychologist who worked at the St Louis State Hospital and worked on the research and evaluation of the Community Homes Program stated recently: “Hilary

implemented a practice that was widely accepted nationally at a later date, variously called the Vermont Model of Supported Housing or Housing First. Her idea to skip all of the unnecessary steps to ‘prepare’ people to move into the community, but to just help them move to their desired target independent living setting along with necessary supports was way, way ahead of its time. Lots of places have still not accepted this approach.”

## National Trends: Continuum of Care for Residential Placement

During the ’70s and ’80s, as states struggled with the best approach to housing and services for these thousands of discharged patients, there was a recognition that not everyone needed the same array or level of services. States began the process of creating a Continuum of Residential Care. This looked different in different states but the basic idea was the same. There was a continuum of housing from most to least restrictive, and, in theory, individuals could move along this continuum as they learned new skills and adapted to independent living.



States, including Missouri, began to develop first a theoretical model of this continuum and then actual brick and mortar buildings that included things like Residential Care Facility (RCF) I and II; Group Home I, II, III; Forensic Group Home; Semi-Independent Apartments; Clustered Apartments; and Supported Apartments. Each residential setting had its own set of “entrance and exit criteria.” There was even a scale developed to measure or assess where in the continuum the person should be placed based on functioning and skills.

There were pros and cons to this continuum model. Clearly, it was an important recognition that “one size does not fit all.” Different people need and want different things.

But there were also problems with the continuum or at least in the way the continuum was implemented. Where the continuum was used as a series of steps or stops along the path to independent housing many concerns were identified.

1. One of the first problems with the continuum as a theoretical model is that mental illness is not a linear process whereby individuals just get “better and better” and move from one level of housing to the next level of more independence in a straightforward way. The course of mental illness for many people, as the course of life, is full of ups and downs and peaks and valleys. In a model that tries to link functioning and symptoms with one specific residential setting, a person might be moving back and forth through the continuum as they experience relapses or as their symptoms stabilize.
2. Another issue with a rigidly implemented continuum was that it did not take into consideration individual choice. People were expected to live in the level of care where someone else’s assessment placed them. When individuals refused what was offered, they were left out of the system altogether.
3. The idea of learning skills in one setting (cooking on a stove in the group home, for example) that one would then later use in another setting proved problematic, as well. Most research in the field of psychiatric rehabilitation has shown that skills do not necessarily transfer from one setting to another. It is always preferable to teach a skill in the setting where it will actually be used (in vivo).
4. There was often an assumption that the more symptomatic or acutely ill a person was, the more restrictive the environment should be. This also was a source of problems. We know that sometimes the closeness of a congregate setting or a very highly structured environment can aggravate or escalate symptoms for some people, and, in fact, they do better in a completely independent setting.
5. Symptoms and functioning do not necessarily correlate. Frequently, an assumption would be made that a person who was very symptomatic (delusional, hallucinating) must also be functioning at a low level. Research and experience do not support this. Many people, even those with significant “positive” symptoms may be able to function quite well in independent settings with the proper help and support.
6. Finally, it became clear that the idea of “moving people through” to complete independence was not happening. Frequently, people were placed in a congregate setting or residential care facility and they just got stuck there. There was also a financial disincentive to move people towards independence. Agencies and private residential providers who invested in building and buying buildings wanted to keep them filled, and it was easier to keep them filled with residents who had acclimated to the structure and rules of the facility as opposed to taking a chance on new residents who were more of an unknown factor.

## Paradigm Shift

For all of the reasons above, there was a huge shift nationally and in Missouri. A 1990 issue of the *Psychosocial Rehabilitation Journal* was devoted to the “new” concept of Supported Housing and the paradigm shift away from the continuum of care. The issue contained poignant and eloquent expressions from consumers who felt that the continuum of care model was keeping them stuck in a role of “patient” or resident of a program as opposed to a member of a larger community.

Other articles laid out the basic principles of a supported housing model based on client choice and individualized supports.

Priscilla Ridgway and Anthony Zipple laid out the key conceptual differences between the Continuum Model and a Supported Housing approach (p. 26):

<b>New Paradigm</b>	<b>Old Paradigm</b>
A home	Residential treatment setting
Choice	Placement
Client control	Client role
Social integration	Grouping by disability
In vivo learning in permanent settings	Transitional preparatory settings
Individualized flexible supports and services	Standardized levels of service
Most facilitative environment, long term supports	Least restrictive environment, independence

In Missouri, this paradigm shift was reflected in the name change from Community Placement Program to Supported Community Living Program. There was great excitement among providers and consumers at what many saw as a “freeing up” to really help people live in housing of their choice with the ability to provide flexible and intensive services as needed.

What we did not see coming, however, was a complete swing of the pendulum to include an interpretation of this paradigm shift as meaning:

- Everyone should live independently
- Any provider-owned housing is bad because providers should be in business of providing services, not housing.

- Housing and services should never be linked
- Congregate or clustered housing is always stigmatizing and creates mental health ghettos

An unintended and unfortunate consequence of this period was that providers were strongly discouraged from developing or owning any housing. The hope and plan was that nonprofit mental health housing corporations would be created to develop “generic” housing where consumers could live and mental health providers brought the services to them. There was also a reliance on vouchers and working with individual private landlords.

In some areas of the state, particularly in the Kansas City area, the concept of the nonprofit housing development organization actually was implemented, and it developed a number of housing opportunities (see section on CHN). In other areas of the state, housing development came to a standstill or housing was developed by providers with little to no support from the prevailing ideology.

The result has been, in this writer’s opinion, an uneven and inadequate approach to housing over the past 20 years. What most would agree that we have learned is:

- Most people, even those with the most serious of psychiatric disorders, want to and can live in independent community housing, provided appropriate supports are available.
- There is probably a minority of people who need (and in some cases want) a different housing model with on-site supports and services available.
- We should be talking about an array of housing choices and options rather than a continuum.
- Housing for people with mental illness has not been a priority for funders or developers of low-income housing in this state.
- There is a disproportionate and inappropriate number of people with mental illness living in skilled nursing facilities and residential care facilities because of a lack of appropriate housing resources.

## Summary

This manual is an attempt to present an honest overview of where we, in Missouri, have been in our approach to housing and what we have learned. Most importantly, it is an attempt to showcase the wonderful and creative housing initiatives that have taken place all over the state, to share information about resources and models, and hopefully to provide tools to continue to move forward in providing for consumers of mental health services the same thing we all want—a home of our own.



# The How and Why of Housing Creation and Management

# chapter 1

# Getting Started

## Question 1: Why Develop/Create Housing?

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The first and most obvious question is WHY would we develop/create housing?

What is the problem we are trying to address? Who are the people whose housing needs are not being met appropriately?

There are both programmatic/clinical and financial reasons to develop housing. The programmatic or design and control issues are fairly obvious and are discussed below, but what are the financial reasons to undertake this process? To successfully support people in safe, decent housing of their choosing, you should think of three legs of a stool—all are required to make it stand:

Leg One—The actual housing unit, the bricks and mortar part

Leg Two—Money to support or operate the unit (vouchers, subsidies, grants)

Leg Three—Services and the dollars to pay for those services

Assuming there is a limited pool of money available in our agencies and in DMH to support all three, we need to look at how we can access and or leverage other dollars specifically for the housing and operations so that more of our dollars can go into providing services. Every time we move someone from a DMH or T1-supported subsidy<sup>1</sup> into another subsidy that we create or secure, we have freed up dollars for some other use. So this manual will hopefully provide some guidance in:

- Ways to secure capital and operations dollars
- Examples of how to match the housing with services
- Walking us through the process of creating, designing, paying for housing and services

**So here are some of the questions we must start with:**

Whose housing needs are not being met and why?

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<sup>1</sup> T1-supported subsidy is general revenue that is not matched by federal funds and is used for housing subsidies and services.

Is there a shortage of safe affordable housing in general?

Is there a shortage of specific housing models, e.g., independent units with on-site services?

Are there specific groups of people who have been “locked out” of housing or unable to maintain housing because of complex disorders and behavior issues?

The answer to the questions above will dictate what directions to turn for funding resources, building design, and service array. But you must be clear first about the *why*.

Providers have used a multitude of ways to answer these first questions. Often, good clinicians know from their own experience what trends they are seeing in people’s difficulties in finding, securing, and keeping housing and that is what prompts this question in the first place. But it also helps to have some data, especially as you go forward looking for funding and support.

For example, at one agency, caseworkers were noticing an increase in evictions and requests for clients to vacate housing. A two-year review of those people who had been evicted or lost housing showed a clear trend—the overwhelming majority was people with a long history of co-occurring disorders (mental illness and addiction). This led to a literature review of successful housing models for people with co-occurring disorders, followed by focus groups with staff and consumers to test some of the ideas that were emerging.

Other approaches include a broad assessment or survey of where consumers you serve are living. If a large number are still living in institutional settings (skilled nursing facilities [SNF], RCF, Assisted Living) you have to ask the question, “Why?” What is missing in your housing array that is keeping a disproportionate percentage of consumers in institutions decades after deinstitutionalization? What kind of services or housing would it take to help these individuals move to more independent settings?

The obvious way to determine what your housing needs are, of course, is to ask your consumers. Where are they living, what would they change about where they are living, what would they need in their lives to be able to live in their own apartments?

In some parts of the state, the need is less for specialized housing and simply for decent affordable housing with services provided by off-site community support staff.

Some of the “populations” that have been identified by providers as people who *might* benefit from some housing designed with their particular needs in mind include:

<b>People*</b>	<b>Barriers to Address in Housing Design</b>	<b>Housing Solution</b>
Single adults with mental illness and addiction	The most frequently cited reasons for eviction is “traffic,” too many people in and out of the apartment.	“Concierge” model with single controlled entrance and 24/7 coverage at door or front desk
Custodial parents with mental illness and addiction	Mothers struggling with multiple disorders and stressors of parenting are more likely to relapse and or lose custody.	On-site staff support, shared child care opportunities, parenting-specific groups and activities
Young adults with mental illness aging out of foster care or homeless	With a lack of family support, a lack of history of stability, and possibly trauma, young adults aging out of foster care or who are homeless may have judgment issues around who moves in with them.	On-site staff to help with judgment issues and to provide safe and secure environment, assistance with building support network, limits on visitors
Young adults experiencing “first break”	At first break, young adults frequently have difficulty living with parents, including frequent conflicts, as they learn to cope with symptoms of illness.	Semi-independent apartments with illness management supports
Individuals with extreme anxiety, paranoia, active symptoms	They may become frightened living alone in an apartment and may experience heightened anxiety at night.	Overnight staff to provide support, reassurance, crisis management
People coming from long-term institutionalization (hospital or RCF) possibly with guardian	People moving from long-term institutionalization typically need assistance with relearning ADLs, medication management.	Personal care aides to assist with transition to independence, overnight support

\*Note: This is not meant to assume that special housing is required for everyone in these groupings, purely to provide examples.

Understanding who needs housing and why they need housing is the most important first step in creating your housing strategy. Beyond that, you must start to identify priorities and targets for how many units over how many years you want to create.

## Question 2: Who Should Develop the Housing?

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Once you have answered the “Why,” now you need to answer the “Who.”

There are several ways to approach housing development and each has pros and cons, of course. The answer will be determined by many different factors, some of which are listed here:

### Doing It Alone

You may choose to have your organization be the developer, the owner, and the management entity. Some of the advantages of doing it yourself include:

- More control over design, management policies, tenancy issues, tenant selection
- Building long-term equity for your organization
- Flexibility in changing service design based on changing populations
- As developer, your organization can be paid the development fee established in the project budget which can then be used to seed more development
- As a nonprofit, you have the ability to raise other dollars to help fund gaps

There are, of course, some downsides in doing it yourself that include:

- Lack of experience or expertise in this area
- Lack of capacity or staff time
- Financial risk
- Conflict over different roles of service provider and landlord

### Partnerships

There are a variety of ways to develop housing in partnerships.

- Partner with a professional housing developer to create and own the housing and contract with them to provide management, clinical, and program services. St Patrick’s Center in St. Louis is partnering with a developer (Loftworks). Loftworks will develop and own 56 single-resident occupancy (SRO) housing units and St. Pat’s will provide support services through its Continuum of Care contract with the City of St. Louis.
- Create a regional housing development organization that can be the developer and owner and the mental health agency provides services. This has been a successful model used in the Kansas City area. (See “Community Housing Network” in Part II.)

- “Contract” with a developer to identify set asides within a new housing development for your clients. Crider Center recently negotiated this arrangement with Gardner Development in their area of Warrenton.
- Work with other community organizations such as Community Action Agencies to be the housing developer. Pathways has worked with West Central Missouri Community Action Agency in this manner.

## Hiring and Working with a Consultant

A third option is one chosen by many providers who want to have control over the project but don't have the experience to proceed with confidence. There are a number of consultants available to contract with you to help you create the project, and the DMH Housing Unit can provide a list of these resources. If you are a first-time developer, you can pay them to do pretty much everything or negotiate with them to do the parts of the project you need most help with.

*Your* tasks will be to:

- Identify your target population.
- Identify the services they need and the staffing structure.
- Be prepared with any important design ideas for the project.
- Be able to show how you will pay for services.

A good developer can:

- Identify the best funding source and number of units to ask for.
- Help write and package the application for funding.
- Prepare the capital budget and help you with your operating budget.
- Assemble your team of architect, general contractor, market surveyor, accountant, and attorney.
- Help you with location and local community or political considerations.
- Provide you with templates and ideas for management policies and procedures.
- Help you identify gap funding (the money you still need to complete the project over and above your core funding source).
- Help with land purchase.
- Help oversee construction and money disbursement.

You may not need help with all of these things, so you can contract with your development consultant to do all or part of these tasks based on the capacity and resources you have available within your own organization.

### Question 3: What Is the Role of My Board in This Process?

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It is very important to involve your Board in this process early on. Ideally, it is a direction that has already been identified as part of your strategic plan. There is risk involved and your Board needs to understand and weigh the risk. One thing that is at risk is any money you spend in predevelopment. Before you can even submit an application to the U.S. Department of Housing and Urban Development (HUD) or for tax credits, you will have to spend time and money. Below is a sample of some potential predevelopment costs:

Preliminary Architectural Designs	\$25,000
Market Study	\$3,500
Environmental Audit	\$3,500
Survey	\$3,000
Land Holding Costs	\$15,000
Initial Consultant Fees	\$20,000
Application Fees	\$1,500
Initial Building Security	\$5,000

All pre-development money is “at risk.” In other words, this is money that is spent whether your project is funded or not. Clearly, you need Board buy-in to spend this money with no guarantees of a return.

Your Board may need and want to be involved in decisions about the contract with the consultant or the ownership arrangement. This is especially important because many housing development funders (e.g., HUD) require a separate single asset corporation to be created to own the property. This is done primarily to protect the housing asset should the parent organization come into financial problems in the future. Your Board needs to understand the role of the new corporation and may want overlapping Board membership.

Housing development can be complicated and it may not be possible for all of your board members to understand the details of the project. It is important, however, that at least some key members of the Board understand the project and the risk. This could be your Executive Committee, the Finance Committee, or a special committee of the Board created to advise you

on this project. You may want to add a Board member who has experience in housing or development to assist you with oversight of the project.

## Question 4: How Do I Choose the Site?

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There are some obvious considerations that supported housing projects generally take into consideration when choosing a site:

- Proximity to public transportation
- Easy access to shopping and services
- Safety of a neighborhood (understanding that this is a subjective and relative concept in different parts of the state)
- Environmental issues or lack thereof!
- “Saturation” of social service providers in a neighborhood (which can be a reason to locate or not to locate there)

Beyond that, there are, of course, neighborhood, community, and political considerations. While it is true that Fair Housing Legislation gives people the right to live where they choose without discrimination, there can be all kinds of ways for municipalities to get around this if they choose. Many suburban areas have created their own specific occupancy and zoning codes deliberately designed to prevent group or congregate living situations. It would obviously be important to investigate this in any area prior to purchasing land or a building. It should be noted that these ordinances generally only cover group living and cannot usually be applied to exclude people living in independent apartments even if there are services on site. (However, one provider noted a problem with zoning when they tried to mix office space with apartments as it was considered mixed use in an area zoned for residential.)

Beyond these requirements, however, it may be important to work with your local community even if you are not required to by law. Most successful developments have done some pre-work to educate communities prior to building. This does not always avoid a fight but at least the community knows they are working with a provider that is up front and honest and responsive to the best of their ability.

Staff of Crider Center worked with their local mayor and police chief prior to building their facility. Tri- County, building in an area without neighborhood associations, had staff go door to door in the immediate area to talk with neighbors about the project. In the city of St. Louis, it is always almost required to have aldermanic buy in and support, especially if any local funds or reclaimed land are needed for the project.

When there is significant neighborhood opposition, our best ambassadors are often our clients. While we would not want to subject people to large angry neighborhood meetings, arranging

small get-togethers of neighborhood leaders with potential residents or in other projects you have developed will often go a long way to defuse a situation.

Finding a consumer who has family in the area where you want to build can be a powerful message as well. It can help people to understand that these are truly our sons, daughters, sisters, and brothers.

When working with neighborhood resistance, it is important not to be on the defensive. You have a right to be there. Our clients are generally less disruptive and less likely to be involved in criminal activity than the population at large. But we cannot overpromise—all we can really do is promise to respond quickly to situations that may arise. It is also important to remind our neighbors that people with psychiatric disorders will be living in their community whether we build or not. Their chances of being a good neighbor are greatly enhanced if they are living in decent housing with easily accessible services.

For most funding applications you will need to show that you have site control. This does not mean that you have to buy the property; a contract contingent upon your getting the funding will generally satisfy most funders.

## Question 5: Do We Renovate or Build New?

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This is an important question. Most of the projects we have looked at have been new builds. While there are good reasons to save and renovate good and historic buildings, the current climate can make that more costly and difficult. The practice of using a combination of historic tax credits combined with low income housing tax credits is becoming more difficult. It is also difficult to find pre-existing housing that has the structural design aspects you may need or want. Older housing is almost definitely not up to new codes. Finally, renovation of historic buildings will often raise the per-unit cost, making it harder to have your project funded.

Building from the ground up allows much more input on design functions that will support your service model.

## chapter 2

# The Building: Design and Modifications



### The Architect's View

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Jeff Brambila is an architect who has done many housing projects for nonprofit social service and mental health organizations, both new build and historic renovations. When asked about the most important thing he learned about working with these organizations he said without hesitation, “Flexibility!” There is no way to predict every eventuality and a good manager is willing and ready to change if they find their design does not support their program or tenants. In response to a question about what he has learned in working with supported housing developments, Jeff said:

“I need to expound on the concept of flexibility as I talk about it. As an architect, I have always been aware of one concept of flexibility in planning a physical structure. It’s an easy concept to understand—labeling a room ‘Conference’ and knowing that it could end up being a TV Room, Storage Room or Office, or whatever, isn’t really that difficult unless there are code implications. The more challenging concept of flexibility is learning as much as you can about the reasons for the unpredictable nature of the project and trying to use that knowledge in planning each project. The client/occupant that is being served by these projects is very different than most and the owner/manager of the project has concerns that often differ greatly from other project owners. There are myriad reasons for this. The more challenging flexibility that I refer to involves the design of the project that will try to minimize the need for future physical changes. Subsequent alterations cost money and takes away from operating funds. If there is enough flexibility within the structure, beyond simply labeling a room ‘to be announced,’ then the flexibility that is required in operating the facility can be best accommodated.” (Email communication)

## Design Serves Function

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Once you know the reasons why you are building and the services that your tenants might need as well as how you will provide those services, you are probably ready to start sketching out your design. The next set of questions you will need to address include:

- Is security a big issue—do you need single entrance?
- Will that entrance be staffed?
- If services are delivered by on site staff, how much office, interview, and meeting room space do you need or want?
- If you are serving families or custodial parents, will there be a play area?
- Do you want a congregate area? Do you want more than one congregate area? (One provider stated they wished they had more than one lounge so that people who are not getting along can still socialize but not necessarily in the same place!)
- Will you ever do group meals for special occasions, so do you need a kitchen in the common areas?
- If the units are very small (SRO style) will you provide additional storage area in the building?
- Will you be providing any emergency or transitional housing in this building?
- Is there any need for classroom or training area space?
- What will do you about smoking? Where? Do you need an outside area constructed?

In another section of this manual, you will see a number of design models being used by providers in Missouri. One model that a number of providers have used and that seems to allow the most flexibility is one that includes:

- A common entrance
- Congregate or program space
- Individual apartments each with small kitchen and private bath.

An arrangement like this can easily lend itself to serve clients who need intensive services but want their own space, individuals needing minimal assistance, or fully independent apartments. The only thing that changes is the way the program is staffed.

## Trauma-Informed Housing

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Many Missouri providers mentioned that most people 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 (more on trauma under Management Policies).

## Modifications to Consider

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The following are things to think about before the architect and contractor ask you! There are no “right” answers to the design alternatives available and discussed below. They will depend on your residents, your neighborhood, your operations staff and in some cases agency philosophy. They are, however, things you should be thinking about as you began to talk with your architect and contractor.

- Flooring—It should be durable, easy to clean, non slippery. Some providers are adamantly opposed to carpeting and others seem to manage it quite well. It will depend on the housekeeping practices of people you serve as well as how much time and money you have to spend on cleaning. There is a huge selection of different kinds of flooring now available. Carpeting is generally cheaper in the installation but more costly in ongoing upkeep.
- Appliances—Again, the housekeeping practices of your tenants will suggest the size and nature of kitchen appliances. One agency originally only supplied half size fridges with a small freezer thinking that their residents (formerly homeless people) would not do much cooking and found that this was a mistake. When people go shopping with a community support worker, they like to stock up and the freezer space was inadequate in the half size fridge.
- After visiting a program in Seattle, one provider came back determined that future stoves would be fitted with timers! Grease fires are the most frequent cause of fires in affordable housing units and in particular if you are working with people who have any memory deficits, you may need to accommodate for that. And the range should be non-tipping!
- Microwaves are handier and easier to use for many people.
- Keys—A constant source of frustration and expense can be lost keys, especially if the key accesses a main outside entrance. The cost of changing a lock and replacing keys for all tenants is very high. Many providers have moved to an electronic key fob system where the owner can reprogram locks on site.
- Window covers—Vinyl shades are easy to clean and use. There are also mini blinds that can be built into the window frame
- Security Cameras—Again, depending on who your tenants are, what their needs are, how you will have the facility staffed, you may or may not want cameras. One provider struggled with the concept feeling that it might send the wrong message to residents—

that they were not trusted. To the surprise of that provider, tenants said they liked the sense of additional security offered by the cameras.

- Will you be storing medications on site? How and where will they be secured?
- Alarms—If the building has controlled access, will fire exit doors be alarmed?
- Delivery port—Will you be buying anything in large quantities or regularly having deliveries? If so, do you need a dedicated delivery entrance easy to access from the street or parking lot? Ideally, this entrance has a wider doorway for large appliances, etc.
- Parking spaces—If you have limited space for parking around your building, you may need to apply for a waiver from your local municipality. Some providers have successfully argued that the majority of tenants do not own cars and so the facility may need fewer parking slots than generally required in a commercial apartment building.
- Curb cuts—Is this something you will need or request from your city?
- Green space and landscaping—Keep it simple! You can always add more landscaping later. Upkeep for weeding can be costly. Residents who initially say they will take care of the garden may tire of it or move and then you are paying staff to weed! Consider working with your architect (or even a local volunteer garden/green group) to find native grasses or plants that are low maintenance.
- Bathrooms and laundry rooms should have floor drains for the inevitable tub or toilet overflows.
- Will tenants have individual heating and air units that they control themselves or will this be centrally managed?
- Will each unit be phone and cable ready?
- What is your policy on smoking? If there is no smoking inside the apartments, is there any place on the property it will be permitted and if so, will you provide shelter for that area?

The Affordable Housing Design Advisor website <http://www.designadvisor.org/> provides a wealth of information, ideas, and resources related to successful design.

As you look at design issues, you may want to pay special attention to “building green.” Building in environmentally friendly operating systems or construction sometimes costs more up front but shows savings in utility or maintenance over time. Some grants will pay for a “green consultant” or for specific energy-efficient approaches (see, for example, [http://kresge.org/index.php/what/environment\\_program/](http://kresge.org/index.php/what/environment_program/)). In addition, many funders will give you extra points if you can show that you included specific “green” or energy efficient initiatives in your planning (e.g., native plants for landscaping, good insulation, passive solar building design, recycled building materials, use of grey water or green roof).

## Furniture

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The Corporation for Supportive Housing also has a web page devoted to suggested furniture and a calculator to estimate costs

<http://www.csh.org/index.cfm?fuseaction=Page.viewPage&pageId=4555&grandparentID=10&parentID=3647>.

## Examples of Designing for Tenants

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The Corporation for Supportive Housing has available on its website (<http://www.csh.org/>) a wonderful resource called “Toolkit for Ending Long-Term Homelessness.” The manual presents examples of supported housing and talks about special design aspects each has adopted to fit the people served.

### Anishinabe Wakiagun

This project is based in Minneapolis, Minnesota, and was designed specifically to serve homeless, “chronic inebriates,” many of whom are Native Americans and also suffering from medical problems related to alcohol use. Here are some considerations and modifications made at Anishinabe Wakiagun to support their tenants:

- Since many residents need crutches or wheelchairs, accessibility was paramount as was easy access for emergency vehicles.
- Residents were heavy smokers so fireproof construction was a priority.
- Sobriety is not a condition of residency. It was expected that some residents will be inebriated so hallways are deliberately narrower to “enable residents who are staggering to use walls for support.”
- Glass blocks bring daylight into the hall from the rooms and at night allow visitors and staff to see if lights are on or off without seeing into the unit.
- Elevator large enough for medical gurney
- Each room has a window projection to provide a wide view of the outdoors which “is meaningful for people who have spent many years outside on the street.”

Anishinabe Wakiagun is also culturally relevant and sends the message that the people who live there are valued regardless of their alcohol or drug use. In the front of the building is a “Memorial Tree” or blessing tree commemorating the homeless, late-stage alcoholic Native Americans who died or were killed in the years before Anishinabe Wakiagun was built. The tree was wrapped in tobacco ties, cedar, sage, eagle feathers and note cards with the names of loved ones written on them.

This project may seem an extreme example, but if we are serious about supporting people at any stage of their recovery, this is a wonderful example.

Outcome research on this project shows significant reductions in detox use and police bookings. There is a reduction, but a small one, in ER use primarily because by the time people enter this program, they are already medically fragile.

## Canon Barcus: Family Housing

Canon Barcus is a 48 unit building in San Francisco designed for low income families with special needs including mental health, substance abuse, HIV/AIDS. A building for these families will, of course, be designed very differently than a project like Anishinabe Wakiagun.

In designing units for families, creating *more* but *smaller* bedrooms will give you more flexibility than units with fewer but larger bedrooms. This allows you to serve families with children of different genders or ages and not force them to share rooms. This is especially important for families with teenagers.

Adequate indoor and outdoor space for play areas will obviously be important as well. The developers of Canon Barcus caution to make the indoor space a flexible area so that it can be used in different ways for children of different ages. The outdoor space needs to be in a semi-protected area, an interior courtyard or otherwise protected from the street.

Families may also have a greater need for additional on-site storage space.

In a building for families, it is also important to consider the local school and transportation to school.

# chapter 3 Housing Philosophy and Management Policies

This section will contain questions you will need to be prepared to answer but it won't, of necessity, provide answers. The answers depend on your agency philosophy, your tolerance for risk and the goals of the particular housing you are developing.

By the time you have gotten this far in your planning, you likely have a good idea of who you are serving, the special needs of your tenants, and the mission and objectives of this project. Now this all has to be translated into your management policies.

If you have made the decision to contract out the management, this may be less complicated as you will have less control and responsibility in these areas. This, then, is really the first decision: Are you the landlord or is someone else?

There are obvious pros and cons to either approach.

The one primary advantage of being the manager is that you have more flexibility to tailor your policies and procedures to the special needs of your tenants. You also, hopefully, have staff who have skills in communicating with people with a variety of disorders. Some providers feel they are able to prevent evictions by working with tenants and going the extra mile in a way that a separate management company would not.

The disadvantages of being the landlord are probably pretty obvious as well:

- **Time**—It can take a lot of time, not just in creating policies and procedures, but in staying on top of maintenance, preventive maintenance, tenant grievances and requests
- **The “two hats” problem**—The question frequently arises as to the potential conflict of being both the service provider/client advocate and being the landlord/enforcer-of-rules, collector-of-rent.

While it does not completely solve the “two hats problem,” one approach that helps is to have landlord and community support functions clearly separated by staff. The community support staff help the tenant meet the legitimate demands and expectations of the landlord, as they would with any landlord in the community.

## Management Issues to Address

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Whoever is the landlord/manager, there are a myriad of policy and procedure decisions that will have to be made and, depending on your funder, there may be even more. HUD will have its own set of guidelines, expectations, and reporting requirements and so will most any large funder. These are some of the things you will need to address in your Management Plan.

- Marketing—A plan to market your housing to potential referral sources and evidence that staff have been trained in Fair Housing requirements.
- Tenant Selection, Screening, Application—Given the people that many of our agencies serve, this needs to be a very flexible and broad process so we do not inadvertently screen out the very people who most need services. Downtown Emergency Services (DESC.org) is a leader in providing housing and services for people with very challenging backgrounds including active drug use/mental illness/criminal backgrounds. Their research shows that a criminal background in and of itself is NOT a predictor of housing failure or success (see website for research). Sadly, many housing policies and providers screen out the people who might most benefit from supportive housing options. Again, this is a decision that will be grounded in who you are serving in this particular housing unit and what your definition of a successful outcome is.
- Rent Collection, Evictions, Temporary Absences—These are the difficult areas of being a landlord and speak to the argument for having separate staff who do housing management and different staff who are support workers and advocates.
- Guests—You have the right to set limits on guests and how you do that will, again, partly depend on the type of housing you are providing and the particular issues and needs of the tenants. Bear in mind that safety is a primary value in trauma-informed housing, and your policy on guests, especially overnight guests, will be very important to your tenants.
- “Substances”—What is your policy on tobacco, alcohol, use of street drugs on site? Are you intentionally operating a dry, damp or wet house? There is a need for all options but you need to be prepared for what kind of program you want to run. And if you set prohibitions on any substance, what are the consequences? Are you prepared to evict people who violate the rules, or is there a period of time where staff and tenant work on a plan to address behaviors that are potentially dangerous or problematic? Remember also that HUD and most other public funders have strict rules about a tenant’s right to appeal an eviction.

- Physical Plant maintenance—You will need to decide if you want to contract out housekeeping and maintenance services or if you have staff able to keep up the facility and plan preventive maintenance and upgrades. Likewise you may want to hire an outside firm to do basic cleaning and housekeeping in common areas and groundskeeping. Some agencies find that it promotes ownership and empowerment of tenants to hire tenants to do these jobs.
- Documentation and Reporting—As with all publicly funded programs there is in fact an enormous amount of reporting and documentation. Tax credit and HUD programs (and some private funders) will require documentation of all of your processes regarding tenant selection, proof of eligibility, applications, waiting list, informing people of rights, grievance processes, recertifications, etc. You will need a separate file on each resident. You will need to prepare annual budgets and have audits conducted. For some funders, you will need regular reports showing that you are serving the people you said you would serve (e.g., chronically homeless, under certain percentage of poverty, etc.).

Your management plan should identify who will track all of the above data.

## Interface of Program and Management Philosophy

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Early on in the process of deciding to develop housing you may have already made decisions about some of the following concepts but it is important that they be addressed clearly and intentionally.

### Stages of Change/Harm Reduction

It is clear by now that some of those with the greatest difficulty in keeping housing are those with a history of both serious mental illness and substance abuse disorders. It is also clear by now that for many people, both of these disorders can be chronic and relapsing, especially if they are long standing. For that reason, many people with co-occurring disorders have not done well in abstinence-only programs and they are over represented among the homeless and in prisons.

We have also moved from an “either or” (either you are using or you are not using) approach to addiction to a stages of change approach where we recognize that change may come along a continuum. People in early stages of change may still be using drugs or alcohol but *can still make changes in behavior and in their use that can keep them safer and help move them along to recovery.*

In the same way that we try to provide appropriate treatment interventions for people at different stages of change, it makes sense to provide different housing options for people at different stages. To offer someone housing who is still pre-contemplative (not yet committed to changing his/her substance use) and require that they be abstinent is unrealistic and setting everyone up for failure and conflict. Offering that housing to someone further along, in a relapse-prevention stage, for example, may be entirely appropriate. The goal should be to have a range or array of

housing options for people in different stages of their paths to recovery. The concept of wet, damp, and dry housing has naturally evolved from this recognition of stages of change.

You may find it helpful to talk with other providers who are working with this approach. Two well-known national programs that have published on their experience in this model are Thresholds in Chicago and Downtown Emergency Services in Seattle. The Harm Reduction Coalition also offers this sample Management Policy document <http://www.harmreduction.org/article.php?id=1148>

If you choose to provide housing for people in early stages of change (“damp” housing), you will clearly need to think through your approach to use and possession of drugs and alcohol both off and on site.

There is no doubt that this approach presents more challenges and requires thoughtful, careful and honest dialogue among staff, residents, and even neighbors. In having these conversations, one theme is shared and is dominant among all groups—safety. Staff, residents, neighbors want and need to feel safe and using this as a starting point can help keep the conversations on track and emphasize a common goal rather than an “us versus them” dynamic.

Building a sense of mutual trust, respect, and community will be critical especially in this type of housing. If residents can talk honestly with staff about their drug use, they can work together to create a plan to stay safe and help keep others safe and move forward to abstinence. If residents care about their fellow tenants, they will not want to jeopardize housing for themselves or their friends. In working with neighbors, it is often important to emphasize that individuals with these disorders are already in the community. By safely housing them with on-site and available supports, we can reduce the harm to them and to the community.

(In choosing a site for a “damp” house, where people are in early stages of recovery from addiction, you may want to consider a location that is somewhat set aside from a strictly residential neighborhood!)

Finally, if you intentionally are creating housing for people with co-occurring disorders you may want to look carefully at how you define success. The old paradigm of whether people are using or not using may not be the most helpful for people with long and difficult histories. Rather, you may choose to set your objectives in terms of:

- Reducing arrest and incarceration
- Reducing emergency room use
- Reducing homelessness
- Increasing participation in medical care
- Improving health outcomes

These outcomes are all very achievable even for people who are still ambivalent or undecided about giving up their use of drugs and alcohol. The most important value in this housing, however, is that you are sending people the message that even though they have these difficult disorders and behaviors, they still have value and they still deserve a safe place where they are welcome.

## Trauma-Informed Management Policies

Trauma comes in many forms but at the heart of trauma is generally the feeling of great threat and being powerless to effect or control the threat. As service providers and housing providers, we are inevitably in situations where, if we are not careful, we can unintentionally replicate in our clients that feeling of powerlessness. We have access to and control over resources that our clients need and want and so we have an added responsibility to be aware of the impact of this power we have (even if we do not want it!).

Residential settings, in particular, can replicate traumatic events for individuals. For many people, previous traumatic events have taken place in the very places where they were supposed to be safe—their own home, bedroom, bathroom. Staff in residential settings (group homes, semi-independent, supported housing) need to be especially sensitive to situations and policies that can be retraumatizing or threatening.

In an article in *New Directions for Mental Health Services*, Richard Bebout of Community Connections in Washington, D.C. gives examples of behaviors we may see in residential settings that are related to past traumatic experiences:

- Sleeping with clothes on or on top of covers
- Sleeping only in common areas, not in own bedroom
- Staying awake and watchful at night and sleeping during day
- Not wanting to bathe or shower
- An obsession with cleanliness or too long in the shower

It is easy to see how all of these behaviors could be related to traumatic experiences, and it is also easy to see how they could become points of conflict in residential settings if staff are not particularly sensitive to the root cause of the behavior.

Bebout also points out that people with trauma in their background often engage in what he calls “self-soothing” behaviors. Often these are things that can present problems like drinking, overeating, self harm. Bebout suggests housing provider try to support and provide “adaptive self-soothing” opportunities including things like:

- Quiet space in addition to a bedroom

- Music and stereo equipment available
- Exercise equipment
- Healthy foods and snacks

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. Residents should know that staff (or other residents) cannot enter their rooms without permission. Some tenants may feel more comfortable keeping the door open when staff are in their apartments.

Avoiding secrets is also especially important in working with people who have suffered abuse as, typically, the abuser has warned that the episode must be kept “secret.” Residential staff must be especially careful to avoid doing or saying things that they then ask residents to “keep as our little secret,” even if the incident appears harmless.

Finally, involving tenants in decisions and discussions about safety and house/facility rules can help people be and feel more empowered and in control.

# chapter 4      How Do I Pay for It?

So you have decided you need and want to develop a supportive housing project that will serve very low income people who need supportive services to successfully maintain their housing. You have the design and the rationale for why this project should be supported. Now how do you pay for it?

There are, broadly, four different kinds of funding you will need:

1. Pre-development—Money you will spend on initial planning stages before you even submit an application for your capital funding.
2. Capital—Money required to purchase/renovate or build new including both hard and soft costs for consultants, architects, construction, and associated costs.
3. Operating money—To actually operate and maintain the building (insurance, utilities, housekeeping, preventive maintenance) including client rent and subsidies
4. Service money—Cost of providing services to the residents of the housing.

## Pre-Development Dollars

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In order to put together a successful application, you will need to be able to show your potential funder a number of things and each of those things may have an associated cost:

- Site Control—You must be able to show that you actually have a workable site and the land is useable and available to you (ideally under your control, which you can do with a contract with an option contingent upon getting funding). So this may require either a purchase of land or earnest money to secure a contract. It also may mean surveys or environmental studies to be certain the land will work for your purposes. Some providers have had land donated by their municipality if they can show they are serving a real community purpose. In some areas, you may have land donated by a private owner or be able to purchase for a low cost land that has been reclaimed for back taxes. There may also be some “holding costs” associated with the site control. If you have actually acquired the land or property there may be insurance, utilities, security, upkeep, etc.
- Market Study—You may have to pay for a market study to accompany your application to support your claim that this type of housing is needed and marketable.

- Environmental studies
- Architect and other consultant fees—You must know the total cost of the project—your cost for architectural and engineering plans, hard construction costs, final acquisitions, loan service, etc. To obtain this figure you will likely have to work with an architect for preliminary plans as well as a consultant or accountant to help put together your final budget or even a feasibility study. The consultant may also be the person or firm that helps you create the final application.
- Application fee

There will, of course, be a range of pre-development costs based on the variables above, but most providers have found they have invested between \$50,000 and \$75,000 in pre-development work.

There is good news and bad news about pre-development dollars.

First the good news—Most of it will be an allowable cost in your project budget, so you may get it returned to you at closing—*if* your project is funded. (It should be noted that many public funders have caps or pre-determined schedules for paying consultants, architects, developers.) Depending on where your pre-development funds came from, you then can pay back the lender or use that money to seed another project.

It is not unusual to have to submit an application to a major funder (HUD, Missouri Housing Development Commission [MHDC]), several times before it is funded. Much of your pre-development costs are one-time costs (land acquisition, architectural plans, environmental surveys) and will not need to be duplicated in re-applications for the same project.

The bad news, of course, is that all pre-development dollars are at-risk and if your project never gets funded or developed, that money never comes back to you—another reason to have thoughtfully worked through your options, your (and your board's) commitment, and the feasibility of success.

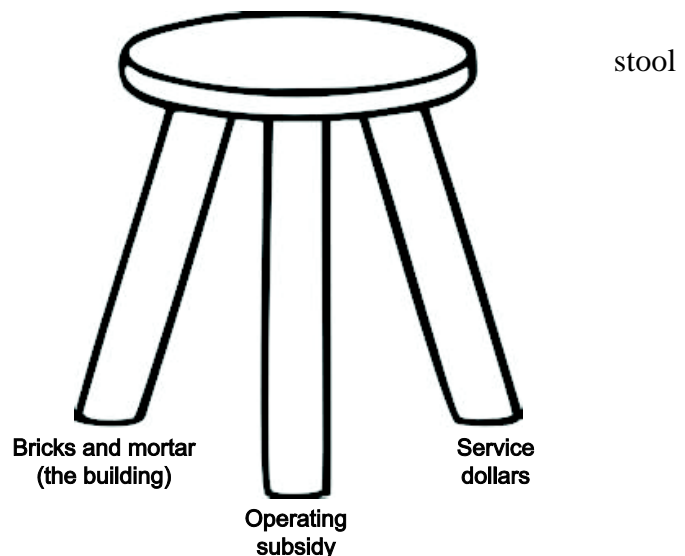
## Reducing Costs and Risk

Since your agency is at risk for this money, you may want to negotiate your contract with your consultant in such a way that he/she does not get paid or gets paid only a small amount unless and until the project is funded. Likewise, you may get land donated or get an option (contract purchase triggered by securing funding) on land rather than completing purchase to keep your at risk costs minimal.

## Funding Pre-Development

- The obvious way to fund predevelopment is to use your own agency resources.
- It may be possible to work with the Department of Mental Health for assistance, especially if the project is part of a regional housing plan.
- HUD has, in the past, provided demonstration project planning grants for their 202 program (housing for elderly). While HUD funds are in short supply at this time, it is still worth checking the website.
- LISC of Greater Kansas City has an Acquisition and Predevelopment Loan Fund and could be a source for assistance.
- On the eastern side of the state, the Regional Housing and Community Development Alliance in St. Louis has a Predevelopment Loan Fund for nonprofit organizations. (RHCDA can also provide technical assistance and support with research for your project.)
- IFF is a nonprofit community development financial institution that offers flexible, below-market rate financing to nonprofits serving low-income or special needs populations in Illinois, Indiana, Iowa, Missouri, and Wisconsin. IFF works with many types of nonprofits, including, among others, developers of affordable and supportive housing, health care providers offering services to the underinsured, and agencies that support individuals with disabilities.
- The Rural Development Loan Fund has a list of targeted communities for which applicants may request loan funds. It may or may not be a resource for your area, but is certainly worth building a relationship with the staff of the Missouri office so that you can be aware of resources that may be available. (See “USDA Rural Development Programs” later in this chapter.)

Now that you are ready to assemble your project you should think of a three legged stool with each leg being essential to have secured to make a successful project: Capital, operations, services



# Capital Financing

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Capital financing is the money you will need to acquire and renovate or build new. It includes all the one time costs associated with the project from architectural and engineering plans to actual construction.



The Corporation for Supportive Housing referenced earlier is probably the best source for all things related to this topic.

**It should be noted early on in this discussion that the world of capital funding for supportive housing is in the midst of significant transition and change. It is not possible to create a recipe for how to apply for the “traditional” sources of capital funding that will be relevant a year from now because new regulations are just now being worked out.** This particularly applies to the HUD 811 program and will be discussed in the next section.

The good news, however, is that the result of these changes may be a more flexible approach to combining capital funding streams. It will be very important that social service/behavioral health providers participate in the development of these new procedures and policies so that the interests of the individuals we serve are not left out of the planning and they, too, can have better access to decent housing.

The Corporation for Supportive Housing did a national survey of supportive housing providers to determine what source of funds most providers used for their capital financing. On the national level, findings were as follows (the percentage refers to the % of providers who used this funding source in their bundled package of funding):

Low Income Housing Tax Credits (LIHTC)	75.5%
Home Investment Partnership (HOME), Community Development Block Grant	70%
State Housing Trust Fund	52.7%
Section 811	32.9%

This is worth reviewing because the experience in Missouri is *very different* from the national picture. Most mental health providers in Missouri who have actually developed supportive housing have used the HUD 811 program. Very few projects in the area of mental health supported housing were done with state tax credits for a variety of reasons which will be discussed later. This is going to have to change, however, since a restructuring of 811 funding will involve combining it with tax credit and other funding sources.

## United States Department of Housing and Urban Development—HUD

### **811 and 202**

Two programs that have been used extensively in Missouri in the past are the HUD 811 and the HUD 202. (See Crider Center, New Horizons, SEMO Safe Haven, Tri-County, Pathways, Family Guidance, Places for People, Independence Center, Burrell for examples in Part II of this manual.)

811 provides funding to nonprofit organizations to develop rental housing with the availability of supportive services for very low income adults with disabilities. A key additional and important aspect of the 811 program is that it also provides rent subsidies attached to the project.

202 is a very similar program except that it is now used for housing for elderly. At one time, both projects were combined under the 202 program. This explains why some Missouri providers have 202 projects that serve people with disabilities as they were developed before the programs split off.

Since the separation of 811 from 202, most new supported housing projects in Missouri have been built with help from the 811 program

### ***Key Aspects of the Program***

- 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).

### ***Flexibility in Design***

The exact household configuration or housing design is not dictated by HUD. This manual gives a range of examples of how 811 funding has been used for quadraplex, four-family units, to a more traditional group home model where individual rooms are counted as one unit, and everything in between. Likewise, the service design ranges from no on-site services, to very intensive 24/7 availability of services, and everything in between. What is required is simply that you are able to make the case that your model fits the service needs of the particular group of people you are designing for.

### ***Total Project Cost and 811***

As we reviewed 811 projects around the state, we found great variability in the percentage of total costs that the 811 funding provided. We also found that the per-unit or per square foot of the cost varied widely depending on such things as:

- Whether land was donated or purchased at market rate
- Whether labor was provided by union contractors
- Whether there were historic district considerations or requirements
- Whether considerable preparation to the ground or demolition was required prior to building
- The amount of common or program space

All of these factors obviously impact the cost. It was also generally true that building in urban areas was more costly per square foot.

For those providers who had a gap between the total cost and the amount that HUD provided, there were a number of different solutions:

- In some areas, it is possible to go to the local HUD office and request additional funds.
- Some agencies used their own resources to fund the gap.
- Most agencies found other capital sources, like the Federal Home Loan Bank, housing trust funds or private foundations.

A good consultant can and should assist an organization in putting together the whole funding package so that the cost to the agency is minimal.

Historically, the Notice of Funding Availability (NOFA) for 811 has gone out in May and decisions are usually finalized in September or October.

***Important Changes in the 811 Program and The Frank Melville Supportive Housing Investment Act (Modernization of the Section 811 Program)***

As noted above, one of the additional benefits of the HUD 811 program has been the attached PRAC, or rental/operating subsidy that attaches to each unit. Most other capital financing sources do not generally have a rental subsidy attached. Providers often cited this lack of operating subsidy as a reason *not* to pursue other funding streams (such as low-income housing tax credits). On the other hand, some advocates for people with disabilities have complained that the 811 program segregated individuals with disabilities into group homes or segregated-living arrangements.

***But now all of this is changing!***

For years, advocates have been trying to pass the Frank Melville Supportive Housing Investment Act. It was passed in 2010 and signed into law by President Obama in January, 2011.

For a good overview of some of the key elements of the legislation, please see the following website: <http://www.shelterpartnership.org/common/documents/FMSH-Investment-Act.pdf>. Here is a brief summary of the changes most important to service providers:

The Act will now allow the separation of the PRAC (the rental subsidy) from the capital advance (the money to build or renovate). So a provider using other funds to develop a project could still apply for the PRAC dollars to subsidize units for new or existing projects.

The Act will also specifically create demonstration programs to leverage set-aside units of supportive housing within federal Low Income Housing Tax Credit properties and HOME funded projects. The demonstration projects would provide the project-based rental subsidies to keep these new units affordable to individuals with very low incomes. To qualify for this demonstration, the state Housing Funding Authority (in Missouri, most likely MHDC) will need to show a strong working relationship between the state housing and human services agencies.

The rental assistance can only be used for projects identified in an agreement between the state agency responsible for health and human services programs and the state agency designated to administer or supervise the state Medicaid plan. The agreement must identify the target population to be served, the outreach and referral methods and provide appropriate services for the tenants.

The hope and belief is that by using 811 dollars to provide project-based subsidies, you will accomplish two important goals:

1. More integration of people with disabilities into the larger community
2. Creation of more units for people with disabilities by leveraging other capital funds for development

This should also begin to create a climate where developers routinely look to partner with providers for set asides within their project.

For service providers, it means that you can develop projects that include a wide variety of funding sources for the capital and still be eligible for the rental subsidies and not have to rely on other sources like Shelter Plus Care or DMH T1 dollars.

The HUD website description of these new programs also states ([http://portal.hud.gov/hudportal/documents/huddoc?id=Housing\\_w\\_Disability\\_2012.pdf](http://portal.hud.gov/hudportal/documents/huddoc?id=Housing_w_Disability_2012.pdf)):

“The model of integration in multifamily housing is not appropriate for all disabled populations so HUD still intends to provide funding for group homes, independent living facilities, and condominium projects. Regardless of the specific type of housing supported under Section 811, HUD is working to better ensure that Section 811 program funds are awarded to higher capacity sponsors who have projects that are line up and ready to go.”

The implications for creating supported housing for consumers served by mental health provider are enormous and exciting. The following link is to a PowerPoint presentation of the changes and the process for implementation:

<http://portal.hud.gov/hudportal/documents/huddoc?id=HUPRAPresentation041411.pdf>

## **HOME Funds**

Another important HUD program is the Home Investment Partnership or HOME Program.

This 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.

In order to be eligible for this funding, states must submit a **Consolidated Plan** that includes an assessment of the need for affordable housing and a five-year Comprehensive Plan (updated annually) identifying the activities needed to address the needs.

*This is another area where advocates, consumers, and providers could play an important role in seeing that the needs of consumers of mental health services are addressed in this needs assessment and plan.* Staff of the DMH Housing unit are knowledgeable about and involved in this process and always welcome input from consumers and providers about the need they see. This plan will also be used in allocating Community Development Block Grant dollars discussed below.

In Missouri, MHDC is the HOME fund administrator. 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 other tax credit or bond financing through MHDC. 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.

### **Community Development Block Grant (CDBG)**

A third program within HUD that can be used in development or operation of supported housing is the Block Grant program known as Community Development Block Grant. The amount of funding allocated to a state or entitlement community (cities over 50,000) is based on a formula involving community need, population, poverty, housing overcrowding, age of housing, and population growth.

## ***Administration***

Appropriations are divided to provide 70% of funding for entitlement cities and counties and 30% for non-entitlement communities.

Incorporated municipalities under 50,000 and counties under 200,000 in population are considered *non-entitlement* areas.

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.

(A list of entitlement communities and the contact information for grant administrators can be found in Appendix D of this document.)

## ***Use of Funds***

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.

As with the HOME funds mentioned above, the **Consolidated Plan** addressing the need helps determine the priorities for use of these dollars. Again, this is an area where advocates can become involved: at public hearings, commenting on drafts of the plan, submitting data documenting the need for supported housing.

In Missouri, the state Department of Economic Development is the designated lead agency for the Missouri Consolidated Plan and Action Plan which helps direct the activities of the CDBG fund, HOME funds, Emergency Shelter Grants and HOPWA (Housing for Persons with AIDS).

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>

## **Supported Housing Program (SHP) and the Continuum of Care**

As with the other programs in this section, SHP is a HUD-funded program. It is more limited than the others listed above in that it is specifically designed for people who are homeless

(sleeping in places not designed for human habitation or using an emergency shelter as primary nighttime residence). The range of eligible activities, however, is very broad and allows for creativity in service design.

The purpose of this program is to create a coordinated community collaborative plan that will help develop housing and necessary support services to help people move from homelessness to independent living.

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 homelessness.
- **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.

### *Eligible Activities*

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.

### ***Who Can Apply and How?***

As with other funding streams identified above, funding for SHP grants is 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). The process for doing this is called the Continuum of Care, or CoC. HUD’s definition is:

“[A] community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness.”

The key words are “community” and “plan” which makes this process different from a single agency creating a proposal for a program. The intent is to encourage communities to bring together potential partners to create a plan with action steps for the best use of these funds and that together they can implement to end homelessness. 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 Missouri Association for Social Welfare maintains information on their website about both entitlement and Balance of State (BOS) CoCs: <http://www.masw.org/HMIS/map.php>

If your long term plans involve providing services and/or housing for people who are homeless, it is important to become involved with the CoC in your community.

### **Missouri Housing Development Commission (MHDC)**

As cited previously, MHDC has not historically been a key player in developing supported housing for people with behavioral health disorders in Missouri. ***There is every reason to***

*believe that this is changing dramatically and if you are interested in providing housing or increasing the availability of affordable housing for consumers of mental health services it is critical that you become familiar with MHDC and opportunities to advocate for a fair share of resources for your consumers.*

The official description of MHDC from their website (MHDC.com) is:

### **Overview**

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.

The commission administers the

- federal and Missouri Low Income Housing Tax Credit (LIHTC) programs, federal HOME funds,
- the U.S. Department of Housing and Urban Development (HUD) Project Based Section 8 rental assistance contracts,
- 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.

## Relevant Programs

### *Housing Trust Fund*

If providers are aware of any program with MHDC it is most likely the Trust Fund. The Trust Funds operates more like a traditional granting program. 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. A word of caution, however: members of the Missouri Legislature have taken the position that the authority over allocations of the Legislature is absolute and even earmarked funding sources can be waived. What that means is that, while rare, it is possible that the legislature can redirect money slated for the trust fund in a given year.

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.

It is easy to see how any of these categories could be useful to service providers. The program is competitive, however, and the amount of need generally far exceeds the amount of grants. As with all funding opportunities, it is important to develop relationships with the staff of the Fund who are able to provide assistance in understanding what qualifies as a good and competitive request. It is sometimes also important to advocate for certain specific populations or services that may historically have been underfunded.

### *Funding Cycle*

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.org

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.

### *Low-Income Housing Tax Credits (LIHTC)*

Behavioral Health Providers in Missouri have typically not used this development source extensively for several reasons, including:

- It can be complicated (legal, corporate, and accounting intricacies) and hard to understand for first time users.
- Those legal intricacies have associated costs (consultants, attorneys, accountants) that make the total cost of the project look high.
- You need relationships with lending partners and equity partners to use the tax credits.
- It does not have an automatic subsidy (e.g., PRAC) provided for the units as an 811 project does and without some subsidy (voucher, DMH dollars, Shelter Plus Care, Trust Fund, etc.) the rent can be over 30% of base income for people on Supplemental Security Income (SSI).
- Until 2010, Missouri did not have a special set-aside allocation for special needs projects and historically, it was difficult for nonprofit “special needs” providers to compete with large development projects favored by municipalities.

As stated previously, however, this is a program that is *changing significantly* and it is definitely worth taking another look at it for the following reasons:

- There are competent and reliable consultants who can lead you through the maze and put together the application package and the team.

- The cost of the consultant is an eligible project cost (with a cap), so if funded, the project pays for the cost. In addition, if your agency is the developer, your agency can be paid through the project for its work as the developer, thus not only covering the cost of your time but creating a fund for potentially developing more housing.
- MHDC, which administers the program, has been going through a sea change in its approach to allocation of these credits and now is clearly on a path to fund a greater percentage of “special needs” projects. Beginning in 2010, MHDC Commissioners, under then Chair, Treasurer Clint Zwiefel, for the first time created a special needs set aside in the Qualified Allocation Plan. MHDC is now encouraging service providers to submit projects under a new special needs set aside (where you compete with other special needs providers rather than the overall pool of developers). In addition, private for-profit developers are being encouraged to work with nonprofit social service providers to create set asides within their large developments.
- As discussed above (in the HUD 811 section) the new Frank Melville Supported Housing Act will offer MHDC the opportunity to participate in demonstration projects involving the use of PRAC (those rental unit subsidies) dollars in combination with the tax credit funding.
- The Missouri Department of Mental Health has recently developed new Medicaid rates to help support services for people needing 24/7 service availability (the third leg of the stool of housing, subsidy and services!)

Because these applications tend to be complicated and time consuming, they are generally better suited for larger projects or in partnership with a larger development. (Note, this has been more true nationally when dealing with larger syndicates; Missouri has actually seen a number of under 20 units projects funded).

Also, because there is a long-term commitment to run these projects, you want to be sure your design is “generic” enough that it could be turned into market rate housing if necessary. This will make it more attractive to your potential investment partners.

**Ultimately, the best reason for participating in this program is that this is the largest fund for creating affordable housing in the state and there is a great need for such housing among our consumers.**

**The above points are the most important things to know about the program—everything else you can learn at the feet of a good consultant—but if you want to know more, below is a brief and simplified overview.**

## *Overview of the LIHTC Program (Low Income Housing Tax Credits)*

The Corporation for Supportive Housing has an extensive discussion of LIHTC at <http://documents.csh.org/documents/ResourceCenter/DevOpsToolkit/UnderstandingLIHTCspdf.pdf>.

Key features of the tax credit program:

- 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 eligible costs which are claimed over a ten-year period (so obviously the 9% credits cover more/most of your costs and are more competitive). In most cases, investors or tax syndicators usually pay this equity amount up front and those funds are used to develop the project.

### *Eligibility*

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
- Be economically feasible
- Balance sources and uses of funds

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.

### *Packaging the Funds*

As noted above, reviewers are looking for applicants that can demonstrate the ability to both use (sell) the credits and leverage the credits with additional fund sources. HOME funds can also be used in your total budget. Timing is important and you may be applying for various other capital funds at the same time you apply for your credits. Granted, this can be difficult to coordinate, but it is not uncommon to have to reapply or resubmit for credits if part of your funding package is not yet in place.

Another source of credits that has been used in the past, primarily in the St. Louis area, is historic tax credits. After 2010, the use of these credits will likely be more limited, but in the past, they have been packaged with the LIHTC to almost fully fund the rehabilitation of buildings on the National Register of Historic Places. Some key aspects of the program:

- Renovation costs must be at least 50% of the acquisition cost
- Plans must be approved by the Missouri State Historic Preservation Office
- The Tax credit may be equal to 25% of the eligible expenses of the renovation

Large urban areas have benefited from this program and when combined with LIHTC some significant developments have been created. The cost of historic renovation, however, may generally be higher than a new build and the combination of LIHTC and historic credits is a difficult sell in the post-2010 climate.



Places at Page in St. Louis is an example of a project that was developed using a mix of LIHTC, Historic tax credits, HOME funds and a range of other public and private funding. The building, built in 1908, was on the National Register and was originally “The Blind Girls Home.” It now provides 23 individual supported apartments (mix of one and two bedroom), common area space for congregative use and office space, and 3 overnight or respite rooms.

### *Corporate Structure and Partnerships*

There are legal requirements for how the ownership and partnerships are structured in a tax credit project. Again, the details of this are best left for your consultant and attorney and there are different ways the corporate relationships between the nonprofit sponsor and the tax credit investors can be organized. Generally, the nonprofit is contracted with to maintain and operate the building and associated services and at the end of the ten-year tax-credit allocation period, the investors' interest in the project is over.

### *Project Sponsor or Set Aside within Development*

Both of these options are available to providers within the tax credit program and as discussed in an earlier section, there is a good case to be made for either approach. Some additional considerations may be:

For the provider to consider before approaching project owner:

- Will your tenants/consumers need on-site services and if so will the owner/landlord make that space available to you?
- Will the mix of your consumers impact the marketing of the units for the owner/landlord?
- What role will you have in tenant selection?
- Will the owner/landlord allow your staff to create eviction prevention plans and work with people who are having difficulties prior to starting eviction proceedings?
- Will you be able to guarantee rent payment through a master lease for x number of units or will your clients rent directly from the project?

### *Benefits to the Owner/Landlord*

- Assistance and support available for consumers of the organization and for property manager—they will know who to call for help
- Higher occupancy, as those units will generally stay occupied
- Extra points or even preferences are awarded for projects working with a nonprofit service provider and in an increasingly competitive climate this can make a critical difference in the success of the application
- Additional gap funding made be available to the developer if a nonprofit serving very low income with special needs is a partner

According to the Affordable Housing Finance publication in their 2011 forecast, national trends are for tax credits to become more and more competitive. Funders will increasingly be looking for developers who have experience and can produce, with the application, a commitment or letter of interest from a LIHTC syndicator.

***One More Reason to Become Familiar with MHDC:  
The National Housing Trust Fund***

In addition to the changing funding environment and new doors opening with the Melville legislation, there is one additional funding stream that will likely be administered by MHDC, the National Housing Trust Fund (NHTF).

The NHTF is:

- A permanent program with a dedicated source of funding.
- A program requiring at least 90% of the funds to be used for production, preservation, rehabilitation, or operation of **rental housing**.
- A program requiring that at least 75% of the funds for rental housing benefit extremely low (30% of area median income) income households and all funds must benefit very low income households (50% or below of median income).

Advocates had tried for years to get this legislation passed and it was finally passed into law in July, 2008. Unfortunately, the financial crisis that followed shortly after that 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.

It is anticipated that when funded, the Fund will bring approximately \$15,000,000 into MHDC in support of the creation of new low-income rental housing. As with other publicly funded programs, the state will have to submit an allocation plan. This link from the National Low Income Housing Coalition provides answers to basic questions: <http://www.nlihc.org/doc/FAQ-NHTF.pdf>

## Federal Home Loan Bank of Des Moines Affordable Housing Program (AHP)

The Federal Home Loan Bank is another **good source of gap financing** for affordable housing projects whether funded primarily through HUD 811 or tax credits.

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 earning 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 last 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](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](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.

## Additional Gap Funding

Providers throughout Missouri have found a wide range of creative ways to finance the gaps in their capital financing.

- Partnering with Church groups or civic organizations
- Corporate or individual donors who would like to participate in a naming opportunity for a room, a wing, a playground, etc.
- Private foundations that fund capital

There are, of course, a number of foundations that have supported projects in Missouri. One that is worth looking into for Missouri providers is the J.E. and L.E. Mabee Foundation. It was founded in Delaware but operates from Tulsa, Oklahoma. It only funds programs in Arkansas, Kansas, Missouri, New Mexico, Oklahoma and Texas. It should be considered as a source for a challenge grant to help finish raising the last bit of money to fund your gap.

Note: It does not provide grants for deficit financing and debt retirement. (If a construction contract has been executed prior to the time an application is to be considered by the Foundation, it will be treated as a request for deficit financing.)

## VA's Homeless Providers Grant

If, among the people you serve, 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

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](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](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](http://www.rurdev.usda.gov/LP_Subject_HousingAndCommunityAssistance.html)

Again, it may also be possible to partner with a developer for set asides in new low income housing projects.

## Other Options for Securing Your Building

Much of the above discussion assumes that the service provider is involved in actually creating or partnering to create the housing. There are other options that have been used to provide a building/apartments/units.

### **Private Acquisition of a building**

It is, of course, always possible for a provider to secure a building through more traditional and less complicated means including:

- Accepting donation of a property
- Use of agency funds to purchase and finance a building

Both options above have warnings associated with them, however.

Often a property owner with a building in disrepair will be eager to donate to a 501(c)(3), as taking a tax deduction and being rid of the property is often easier than coming up with the capital to repair it. Prior to accepting a donation of property it is important to thoroughly investigate zoning and occupancy issues as well as conduct a thorough inspection of the buildings and upgrades that may need to be made. You may find it is not worth your while to accept the donation.

Likewise, if a building is currently even partly occupied you have a moral (and perhaps legal) obligation to help replace tenants before you can use the units.

Certainly there are opportunities to purchase property at below market prices right now. Even at low rates, however, paying off debt with rents collected from very low-income people is difficult. The cost of maintaining a unit *even without a debt load* is conservatively between \$300 and \$400 a month (utilities, upkeep, insurance, repairs security, trash, administration, etc.). To keep rents affordable and under various rental caps, it does not leave a lot of additional room for paying off a mortgage.

### **St Louis Model of Collaboration**

One innovative approach initiated by the City of St Louis Mental Health Board involved a partnership with the St. Louis Equity Funds (SLEF) and the Mental Health Board (a county taxing board for behavioral health services). SLEF made available vacant properties they had acquired to be donated to the project. The Mental Health Board provided this list of properties to providers. In addition, the Mental Health Board made one-time funds available through a granting process to make repairs on the buildings. The service provider organization was then able to put together the housing and service model that would work best for their particular need. Three agencies in St. Louis took advantage of this offer.

## Master Lease Agreement

A master lease agreement is another approach to securing units and is one that has been successfully used by several agencies in Missouri (see section on housing models). The organizations may lease a whole building and then sub lease to the tenants/consumers.

The advantages are significant and obvious:

- Little to no capital expenses
- Fast turnaround to house people since there is no need for construction etc.
- Not the 15- to 30-year commitment required by some public funding

The primary disadvantages may be:

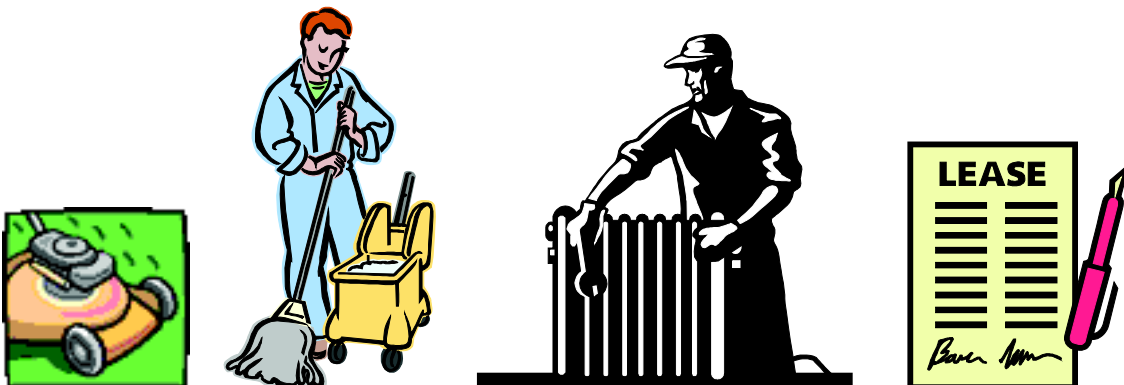
- Lack of ability to restructure or redesign building to best meet service and/or security needs
- Lack of ability to control rent or keep rents low

The primary difficulty may be simply finding an empty building, in decent repair that the owner is willing to rent in a master lease agreement. This may be a good option in smaller communities where there is not the density or volume to support a large supported housing facility.

## Funding Operations

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Now that you have secured financing for your building you need to be able to show you can adequately operate this building over time. Generally, this will have to be part of your application submittal when you apply for your capital financing.



Operation costs are those expenses that come with the operating and maintaining of your property. It could include such things as:

- Utilities
- Insurance
- Costs associated with management (rent collection, processing applications, audit, etc.)
- Security (e.g., alarm service)
- General housekeeping services
- Maintenance and repair
- Preventive maintenance (tuckpointing, scheduled painting, carpet replacement, etc.)
- Property tax (depending on how your building is funded, it may be owed by a for-profit partnership )
- Allowance for depreciation or reserves

As discussed previously, conservatively these costs will usually average from \$350 to \$400 a unit. There may be some small savings found by operating larger buildings with more units. *Remember, this is without including a cost for debt or mortgage.*

In market rate housing, the owner or landlord raises the rent to a level to cover all expenses and also show at least a small profit. In affordable, supportive housing where tenants are on very limited and fixed incomes, this is generally not an option, so operators of supported housing look for other ways to subsidize rents.

There are three broad categories or ways of looking at subsidies:

1. Rent subsidies that are attached to the project. ( HUD 811 is an example: PRAC comes with the project, when the person moves, they lose the subsidy)
2. Subsidies that the tenant brings with them. (Shelter Plus Care would be an example of a voucher that the tenant acquires and then brings to the project. Likewise it goes with the person when they move and does not stay with the project.)
3. Subsidies that the sponsor of the project controls. (The subsidy is “moveable” and can be used to subsidize any unit the sponsor owns or controls; grants to the organization might fall into this category)

## Sources of Operating Support

Aggressively looking for operating support or subsidies will be important in order that:

1. You can provide housing for those with very low incomes
2. You do not have to use agency or T1 dollars that need to be used for services.

Some of the same funding streams that helped pay for capital financing are also resources for operating subsidies:

### **HUD 811 and 202**

As previously discussed, if you successfully received funding for an 811 or 202, a housing subsidy (PRAC—Project Rental Assistance Contract) is a part of that project award. Again, many providers find this a great program because the subsidy is ongoing. See pages 36-40.

### **HUD Supported Housing Program**

This program is administered through your local Continuum of Care, and operating support or rental subsidies are legitimate activities. As with any competitive granting program, these funds are not guaranteed except through the time of the grant (generally three years). See pages 42-44.

### **MHDC Housing Trust Fund**

This is a competitive grant process renewed annually. See pages 44-52.

The above programs are examples of operating support that come with the project or to the sponsor.

**Other sources of operating support funded through HUD include:**

### **Section 8 Housing Choice Voucher Program**

This is the largest sources of rental assistance in the country. Section 8 is administered by the Local Housing Authority (LHA) in your area. The subsidy may be voucher-based or tenant-based. The LHA has some discretion in how these vouchers are used in that the plan they create does not have to include project-based vouchers and, if it does, it can be no more than 20% of the total.

The LHA, however, has some flexibility in how they use the project based vouchers, so it is always a good idea to develop a relationship with your LHA to see if any of the vouchers can be directed towards your housing program.

The Section 8 tenant-based voucher, in many communities, is in great demand. In some areas, people cannot even get their names on a waiting list because the list is so long that it is closed

except for brief periods of time. As a part of a long-term housing plan, however, it may be good to help some of your consumers to get on this list so that they have more flexibility and choice in their future housing plans.

The Section 8 Program has had considerable changes in regulations over time and one place to track these changes is the National Housing Law Project <http://www.nhlp.org/html/sec8/index.htm>.

## **Shelter Plus Care**

This HUD program provides rental assistance to individuals who are homeless and have a disability (shelter) and must be associated with a service provider (plus care). Typically, the resident pays no more than 30% of their income towards rent and the Shelter Plus Care voucher pays the rest up to a cap. The Shelter Plus Care cap is generally higher than that used in some regions for SCLP subsidies.

This program has been used widely in Missouri and in particular the Department of Mental Health has been very active in securing funds for Missouri. The DMH housing website <http://dmh.mo.gov/housing/ShelterPlusCare.htm> provides lots of good information and contacts about the program in Missouri.

Grants are available for up to five years and can fund four types of housing assistance:

- Tenant-based rental assistance (similar to a voucher where the subsidy is with the individual)
- Project-based rental assistance which is linked to a particular building and the contract is with the building sponsor
- Sponsor-based rental assistance where the contract is with a nonprofit agency
- SRO-based assistance and the contract is with a public housing authority.

If you are planning to develop a housing project specifically for people with disabilities who have been homeless, it is worth considering applying for project-based rental assistance through this program. To understand more about this program see <http://www.hudhre.info/index.cfm?do=viewUnderstandingSpPolicy>.

Some individuals at times encounter difficulties finding a landlord who will accept them and the voucher. See Appendix C, “Working with Landlords.”

## **Public Housing**

HUD provides federal aid to local housing authorities that manage housing for low-income residents at rates that are below market rate housing. Eligibility is based on annual gross income

and immigration status. Some communities have public housing developments that are specifically for people with disabilities or who are elderly.

While at times stigma has been associated with public housing, the experience varies widely from one community to another. In particular, some of the projects that are for elderly or disabled have not had the troubled histories that some family projects have had. It is clearly worth knowing about projects in your community as a source of affordable housing for your consumers. In some cases (as with New Horizons in Jefferson City), it may even be possible to negotiate arrangements with your local Housing Authority allowing on-site services to be made available to residents in a specific number of units.

The link to Housing Authorities in Missouri is  
<http://www.hud.gov/offices/pih/pha/contacts/states/mo.cfm>

## Supportive Services

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Supportive housing is generally considered that combination of affordable, decent housing combined with the services required to help the person live successfully in the housing of their choice.

Supportive services are what put the support in Supported Housing. There are many different ways to provide the services and many different levels of services required. There is no one-size-fits-all formula and services should be flexible and individualized as much as possible.

In Part II of this manual, you will see a wide range of how services are provided. Some of the staffing models include:

- 24/7 on-site staff with structured program with individual daily schedules, strong focus on skill building, symptom management, and transitioning to more independence. There may be groups held on site.

- 24/7 staff available on-site for emergencies, assistance with medication and community support services provided by off-site staff.
- Staff on-site overnight and evenings and community support services provided during the day by off site staff.
- No on-site staff and community support services provided in the community and on-site as appropriate

Even within the different models, there are variations in building design and structure based on the level of “oversight” or security that is indicated. Some buildings have a locked and controlled single entrance and others have separate access to individual units.

The key, of course, is to work with each consumer to create the array of services that will help them be most successful in their own recovery, and that includes housing.

## Service Array

The services needed are often the same menu of services whether the person is living in completely independent housing or living in housing with on-site supports. Those services, typically, include assistance with and support for:

- Coordination of all psychiatric and primary health care
- Assistance with understanding and implementing a health and wellness plan, including medication management
- Case management—linkage to other services, entitlements
- Money management and budget planning
- Supportive counseling
- Illness management (understanding the illness and developing coping techniques)
- Recovery plan (working on things like school, employment, community involvement, regaining custody of children and parenting skills)
- “Activities of daily living”—cooking, cleaning, shopping, arranging and using public transportation
- Social skills and interpersonal relations, developing a support network and community

## Locus of Services

Clearly all of these services can be and are provided to consumers by staff who are based off-site from the consumer’s home. In an earlier section, we discussed some of the clinical or programmatic reasons that services might be provided on-site in semi-independent or clustered

apartment settings. There are also financial reasons why this approach might be the best for some people. For people who need high levels of service or 24/7 availability to feel or be safe, it is generally not feasible to provide this in completely independent apartments as the per-person cost would be so high that few people could be served effectively. So in order to assist people with high service needs to live as independently as possible, providers have developed this range of supportive housing models.

It should also be noted that some individuals want to and prefer to live in settings where they have the option to be with friends or to keep to themselves in their own apartment. Many of the housing models we have looked at give people the best of both worlds—independence and community. The key is that they choose when and how much they want of each.

## Paying for Services

There are two broad ways to look at how the on site services are funded and there are examples of both in this manual:

1. service dollars attached to the individual (e.g. Medicaid funded CPRP)  
(Note: Medicaid pays for medically necessary services – not for rent or food costs)
2. service dollars attached to the program or the housing (grants)

And, of course, you can always do a combination of both—core services provided through CPRP and non-covered services or non-eligible people covered by grants.

## **Paying for Services through Individual Funding**

Advantages:

- The advantages of having funding (like Medicaid/CPRP) that follows the person is that it generally is more sustainable and permanent and not dependent upon a grant renewal.
- It also means that the person is not “stuck” in the particular housing or residential program in order to get services since the service funding follows the person.

The disadvantages include:

- The individual must be eligible and enrolled in both Medicaid and CPRP. This may put some limits on who you serve. For example, if you want to serve young adults experiencing early signs of a mental health disorder, the more successful you are in helping them maintain good functioning, the less likely you are to be able to enroll them in the programs that will fund your services.

- Another difficulty with per unit service reimbursement based on minutes or hours is that it is difficult to fund positions for 24/7 availability. It makes no sense to force services on people that they don't need just to create a reimbursement and funding stream.
- It can be difficult to create an annual staffing budget based on a changing service level or service need. For example, if you know you need 5 full-time equivalent employees (FTE) to appropriately staff your facility and your reimbursement is based on 15-minute units, there is a disincentive to have people move towards independence and use fewer services.

**The good news is that Missouri has created some new service definitions and rate structures that will help address some of the problems mentioned above and this will be discussed in another section.**

Many providers have combined different funding streams to successfully offer core services (mostly Medicaid CPRP), supplemented by other grant funding so that there is flexibility in who is served and how. (One other advantage of grant funding is that less of your allocation and match is used to provide services.)

## **Grant Funding Available for Supportive Housing Services**

Previous sections on funding capital and operating addressed a number of HUD programs that can also provide supportive services.

### ***HUD***

#### ***Supportive Housing Program (SHP)***

This program is administered through a regional Continuum of Care process and can be used to fund on site supportive services.

- 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.

### ***811 and 202***

Your budgets for your HUD 811 and 202 projects can include some funding for a service coordinator.

### ***HOPWA***

Housing Opportunities for People with Aids is another federal program which can be used, in addition to rental assistance and direct housing aid, to pay for supportive services on-site. We know that people with serious mental illness and substance abuse disorders are over represented

among people living with AIDS. If your housing program will serve people with AIDS as a priority population, you may be eligible for HOPWA funding. The HUD website states:

“An essential component in providing housing assistance for this targeted special needs population is the coordination and delivery of support services. Consequently, HOPWA funds also may be used for services including (but not limited to) assessment and case management, chemical dependency treatment, mental health treatment, nutritional services, job training and placement and activities of daily living.”

### ***Department of Health and Human Services***

#### ***Projects for Assistance in Transition from Homelessness (PATH)***

This formula grant program supports service delivery to people with serious mental illness and/or substance abuse disorders who are homeless or at imminent risk of homelessness. In Missouri, the program is administered through the Department of Mental Health. Many of the services that people may need in supportive housing are also eligible services through PATH funding. The Department of Mental Health provides information on their website: <http://dmh.mo.gov/docs/mentalillness/servicedefinitions.pdf>

#### ***Transitional Living Program for Older Homeless Youth (TLP)***

TLP helps support projects that provide long term residential services to homeless youth (ages 16 to 21). The housing may be in group homes, supervised apartments owned by an agency or apartments rented in the community. Eligible services include a wide range of support, case management, and care coordination. There is a focus on skill building and competency and leadership skills. The program is administered by the Family and Youth Service Bureau of HHS and funding announcements are posted on Grants.gov website.

### **CPRP Medicaid Funded Services**

As we have seen in the description of different program models already in existence in Missouri, the CPRP community support services are often used as the core clinical and rehabilitative service category to help support people in independent housing.

For people living in independent apartments, whether agency owned or in other community housing stock, this is the most applicable billing category to fund the range of individual services people need to be successful in the community.

Experience has shown that some individuals, for some period of time, may need more service or support than can effectively be provided by off-site staff. In addition, sometimes the support needed is not the kind of targeted intervention provided through community support services.

- It may be that some individuals simply need a person present to help reduce anxiety around living independently.

- Other people with active symptoms may benefit from being able to do reality testing or obtain regular support from staff on-site whenever needed, including over night times.
- Other individuals (either because of impaired functioning or long years of institutionalization) may need regular assistance with activities of daily living (cooking, cleaning, personal care).
- Some people benefit from a person available around the clock to assist with medication administration.
- People with a history of losing housing due to letting other people move into their apartments often want and need a “buffer,” someone who can help them say no to unwanted or unhelpful visitors.

For all of these reasons and more, some providers have created programs where there is a range of on-site staff available. Availability runs the gamut from:

- Staff on-site 24/7
- Staff on-site during the day
- 2 Shifts covering early morning through late evening
- Community support staff in and out of the facility during the day and overnight staff on-site

As with any good programs, the type, level, and scheduling of staff is directly linked to the specific needs of the people served in a specific setting.

Until recently, providers have struggled to find ways to pay for “availability” and have used many creative ways to provide this service. With new service codes created by DMH in FY2011, however, there is much more support for providing these on-site services.

**It is exciting and encouraging to think that people who, in the past, were not able to live independently because the right amount of support was not available, may now have the opportunity to live with dignity and choice in their own apartments.**

**The new service codes were designed to cover those services provided (mostly on-site but also in the community) to those consumers who need high levels of support and staff availability to be successful.**

There are three different tiers of Intensive Community Psychiatric Rehabilitation in Specific Residential Settings (I-CPR RES) available to fund this support. These services are billed through a day rate. (See Appendix E for definitions and tiers.)

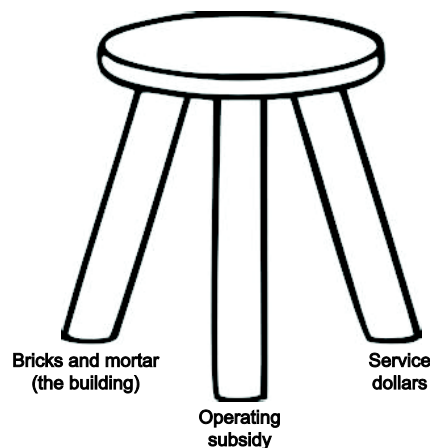
In real terms, who are some of the people who can benefit from this change?

- People living in RCFs, psychiatric group homes or other institutions because they need help managing daily medications, activities of daily living or who have extreme anxiety about living on their own
- People who are currently homeless with a history of losing housing because of poor judgment around visitors
- Young adults aging out of foster care but needing additional support before living on their own
- People with co-occurring disorders who needed extra support available 24/7 to avoid relapse or to stay safe.

Providers now have the service codes necessary to arrange and design the right level of service to meet the needs of all of these individuals.

# chapter 5 Putting It All Together

Supported housing is like a three legged stool— all three legs are necessary to make it stand.



So far, we have identified a range of resources and funding streams available to help pay for the three elements necessary to make a successful project: the bricks and mortar, the operating support or subsidy, and the services available to the residents.

Unfortunately, these resources do not always come in nice neat, readily available and sufficient packages. Some require long-term planning. For example, we discussed the HUD 811 and 202 projects which provide the core of two of the “legs” of the stool—the bricks and mortar and the subsidy. It is a wonderful resource but it generally takes two to three years of planning and implementation to complete a project. **But that is no reason not to start. In fact, it is the very reason to start immediately!** In this third chapter, we will present a variety of scenarios combining different combinations of the three legs of the stool and giving examples of how shifting funding can create new opportunities.

**The creation of the new Medicaid CPR-Res services, will allow providers to replace T1 (unmatched) state housing dollars with the new Medicaid billable services, stretching the available dollars by bringing in federal match.** Providers who have been funding on-site or 24/7 staffing in their residential facilities with T1 dollars can now make better use of those dollars by using them for match against the new services. This will “free up” dollars that can now go to further expand residential services and programs.

The Department of Mental Health is working with providers to give them the flexibility to create new programs with this previously encumbered T1 money (dollars used for rental subsidies or funding on site residential services). This new opportunity gives providers yet another compelling reason to develop housing and housing subsidies using some of the resources listed in the document. Every time a new housing voucher or HUD 811 rental assistance program is created or secured for a consumer who had been relying on T1 dollars, it will free up those T1 dollars to move from a “housing pot” into a “match pot” and create new services or expand current services.

Please remember: The fiscal strategies described all rest on the assumption that **Medicaid funds medically necessary services**, not “bricks and mortar,” rent, or food. What is being accomplished with the new fiscal strategy is changing the categorical nature of how the department previously managed the SCL funds.

## Mixing and Matching

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Let’s start with some disclaimers and some assumptions.

**Disclaimers** first—these “scenarios” are examples of a **process** that can work. It is impossible to give a recipe because there are so many variables in each case, with each provider and in each region. The broad variables, of course, have to do with:

1. People served and the level and type of staffing needed
2. Availability of subsidies and buildings and housing resources
3. Access to and amount of T1 dollars

The other big variables have to do with the individual agencies:

1. Expenses will, of course, vary based on salaries within an agency.
2. Unit costs to deliver services will vary based on agency size, volume and overhead costs assigned to services.
3. Amount of allocation currently matched.
4. Amount of service provided to eligible people over and above your allocation.

Now some of the basic (and probably obvious!) **assumptions** being made are:

1. Most people (but not all) being served in supportive housing will have an income of base SSI of \$674. This means that, to be considered living in affordable housing, their share of rent would be \$202 a month or 30% of their income.

2. Rents and rental caps vary throughout the state. In some parts of the state, the SCLP cap is significantly lower than Fair Market Rent rate (FMR). We can assume, however, that \$400 a month is a base amount necessary to rent and pay utilities for a one bedroom apartment. For projects developed recently, with no debt carried, this is the minimum cost of insurance, maintenance, utilities, repairs, etc.
3. Using figures from 1 and 2 above, we can assume an average subsidy for one person needs to be about \$198 a month.
4. The cost of providing 24/7 on-site services in a residential program will generally break out to about 5 FTEs, allowing for sick, vacation, holiday time and a little overlap in schedules. If your base salary is \$26,000 a year with 20% for benefits, etc, your annual cost is \$156,000. You can add in 10% administrative costs and come up with a figure of \$171,600. (This is an area where provider costs will vary greatly.) There are, of course, many variations possible here, as well. For example, if you are only providing coverage for two shifts (6 a.m. to 10 p.m.) your cost will be 2/3s of the above or \$113,256.
5. The total cost of providing 24/7 coverage will be the same whether you are serving 4 people or 15 people but the per-person cost will be less the more people served. If your 24/7 coverage is spread over two apartment buildings with 14 people in each, your cost is even less!
6. Use a figure for FY12 of a rounded off amount of 36% state and 64% federal share to figure share of match needed for Medicaid services provided on-site.
7. The average SCLP/ T1 contribution for a person living in an RCF I around the state is about \$50 a month. If it is a provider-run RCF with additional services, the additional SCLP contribution may be higher.
8. Finally, this assumes there is a need in your region for specialized supported housing—housing that is affordable, independent and offering intensive and flexible services.
9. This does not take into account spenddown and non-Medicaid individuals.

So with all these disclaimers and assumptions laid out, let's work our way through some different scenarios. The goal of these scenarios is to identify ways we can use the new flexibility with T1 dollars and new service definitions to create opportunities for people who many need additional or on site support to live in their own apartments.

*Note: The new Medicaid billing mechanisms for types of residential support must all be matched appropriately to the treatment plans of the person served. As you review the sample scenarios, assume that step has been taken.*

## Scenario 1: “Ideal Conditions”—Converting T1 Dollars to Support New Services in HUD 811 Project

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In this *hypothetical* situation, Provider A has just completed a HUD 811 project. This new building will have 12 one-bedroom apartments with space in the facility for congregate gatherings and staff offices. Since this is an 811 project, the rental subsidy is a part of the project. Provider A now has “two legs of the stool” and needs the third leg, the service dollars to pay for on-site staff.

In this “Ideal Condition” scenario, the provider also operates a psychiatric group home using T1 dollars to help pay for enhanced and additional services offered in the group home. In the new 811, Provider A will be serving people moving from RCFs who require 24/7 on-site staff.

The current group home serves 14 individuals with an average T1 contribution of \$700 per person per month or \$117,700 a year.

The goal now is to convert those T1 dollars to a service match, some staying with the current group home to cover services there and other dollars “freed up” to be used as service match in the new HUD 811.

### Step I: Converting T1 Dollars to Service Match in Current Facility

One of the new service definitions, billed at a day rate, is the I-CPR RES/IRTS (I-CPR Services in an Intensive Residential Setting). The rate for this service is \$230.15 a day with \$199.54 a day going to the provider.

Assuming that Provider A must bill a total of \$117,700 a year to bring in the same amount of revenue as currently, a total of 590 days a year must be billed at that day rate. For a group home with 14 individuals, this breaks down to about 42 days per person per year billing at the day rate.

### Step II: Using Remaining Dollars to Create New Services for More People

Using the Missouri Medicaid match rate of 36% state and 64% federal, we must use 36% of the \$117,700 towards match for current group home. That new amount needed for the group home is \$42,372.

This leaves \$75,328 available to use as service match in the new HUD 811 supported housing facility.

What will the actual cost of on-site services be in the new facility? Let us assume 24/7 staffing at the pay rate described previously. That cost is approximately \$171,600 a year. 36% of that

required for match is \$61,776. In this ideal scenario, then, the money “freed up” to use as match is more than sufficient to provide 24/7 on-site services for people moving from congregate or residential care facilities.

For this setting, the appropriate Service Code might be I-CPR RES/CA (I CPR Services in a Clustered Apartment Residential Setting). This rate is \$219.09 a day with \$189.95 paid to the provider.

To draw down \$171,600 a year in billing, the day rate would need to be billed 903 days a year in total or 75 days per person a year (6.2 days a month).

If, however, the residents of the new apartment building primarily need assistance with activities of daily living and medication administration, it may be the building would only need two shifts of staff instead of three, further reducing costs and amount of match needed.

In addition, if you are moving people from RCFs each with a \$50 a month T1 subsidy, you have also just freed up an additional \$7,200 a year that can be used for match.

Obviously, as stated above, this is a dream scenario for Provider A and for most providers the timing may not be so perfect, so let’s look at some other possibilities.

## Scenario 2: Converting T1 Dollars to Support Housing without Subsidy

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In another hypothetical situation, Agency P will convert T1 dollars to support housing that does not have a subsidy attached and that has a shortfall for services (less than ideal conditions). Agency P has a Psychiatric Group Home serving 12 people with a T1 subsidy averaging \$541 a month or \$72,000 a year.

To stay whole at \$72,000 a year, Agency P needs to draw down that same amount of dollars by billing 361 total person days at I-CPR Res/IRTS level of billing (provider day rate of \$199.54) or 2.5 days per person per month. This will require \$25,950 a year in match.

We started with \$72,000 a year to provide these on-site residential services. Now we only need \$25,950 leaving us \$46,050.

Agency P has a new apartment building financed with low-income housing tax credits. The building has 23 units for people who want to live independently but need the availability of on-site supports. Some of the units are two-bedroom so there may be 27 individuals at this site.

Using the previous formula for providing 24/7 service availability, we determined that it would take \$61,776 in match to cover the cost of providing that service. So in this case, we may have a

shortfall, plus we have no subsidy attached to the building and residents cannot pay the \$400 a month rent without assistance.

So Agency P has one leg of the stool—the building— and a portion of the service leg! What are the options to create the third leg and fill in the service leg?

Looking back at the resources outlined in a previous section of this manual, there are a number of possibilities to consider.

## Operating or Rental Subsidies

- If some of the residents moving into the new building are coming from homelessness, they may be eligible for Shelter Plus Care vouchers.
- Likewise, if some of the units are set aside for people with mental illness who are coming from homelessness, your local Continuum of Care SHP may be an option for subsidizing your operating costs.
- The MHDC Affordable Housing Trust Fund grant process is another option for rental subsidies.
- If some of the residents of the new apartments are moving from a hospital “redirect” slot, there may be additional resources that follow the person.
- Some residents may be individuals already in your program, in an SCLP housing slot (receiving rental subsidy) but need more support to remain living in an apartment. In this case, the subsidy or slot they bring with them can help support the rent in the new building.
- If you are able to help other people served through SCLP subsidies move into subsidized housing or acquire other kinds of vouchers, you will free up SCLP/T1 vouchers to support people in this facility.
- You can create your own operating trust fund through private fund raising or partnering with private donors who want to help support this project.

Clearly, it would be much simpler if subsidies were attached to the building or the project. Without an operating subsidy attached to this project, you will have to be more creative and clever but it can be done. **Because of the new Melville legislation referenced previously, it should soon be possible (in 2012) to combine 811 subsidy dollars with a project like this and this hypothetical agency would surely do this.**

## Funding Services

We previously determined that the match required for 24/7 services was \$61,776 and new match available to us from T1 conversion was \$46,050, leaving a shortfall of \$15,726. As with the

operating subsidies, Provider P may have to be creative and combine a number of different service funding resources or even consider some kind of restructuring of staffing patterns.

## **Resident Linked Service Match Possibilities**

As with operating subsidies above, it may be that this setting would be appropriate for individuals coming from long term state institutions and **service dollars** would follow them.

Another consideration may be that some of the new residents may be people who have been living independently but their needs are so great that they are requiring very high levels of community support services. By moving them into this setting, their community support needs may go down, freeing up match for the on site services.

## **Hospital Redirect Funds and 3700**

In some parts of the state, allocation was made available to help create plans to address closing of acute care facilities. Clients identified for the 3700 process<sup>2</sup> essentially bring their match with them. In both cases, it may be that there are people who are high users of services who may benefit from a safe, independent apartment with on-site staff and that new allocation or match can be targeted for the on-site housing services.

## **Restructuring Staffing**

If there is space in the building appropriate for office staff, it may be possible to “office” community support workers on-site who serve people both in the building and in the community, creating a presence during the day and then only have the front door or “concierge” staff there for shifts off regular business hours, reducing the total staffing and service cost.

## **Grant Funding**

Understandably, providers are often reluctant to develop programs based on time-limited grant funding. A three-year contract or grant with a local SHP Continuum of Care or other funder, however, may be a way to begin the program while working with your funding streams to put together your whole service package.

Again, the point of this is that providers now have the flexibility to be creative. That is what it will take, but it is possible!

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<sup>2</sup> People identified as high users of medical services, who have a diagnosis of mental illness, but who are not engaged in ongoing care.

## Scenario 3 Creating Housing and Services with No T1 Dollars to Convert

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In this scenario, the provider has no T1 dollars used for services to convert and no agency developed housing with subsidies (no storm at all) but the provider does have T1 dollars subsidizing private rent for current clients.

While this scenario is more challenging, there are still opportunities to be creative. It may take longer to implement a plan but, again, all the more reason to start now!

As with all other situations, there are so many variations by provider and by regional resources that it is not possible to give a formula that will work in every case. There are, however, steps to take and options to investigate.

As always, let's start with the easiest picture possible. Provider NS (no storm!) has been providing "charity care," providing billable services to Medicaid-eligible individuals over and above their match capacity. Let us do the following:

1. In this case, let's assume the value of charity care to eligible clients is \$100,000 and you are reimbursed for none of that.
2. The cost of providing this care is already being covered in your budget, so there is no new expense involved in this process.
3. It takes approximately \$36,000 of match to provide that care.
4. You should move \$36,000 from T1 money into your match, bill the \$100,000 worth of services you are providing.
5. From the \$100,000 you are now able to recoup, you have the following:
  - a. \$36,000 in match used
  - b. \$36,000 paid back out in rental subsidies
  - c. You now have \$28,000 to use in housing support or other services. If that is matched it becomes \$77,777 in potential service dollars.

### What Can I Do with \$77,777 in Service Billing and No Rent Subsidies??

Depending on who you want to serve and what they need, there may be a number of things you can do.

- Negotiate with a local Public Housing Authority for 6 to 8 set asides, depending on their occupancy.

- Identify 6-8 people in RCFs who qualify for and would like to live in Public Housing but have needed additional help with medication management to live independently.
- Since the housing is subsidized, your only need is to provide the service dollars, not the operating dollars.
- Most Public Housing buildings have overnight security on-site so you may only need to provide 2 FTEs to be on site to assist with ADLs and medication monitoring in addition to the community support provided. It may make sense to use 1 FTE and cover the other hours with part-time staff.
- You can draw down your \$77,777 in service dollars by billing a total of 410 days a year at the CPR-RES rate for clustered apartment. If you are serving 7 people this is about 5 days a person a month. (These numbers are all rounded for purposes of these examples.)
- In addition, there was approximately (based on state average) \$600 annually a person in T1 dollars subsidizing the RCF cost so you can add another \$4,300 to your match pot to cover additional service costs as needed.

You have just helped 7 people move into more independence with no new money.

If there are no vacancies in the Public Housing in your region, there are frequently other subsidized properties you may want to investigate.

- MHDC.com has a list of affordable housing developments, some of which contain subsidized units.
- Contact housing developers in your region. There are often apartment complexes with some units being subsidized and with enough turnover that a developer might like the idea of partnering with a service provider to have more support on site and keep units filled.
- Contact the DMH housing staff for help in tracking down potential developer partners or subsidized units in your region.

**You have no T1 service dollars, your allocation is all matched, you are billing the amount of match available to you and no more.**

What does the new flexibility with dollars and new day rates allow me to do?

This scenario is obviously the hardest to work with and there may be little that you can do right now except plan.

The first and most obvious review that should take place is a determination of what other subsidies, vouchers, or other affordable housing opportunities exist in your region that would

work for some of the people currently being subsidized by T1 dollars—since freeing up those dollars would begin to create some capacity for new programs and services.

The next step might be to review your options for future developments.

Do you want to apply for 811 project funding?

Do you want to partner with a developer who is building a low-income housing tax credit project and can give you some set asides within the project?

Have you looked at the possibility of purchasing foreclosures or houses or multi-family buildings selling for much below market value? Prices are low and interest rates are low. You may be eligible for a waiver on property tax further reducing your monthly mortgage and expense cost.

Consider other consumer run options like Fairweather Lodge or Oxford House models for people actively working towards recovery. Both models are based on mutual and peer support. The Fairweather Lodge model generally also incorporates a commonly owned business enterprise as well <http://thecccl.org/FairweatherStandards.htm>.

The Oxford House model has a focus on people recovering from alcohol and drug addictions <http://www.oxfordhousemo.org/>.

## Summary

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The necessary first step in all of these plans is the commitment and belief that people, even those with serious psychiatric disorders, have a right to a quality of life that involves independence and choice. While these are difficult economic times, changes in the low-income housing tax credit program and the HUD 811 program along with new flexibility provided by the Department of Mental Health offer opportunities never before possible for Missouri providers to actively create new and exciting housing opportunities for people we serve.

## References

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# Missouri Models in Housing Design and Services

*Note: The housing models described on the following pages were obtained through phone and in-person interviews with individuals at each project and may not include complete descriptions. Agencies should be contacted individually for additional information. We apologize for any inaccuracies that may exist in the documentation the information.*

# SRO with On-Site Supports | **2 models**

The staffing and design of these two projects are similar but the focus and the development history are unique to each and each represent different approaches and lessons learned.

## Rosati Apartments: A St. Patrick Center Housing Program, St. Louis City

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### Overview

In October 2008, St. Patrick Center and Catholic Charities opened the Rosati Apartments, a 26-unit apartment complex that provides permanent supportive housing for people with a history of mental illness. Each unit is a self-contained, efficiency-style apartment, with a sitting/sleeping area, eat-in kitchen and private bath.

The building is staffed 24 hours a day by a “front desk” person who is available to provide support to the residents as needed and to help “monitor” visitors in order to help residents be safe.

Fourteen of the units are reserved for people who are former residents of the St. Louis Psychiatric Rehabilitation Center (SLPRC) and they receive case management provided by off-site workers from other agencies. The other 12 units are reserved for other St. Patrick Center clients with a history of homelessness and co-occurring disorders. They receive case management and community support services from the Rosati multi-disciplinary team including a Team Manager, nurse, substance abuse counselor, and a Financial Stability Counselor. This blended model has a real advantage in that funding from the SLPRC redirect can provide on-site staff which is a benefit to all residents in the program.

Rents are subsidized by a combination of site-based rental assistance through the 811 program and local HUD Supported Housing Program funds. (See Chapter 4 in Part I, “How Do I Pay for It?”)

This model combines independence and choice with on-site supportive services.

## Development Process

St. Patrick Center is a homeless services provider. In discussing the reasons for developing this project, Greg Vogelweid explained “The motivation is the recognition that the myriad of support services offered are much more effective when the client has a stable housing situation.”

## Strategic Planning

The first step in this process was a major change in philosophy to move from being a “homeless service provider” to being a housing provider. In 2006, the Board of Directors of St. Patrick Center created a Strategic Plan which called for the development of agency-owned housing with on-site services. This was an important and necessary first step before the staff could move forward with approaching potential funders. Funders (public and private) want to know that the Board is behind an initiative like this and that this is consistent with the way the organization plans to deliver services in the future.

## The Team

Once a decision has been made to develop housing, one of the first questions to ask is who are our partners? Will the mental health/social service agency be the developer and owner or will we partner with another organization to be the housing partner and we become the service provider?

For this project, the Board and leadership of St. Patrick Center decided that the Center would be the owner and developer but would engage the help of experienced development professionals. This proved to be a wise move because the funding model they created was unprecedented and controversial.

## Development Funds

St. Patrick’s Center created a revenue plan that include funding from the HUD 811 program as well as from the Low Income Housing Tax Credit (LIHTC) program administered by MHDC.

Through the 811 Program, HUD provides funding to nonprofit organizations to develop rental housing with the availability of supportive services for very low-income adults with disabilities and provides rent subsidies for the projects to help make them affordable.

The LIHTC Program provides tax credits which can be used by equity partners (for-profit entities which can purchase and use tax credits).

The dilemma faced by this project was, however, that HUD 811 and LIHTC funding can not be blended in a project.

St. Patrick's Center, working with their consultants and attorneys and the local HUD office thought they had found a solution in the way of having two separate corporations for each funding stream. As it turned out, this was not acceptable either. The final solution: one corporation was created to own the project, but individual apartments within the project were either designated as HUD apartments or LIHTC apartments. Their expenses and use was tracked and reported on separately.

As with most HUD 811 and LIHTC projects, there is always a need for "gap" funding to complete the project. For the Rosati Apartments, that gap funding came from a Federal Home Loan Bank grant, funding from the Missouri Affordable Housing Trust Fund, and an Enterprise Foundation Green Grant.

## Funding Operations and Services

The 811 Project allows for including some level of operational support in the budget including coordination of supportive services.

For those residents of Rosati Apartments who had moved out of the St. Louis Psychiatric Rehabilitation Center, there was a separate contractual arrangement with DMH to support the on-site services. Other residents' services were funded through the City of St. Louis (HUD) Supported Housing Program grant.

## Lessons Learned?

- When designing the space, get as much input from staff as possible.
- If we had to do it again, we would make some design changes including more one on one meeting spaces, a library or quiet lounge and more "back of the house" space for staff.

## What Could DMH Do to be More Helpful in Encouraging Housing Development?

- It would be helpful if DMH would identify particular needs of the community and start a dialogue with agencies to meet these needs.
- A unified funding stream for both operations and services would be very helpful, particularly in longer contractual increments. This is especially important when working

with programs like the LIHTC that require investor partners who want to be certain that there will be cash flow over the entire period of their investment.

## Next Step

St. Patrick's Center is discussing the pros and cons of being the project developer on future projects or to find/create a housing development corporation and only be the service provider. One consideration is that when creating these projects, a developer's fee is an allowable expense. Agencies like St. Patrick Center can take that developer's fee and use it as start up for other projects.

## CJ's Place: A Project of Places for People, St. Louis City

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## Overview

CJ's Place is an 18-unit SRO (single room occupancy) with on-site supports 24/7. This project was designed primarily to create safe, supportive housing for people with a history of mental illness, addiction, and homelessness or frequent evictions. The project was built in partnership with Doorways Interfaith Housing, an HIV/AIDS service provider.

Each unit is a small efficiency-sized apartment with kitchen and private bathroom. There is a common area with lounge, pool table and small kitchen. There are two additional rooms for staff and office space as well as storage and utility areas.

This project represents the evolving programs and philosophy of Places for People in working with people with co-occurring disorders. In the 1990s, Places for People participated in a federal grant demonstration project that provided outreach to people who were homeless with untreated mental illness and addiction disorder. The study was looking at the benefits of the primary

mental health provider offering integrated treatment over a more traditional broker model for the addiction services. In the process of working with this grant, staff of PfP soon noted several things:

- Safe and decent housing was key in helping people get into recovery, staying safe and improving health.
- People with long standing addiction disorders do not all move into full recovery quickly. Addiction, for many, is a chronic relapsing disorder.
- Many residential program options were intolerant of relapse or people in early (pre-contemplative) stages of recovery.

Another important fact, that in retrospect seems should have been obvious, was that the most common cause of eviction and losing housing for many people with co-occurring disorders was “traffic,” frequent and many visitors. Generally, this traffic was related to the use of illegal substances. People who had been homeless themselves were often particularly vulnerable to the plight of other friends who needed housing. They were lonely, early in their recovery and had a difficult time saying “no” to their old friends.

A quick review of literature and other national models as well as conversations with consumers convinced staff of PfP that there was a need for a housing model that provided:

- High support, low demand or structure
- Independence and choice
- Security
- Support for recovery within the framework of a “stages of change” approach—in other words, a recognition that for some people who are pre-contemplative or contemplative, safe housing is a necessary pre-condition for helping them to stay safe and move forward in recovery.

In the process of our researching best housing practices, we learned about the concepts of stages of change, harm reduction, and wet/damp/dry housing. We saw that other agencies were having success in helping people recover with a housing first approach. We determined that we needed housing for people who were not ready to commit to abstinence but who were willing to make some small changes to make their lives better.

## Gaining Support

The staff of PfP recognized that there were a number of aspects to the proposed project that could be controversial. During the time of the “paradigm shift” from a continuum of care to a supported housing model, there was little to no support for provider-owned or congregate

housing or even for housing with on-site supports. These models were often described as stigmatizing and creating “mental health ghettos.” The other side of that argument, however, was that rarely does “one size fit all” and the reality was that some individuals liked to live in communities of people they knew and expressed they felt safer and more able to avoid relapse with on-site support available.

The other aspect of the project that was potentially controversial was the notion of “damp” housing—a recognition that the people living at CJ’s might be in various stages of recovery from their addiction and some would still be actively using.

Staff felt that the only way to deal with the potential opposition was to confront it directly. The primary argument in support of this approach was that, for a minority of people, the current approaches and options were not working. There was a growing number of people with co-occurring disorders of mental illness and substance abuse that were homeless, in jails, and cycling in and out of hospitals.

## Finding the Site

In all housing development, it is essential to understand the political environment and in the City of St. Louis, that starts with the Alderman. PfP, working with their project consultants, visited a number of different Aldermen to explain the project and ask for support for building in their neighborhood. As a part of this strategy, PfP asked the Alderman to identify a spot they would like to see developed. The next step, after gaining the Alderman’s support, was to take the project to the Neighborhood Association. This proved more difficult, if for no other reason than the fact that there were many more people whose concerns had to be addressed. Neighborhood leaders were invited to visit the agency facilities and other housing. The fact that the housing would be staffed 24/7 was a key selling point to many of the neighbors. Staff stressed that this project could help provide more security and stability to the neighborhood because of the constant staff presence.

## Funding

The project was funded through the HUD811 Program. Pre-development activities, including assembly of land and planning and survey documents, were funded by the local Regional Office. The application was submitted to HUD in May 2001. Since the 811 program does not fully fund the project, other funds used to fill the gaps included:

- Development Loan from Regional Housing and Community Development Alliance, April 2002
- Award of \$360,000 Federal Home Loan Bank of Des Moines (Pulaski Bank, Member), February 2003
- Affordable Housing Trust Fund, City of St. Louis. September 2002 and April 2003

- HUD Closing September 2003
- Grants from local foundations to furnish, etc.

In order to keep costs low, land was assembled from city-owned Land Reutilization Authority (LRA) property. Ongoing funding for operations comes primarily from the Rents and Section 8 Subsidies attached to the project.

## Services

Direct, client-specific services are funded through the community support category of the CPRP. The on-site staff who provide general support, security, and a presence in case of emergency are funded through some CPRP billing as appropriate and a grant from the City of St. Louis Affordable Housing Trust Fund, renewable annually.

## Design Considerations

Because a particular focus of this building was to help people stay safe and to monitor visitors, special consideration was given to how to accomplish this through design. This was accomplished first and foremost by having a single entrance with a buzzer system to let people in. The necessary additional fire exit is alarmed.



The front desk is positioned in such a way that there is a line of sight to the front and back doors, the congregate areas, and the hallways on both first and second floors.



The main lobby has a high ceiling allowing some monitoring of the second floor hall from the front desk.



There is a fenced and gated backyard with sitting, smoking, barbecuing, basketball area.

## Lessons Learned

### **Staffing**

The original plan was to have a split staff—“para professional” staff who would provide the evening and overnight security/support front desk functions and off-site clinical staff who provided community support. The idea was to try to make this as much like a generic apartment building as possible. After two years of trying to make this work, staff visited other similar projects in Chicago and Seattle and came away convinced that a different approach was needed. The new approach was to have one team on-site that provided both the coverage and the clinical and recovery services. This has created a number of efficiencies, as well as helping build a more cohesive community.

### **Neighborhood Resistance**

From time to time, there would be feedback from the neighborhood that residents of CJ’s Place were creating problems in the neighborhood. There were two immediate responses. The first

was to let neighbors know that we wanted a safe area, too, and would meet to address their concerns. The second was to hold an open house for neighbors to visit and meet residents. This was a wonderful success as neighbors met people and heard their stories and their struggles. One result has been that some of the immediate neighbors have been working with residents of CJ's to build a large vegetable garden on the property. Phase II of that relationship includes help raising chickens and operating a stall at the neighborhood farmers market!

### **Building a Sense of Community is Key**

There is no way that a project like this could work unless the residents felt some level of commitment to each other and to the community that was built here. Special and focused effort has to be made to create and support that community. Staff should be hired who have the special ability to do that.

# SRO without On-Site Supports

## Choices: A Project of Crider Center, St. Charles

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### Overview

Choices is a 14-unit (one-bedroom) apartment building built and managed by the Crider Center for people living with mental illness, some of whom also have co-occurring disorders of substance abuse. There are no on-site staff but services are provided by community support staff of the CPRP at Crider Center.

The building is open, light with large windows and high vaulted ceilings in the entrance way. The hallways are wide with seven units on the first floor and seven on the second.

There is a large meeting room area with kitchen facilities attached and an adjoining outside patio area. There is a large parking lot for visiting staff as well as for those residents who have cars.

The building itself is set back off the main road and not in a residential area.

Choices was built with HUD 811 funding.

### Development Process

This was the first 811 for Crider Center. They contracted with a consultant to help put together the project team and the application. Staff stated that the choice of the developer is very important, especially for a first project

Leadership of Crider Center met with the Mayor of St. Charles to preview the project and discuss the location.

Crider Center used its own resources for pre-development costs and the gap funding (the amount not covered by the 811 award).

## Operating and Service Costs

Because this is an 811, rental assistance or PRA subsidies are attached to the project.

The PRA and resident share of rent help pay the basic operating costs. There is a dedicated maintenance/housekeeping person who is also a resident of the building who keeps the common areas and hallways well maintained.

Services are provided through the CPRP funding with no special additional on-site services.

## Building Notes

Each apartment unit can control their own thermostat and each unit is cable ready. All of the first floor apartments are built according to universal design so they are easily made accessible.

## Lessons Learned

In spite of some concern about working with a new funder (HUD), the project is considered a success and staff would consider doing another.

Edwin Cooper of the DMH housing staff was a big help and great resource.

Staff felt the design was a bit extravagant in terms of unused space. The high ceilings and some of the common area seem unnecessary and perhaps could have created another apartment instead.

Most residents have successfully kept their apartments. One observation was that even though no communal activities were required, many of the residents wanted to form friendships and community. This worked well for some people but not everyone. Some individuals prefer anonymity in their home space and even this moderate level of community may be too much for them.

# An Array of Choices and a Process of “Decongregating”

## New Horizons, Jefferson City

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New Horizons in Jefferson City has developed an array and a range of different creative housing options. It provides a good example of flexibility in working with funding and services.

### Dulle Project

Dulle Project is a supervised-living program that is located mainly in the third, fourth, and fifth floors of Dulle Tower. Dulle Tower is a public housing high rise for elderly and disabled in Jefferson City. Residents rent individual apartments and have staff on-site to assist them as necessary. The program is designed to serve individuals who need help with skills that jeopardize successful independent living. It provides a supportive, yet less structured, living environment than a residential care facility. Services include medication administration or oversight as well as participation in CPRP. Staff state that medication administration is the key service that makes this project work for tenants.

The background to this innovative approach was that the local Public Housing Authority was experiencing high vacancy rates due to some behavioral issues with some tenants. This created an opportunity for New Horizons staff to offer a solution both to the occupancy and the “oversight” issues. The Housing Authority provides an office for New Horizons staff on-site and that staff presence has had a stabilizing effect on the whole building operation. Clients of New Horizons live throughout the building and are not segregated in one area.

Obviously, the ability to partner in this way depends on the pressures on the local Public Housing Authority, but in this case it worked well and involved no capital cost.

### Warren Scott Apartments 811

In 2006, New Horizons completed the Warren Scott Apartments, an agency-owned and administered apartment house comprised of 14 one-bedroom apartments. The project was funded through HUD 811 program. On-site staff administer medications and provide additional supports as needed. All residents participate in CPRP. Most of the tenants of Warren Scott moved from a New Horizons Group Home into Warren Scott. That Group Home subsequently closed, establishing a model that confirms the assumption that, with proper supports available, many people currently living in congregate settings can make the move to more independent housing.



New Horizons' Warren Scott Apartments

## Melody House and Conversion to Supported Housing

Melody House was developed in 1988 as a Psychiatric Group Home and specifically for people moving from the State Hospital in Fulton. New Horizons developed this building with agency dollars, using a business plan and paying for the project with income from the building.

The building was designed originally to house two people to a room. Subsequently, staff have felt that was problematic both in terms of working with people's privacy and choice issues as well as with symptoms related to their mental illness.

Every provider knows, however, that numbers are a factor in being able to afford to provide the level of services that some people need. The more individuals in a building, the lower is the per-person cost for some fixed costs (e.g., overnight staff). New service descriptions for intensive CPR Residential will make it possible to "decongregate" this situation.

New Horizons is in the process of developing a HUD 811 with nine one-bedroom units. The plan is to move nine people from the Melody House Group Home and offer them each their own individual apartment in the new Richard Walz apartment building.

The building will be staffed 24/7, very similar to a group home with staff available to assist with activities of daily living, medication assistance, crisis support, and recovery planning. ***The difference will be that individuals will now have the opportunity to live in their own homes within the building.*** Services will be paid for by a combination of community support and Intensive Community Support Residential. The Units (as in all HUD 811s) will be subsidized through Section 8.



New Horizons' Richard Walz Apartments

# Ownership Partnership and Collaboration| **Master Lease Arrangement**

Tri County, Kansas City

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Gallatin Fourplex, Liberty

Tri-County is a Community Mental Health Center in the Kansas City area. In the 1990s, in response to a need to provide housing for people leaving the state hospital, Tri-County leased a four-unit apartment building (fourplex) from a private owner. The advantages of this, of course, are that there is very little start up cost involved and maintenance and property management are the responsibility of the owner.

Gradually, the organization leased all 12 apartments (3 fourplexes). All units are two-bedroom. This arrangement may work more easily when people are coming from a setting like a hospital and know other people with whom they may like to room.

In addition to using the apartments for tenants, one apartment is set aside for personal care staff with one of those bedrooms available for respite care. Since the staff are already providing coverage, this seems to be an effective use of the on-site staff.

Personal care staff are paid for through redirect funds from the state hospital downsizing.

Staff pointed out that, in this neighborhood, there was no neighborhood organization to contact prior to the project start up. Senior agency staff went door to door in the immediate area and

introduced themselves and explained the program. There was no major opposition. Being able to say that a building is staffed with on-site staff seems to be a big selling point in many areas.

Staff made the point that, in addition to the personal care staff, it is important that there be a strong component of community support staff (not maintenance level) to really work within a recovery framework. People who have long histories of institutionalization can be lost without support to help them find ways to meaningfully integrate into the larger community.



Spruce Landing Sixplex

The second Tri-County project was a HUD 811 developed in 2006. This was three sixplexes of one-bedroom units with one unit and community room for the personal care staff. This project was developed in partnership with the Kansas City based Community Housing Network (CHN). CHN is a nonprofit housing development corporation that has developed a number of projects for mental health providers in the Kansas City area. Tri-County partners with CHN in design and contracts to provide services. This has been a highly effective model using the specific expertise of both the housing developer and the service provider.

## Lessons Learned

The one comment staff made in response to the question “what might you do differently” was to provide the option of two-bedroom apartments. While most people prefer to live alone, some people have good friends or even a spouse they may want to live with but do better in individual bedrooms.

As with the other project, services are paid for through hospital redirect money.

# Flexibility, Transitions

## Independence Center St. Louis

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One of the purposes of this manual is to demonstrate how different providers have used the same or similar funding streams with different program designs for different people.

Independence Center has used the HUD 202 and 811 programs in some creative ways designed to provide maximum flexibility for use.

Another unique aspect of the Independence Center model is the link between their Clubhouse program and housing. The Clubhouse is often the source of referrals for the housing.

## Independent Apartments

Independence Center has two apartment buildings they developed simply as independent, affordable, decent housing for their members. Lohmeyer is a 21-unit apartment in Maplewood, and Laclede is a 20-unit, one-bedroom building in midtown St. Louis in walking distance of the Clubhouse.



Laclede Apartments

Laclede Apartments were developed in 1992 under the HUD 202 Program. At one time, 202 was the housing program that provided capital funding for both elderly and disabled. This program was subsequently split into the 811 and 202. HUD811 provided housing for people with disabilities and HUD 202 provided funding for elderly.

As with both 811 and 202, each unit is a site-based Section 8, subsidized unit.

The building has a central and locked front entrance which helps with tenant security. The building is attractive with a meeting space/lounge in the front lobby and small kitchen attached. Each apartment is a one-bedroom apartment with separate living space and bedroom, kitchen and full bath. The building has an elevator. Tenants report feeling safe and proud of their housing.

This was the first housing development Independence Center constructed and tenants were chosen who staff felt had good interpersonal skills and would maximize the opportunity to have independent, subsidized housing. Unlike some other projects visited, not all tenants received support through the CPRP. Those who need and are eligible for this service receive it but others may simply keep contact through their Clubhouse unit staff. An expectation of residents is that they have contact with clubhouse staff at least monthly.

In addition, there is a monthly housing “audit,” when units are checked for basic upkeep and maintenance issues. The person who conducts these checks is not the same as the clinical community support staff. There is also a monthly house meeting for tenants conducted by Independence Center staff.

## Lessons Learned

An interesting point made by staff was that the decision to manage the building themselves or contract out had changed over time. As discussed in an earlier section, different agencies will decide to handle this differently, but Independence Center had originally used a management company. They made the change to manage themselves because they felt they could be more responsive and work better with individual tenants who might be experiencing problems. Independence Center contracts with a housekeeping service to do basic cleaning and maintenance of common areas.

When asked what they would change or do differently, staff replied “more storage!” This is a commonly heard refrain for storage space for cleaning supplies, outside and gardening supplies, tools, and personal items like bicycles.

As an apartment building, tenants are currently allowed to smoke in their apartments but not in the common area. Staff have begun a conversation, however, about working on smoking cessation and potentially becoming smoke free.

## Stupp and Newstead

Stupp and Newstead are both licensed as RCFs built with HUD 811 money in the early 1990s. What is unusual and (from the residents’ perspective) highly desirable is that each individual unit (15 total) within the RCF has its own private restroom and small kitchen area. The facility is staffed and licensed as an RCF and meals are provided but residents also have the option of eating in their own apartments alone or with one or two friends.



Newstead

There is a large, open common area with attached kitchen and office space.

This arrangement also gives the organization, based on changes in funding stream and or client needs and desires, the ability to significantly change the model from a fully licensed RCF to simply efficiency apartments with little to no on-site staff.

As of this writing, the Stupp Building is undergoing a transition to assist with the Inpatient Redesign in the Eastern Region. Independence Center staff are working with the Regional office of DMH to help provide housing and supports for individuals discharged from St. Louis Psychiatric Rehabilitation Center. These are primarily people who have court-appointed guardians and/or conditional-release status. This means that changes have to be made to address court or guardian required security issues. Security cameras have been installed that cover interior and exterior spaces. Windows have had buzzers added to they cannot be opened more than six inches without sounding an alarm.

Because many of the new people coming from the hospital have a long history of hospitalization as well as requirements for additional monitoring and structured programming, the additional costs are covered by the newly created Intensive Community Psychiatric Rehabilitation in Specific Residential Settings (I-CPR RES) which provides for a daily rate.

Stupp is currently a blend of people receiving the I-CPR RES rate and other residents receiving community support and traditional RCF funding. The plan is to gradually transition residents so that the whole facility will eventually be home to people leaving the hospital with this high need for oversight.

The change in this facility has also caused staff to look differently at the use of both Stupp and Newstead. Conversations have begun about making these projects more deliberately transitional. Because they have a strong treatment and recovery focus, staff feel that if a resident is not participating in making changes towards recovery, they might as well be in a facility with less expectations and free a space for someone more actively moving towards change.

There is recognition that a recovery model which helps people plan for more independence is complicated by court and guardian restrictions, but staff expressed the belief that their program is about recovery. Individuals need to know there is hope for change.

# Mixed Use and Financing

## Family Counseling Center

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Family Counseling Center offers a variety of housing services and one of their newest and most creatively financed is their SEMO Safe Haven in Kennett, established in 2007.



SEMO Safe Haven, Kennett, Missouri

### SEMO Safe Haven, Kennett, Missouri

The mission of the Safe Haven is to provide “innovative, safe, affordable, permanent housing, coupled with mainstream resources and supportive treatment services to homeless persons who suffer from mental health and/or substance abuse disabilities in Dunklin County, Missouri.”

The building is located in an area that borders a residential area but is comprised largely of commercial property and government agencies.

### **Mixed Use**

The building provides eight units of permanent (as long as needed and wanted) supportive housing and eight units of 30-day transitional housing.

The building design includes a central corridor, housing congregate and office space, and two wings, each housing four units of permanent housing and four of transitional. Please see the figure below.



1



4



2



5



3

1-3. The main entrance leads to a large, bright lounge complete with large screen TV and individual computer work stations. 4. There is a commercial grade kitchen attached to the common area which serves the dual purpose of a training facility and meal preparation area for people living in the transitional units. 5. The individual apartments are efficiency-sized, with kitchen, living area and full bathroom.

The 30-day transitional beds are one room each. Residents of the transitional units are people who are homeless with a mental health or substance abuse disorder and who have some income, so they will be able to transition into permanent housing. During the 30-day stay, staff work intensively with individuals to help them organize the resources and treatment needed to move on to permanent housing. SEMO Safe Haven is located near a correctional facility and a large

general hospital with behavioral health unit; they receive many referrals from both sources. People using the transitional units are not required to have Medicaid or be enrolled in CPRP services. Funding for services is attached to the staff positions, not to the individuals.

## **Funding and Staffing**

Capital costs for development and construction of the building were provided through a mix of HUD 811 dollars, a Community Development Block Grant (CBDG) administered by the Missouri Department of Economic Development, the Missouri Housing Development Commission Trust Fund, and the Dunklin County Commission. It is a wonderful model of how to creatively layer funding sources.

There is a range of staff and services available, including benefits consultant, nursing and assessment services, psychiatry, and social services and housing specialists.

On-site staff are paid for through a mix of sources as well. The HUD 811 program budget pays for some operational support. Family Counseling Center has a PATH grant which helps pay for homeless outreach, transportation, and benefits support. Staff office of the PATH program are in the Safe Haven. Overnight, the facility is staffed by a security monitor. Those residents who are enrolled in CPRP will also receive community support services through that program.

By mixing the transitional beds with the permanent housing beds, the residents of the permanent housing also benefit from the additional staff presence on-site. One resident explained that he has lived in RCFs and on his own and does much better in this living arrangement because it provides the right mix of safety and companionship.

# Transitioning from RCF to Independence

## Family Guidance Center, St. Joseph's Missouri

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Family Guidance Center (FGC) operates two semi-independent apartment complexes, both of which were developed with HUD 811 funding. The goal for both of these projects is that these apartments are used as transitional living, specifically (though not exclusively) from RCFs to independent housing.

St. Joseph, in northwest Missouri, has high rates of rural poverty. A new pork processing plant has recruited new people into the area putting an additional pressure on the limited stock of affordable housing. Foreclosures on homes, too, have meant that more people are looking for low cost rentals so there is clearly a need for housing.

### Meadowcreek

FGC developed their first HUD 811, Meadowcreek, in 1990. The building is located on a major bus route and near a walking trail. Meadowcreek has 15 housing units with one apartment set aside for staff offices. Staff are on-site in the complex 24/7.

The building consistently remains full with a waiting list.



Meadowcreek

As with all 811 projects, rents are subsidized through project rental subsidies. The complex is divided into four quadraplexes (four units). The division provides less of an institutional dense look by breaking the complex up with walkways and green space.

The on-site staff provide a presence, support, reassurance, and availability for crisis or emergency, but community support services are provided through the CPRP mechanism.

On-site staff are paid for through redirect and DMH T1 dollars.

## Sheltering Arms

With the success of Meadowcreek, FGC undertook another 811 project based on the same model. Sheltering Arms was completed in 2007. It is a similar model of four quadraplexes—15 living units and one apartment for staff. There is also a large community room and outdoor seating. This building, too, maintains full occupancy and has a waiting list. The 811 funding paid for 100% of costs.



Sheltering Arms

## Lessons Learned

As noted above, it is hoped that the availability of these apartments will help the “flow” of people from RCFs to independent apartments. Staff commented, however, that not all RCF operators are interested in a “paradigm shift” to see their own services as transitional rather than permanent. Success *has* come with two Residential Care providers who have demonstrated a commitment to moving people through their own facility to more independent living. This may provide a model or example of how to work with RCF providers in a partnership to:

- Assess people for what skills or supports would be needed to help them move out of residential care;
- Work on a treatment plan to address providing those skills and supports;
- Identify people who want to and should be given opportunity to move and support that choice.

Guardians and RCF providers may have less objection to moving people directly from an RCF into an apartment with on-site staff present than they would if the individual were moving into a completely independent apartment.

FGC would like to develop more housing, but, as other providers have expressed, resources are generally tied up in service provision and responding to the ever changing health care environment.

# Partnering with Private Landlords and Developer

## ReDiscover, Lee's Summit

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ReDiscover, like other providers profiled, has a range of housing options. Two models that have not yet been profiled both involve the agency working with private landlords and private investor/developer to own the housing while ReDiscover provides services.

### The TLP (Transitional Living Program)

Much has been documented about the difficulties and often heartbreaking situations of young adults aging out of foster care, in particular those who might be developing early symptoms of mental health disorders. They are generally ill prepared to succeed on their own in the best of circumstances, but lacking a family support network, dealing with mental health problems and at the same time trying to build a new life can be overwhelming.

ReDiscover had created a special program of housing and supports to assist these young adults to “take responsibility for living life independently, including managing their own unique mental health care needs.” Program Director April Schafersman states, “ReDiscover is one of the only Transitional Living Programs in the state of Missouri specializing in youth with Mental Illness—ReDiscover doesn’t stop services when the child is declared an adult by the state and loses his or her state funding from Children’s Services.”

The program was started with funding from the SAMHSA Healthy Transitions Grant.

The program was so successful and needed it has continued with help from SCLP (which helps cover living costs as needed) and, if the person is still in the custody of Children’s Division a per diem is paid through that Division. All participants are enrolled in CPRP and that funding covers services such as PSR, case management, and community support.

ReDiscover leases apartments from private landlords. Staff review the lease with each program participant and ask them to sign a copy which they keep so they are aware of requirements of tenancy.

Each participant has their own one-bedroom apartment. There are generally not more than four units in one apartment complex. Experience taught that, particularly with this age group, two bedrooms were problematic due to roommate conflicts. Staff stated, “We avoid having lots of units in the same complex because we want people to have a better chance of being a part of a larger community.” It also becomes less of an obstacle for landlords to rent out other units if there is not a high volume of young people in a complex.

Staff of the program have an office apartment in the middle of all the apartment complexes where people are living. There are staff on duty 24/7 with more during the day time and at least one (sometimes two) on evenings, nights, and weekends. Staff go from apartment to apartment checking in, helping people get to work, helping them access leisure activities.

The focus is on skill building, preparing for the future and managing their illness so consumers are involved in school, training, work, GED, recovery groups as appropriate to their own situation. In addition, staff of ReDiscover provide or help access case management, medication management, psychiatric and medical evaluation and health care.

There is no time limit on length of stay but there is an age limit of 25. A gradual decrease of services is built into program design so that when people do “graduate” it seems more seamless and not a huge loss of services and support. Generally, graduates are followed up with CPRP services.

## Amethyst Place—A Community Partnership

Capital—Private ownership leased to agency

Operating—DMH subsidies and services through community providers

ReDiscover also participates in a unique and creative program called Amethyst Place, serving mothers and pregnant women recovering from alcohol or other drug addiction. Amethyst Place is a partnership between private investors, a nonprofit organization which provides the housing and community behavioral health providers who make referrals and provide clinical services and coordination.

Amethyst Places serves 11 families in two- and three-bedroom apartments. Potential residents must have 30 days of sobriety and participate in case management and recovery services. The Department of Mental Health provides the rent subsidies so residents only have to pay 30% of their income towards their rent.

The building was developed by a private investment group which has a Master Lease agreement with Amethyst Place. Amethyst Place uses grants and donations to pay for on-site services and supports.

# An Array of Housing Options

## Burrell Center, Springfield, Missouri

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In addition to providing community support to individuals living in private apartments in the community, Burrell provides a full range of other housing options including congregate and semi-independent apartments.

### START

Capital—tax Credits

Operating SCLP and CPRP

START is an 11-bed co-ed psychiatric group home developed in 1990 as a tax credit partnership project. Subsequently, the partners have gifted their share of the building back and it is fully owned by Burrell.



START

The program is highly structured with a very clear mission of preparing people for more independence. Each resident has a schedule and is expected to have productive daily activity. Staff are present 24/7. Residents receive points or scores based on their participation in the treatment plan. Residents may be people transitioning from inpatient, RCF or young adults learning to cope with their illness.

The project is licensed through DMH as a psychiatric group home but is not licensed through DHHS. This means they do not receive the Medicaid cash grant but it also means they have more discretion to run the program most consistent with their clinical approach. Residents participate in the tasks of running the household based on a predetermined schedule.

The program is paid for through a contract with the regional SCLP office which covers basic residential services and CPRP funding covers the clinical and community support services provided.

## Wilkinson Apartments and Gardine Apartments: Semi-Independent



Wilkinson Apartments



Gardine Apartments

Both of these semi-independent apartment projects were built with tax credit dollars in approximately 1990. Staff report this is a very popular and much requested model. One of the buildings is across the path from the START Group Home. These projects and START share a common Director. The advantage is a smoother intake and coordination process. For example, if a referral is made for one facility and there is no opening or if the Director thinks another program would be a better fit, it is a simple matter for the Director to help the individual find the right place for their stage of recovery and their individual needs.

There is one staff person per shift on-site at each building. This person provides some level of oversight (though not in the sense demanded by licensure). Medications are kept within the staff office unless an individual is actively working on transitioning to self medication (“med split”) in which case the process is somewhat different. There is also one community support worker assigned to each building. Residents are asked to sign an in and out log but, again, there is no high level of control as there is no common entrance and exit.

Many of the apartments are two bedrooms. The one-bedroom units are saved for those people about to graduate to more independence.

Staffing structure is divided into residential staff and clinical staff (Community Support) and each group of staff has their own supervisor.

One of the clear advantages to having one Director of three Residential buildings (in addition to the intake process) is the ability to pool and share residential and overnight staff. Anyone who has staffed a 24/7 program knows the difficulty of always being on call and having to provide back up when staff do not show up for night shifts. With a larger pool it is easier to arrange schedules and provide necessary fill in support. There would be minimal difficulty in cross training staff for the different buildings.

Services for on-site staff in the semi-independent are paid through local T1 or SCLP dollars.

## Clifton and Catalpa Apartments: Permanent and Subsidized Housing

Completing an array of agency-owned housing options, Clifton and Catalpa are both independent apartment buildings with 14 one-bedroom units and common area space for community gatherings. It should be noted that Burrell staff and other providers have expressed strong preference for the one-bedroom units or at least a minimal need for the two-bedroom. One staff person commented that it might seem counter intuitive, i.e., that people who were previously homeless might prefer a roommate but this is generally not the case. Many people who have been homeless for long periods of time have become used to a certain amount of “privacy” and individual space. The one-bedroom apartment serves that purpose well and the common area offers the opportunity to socialize if desired.

Both of these buildings were built with HUD 811 capital funding and, of course, include rent subsidies for the units.



Clifton Apartments

Catalpa is a similar model to Clifton. Both have open space and high ceilings and good lighting with a modern modular design in the units. The cost was completely covered by the 811 funding. Initially, there was a shortfall, but the local HUD office was able to assist with

additional funds. The land for this project was city land that had become a site for a homeless encampment. The city essentially donated the property to Burrell (cost of \$1) in exchange for an agreement that the project would serve a number of people with mental illness who were formerly homeless.

There is an additional large lot attached to the site that is now owned by Burrell, as well, and provides an opportunity for more development in the future.

## Transitions and Training: Decongregating a Group Home and Moving Towards Independence

At one time, Burrell operated a psychiatric group home for adults with serious mental illness. A decision was made to take the funds used to support the Group Home and, instead, use them to support intensive services in the community.

Twelve scattered site apartments are leased, and residents are provided with intensive services and daily contact. Consumers in this program are typically people who need this extra level of support to maintain an apartment in the community. SCLP funding helps provide rental subsidies. Staff are available and in contact evenings and weekends in addition to regular work day hours.

# Partnership with Community Action Agency

## Pathways, El Dorado Springs

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### Cedar Ridge Apartments

The impetus for this project was, originally, the closing of the State Psychiatric Hospital in Nevada. The specific need was to offer community living for people who had previously not been successful in either traditional congregate or independent living.

The building was developed through HUD 811 funding in collaboration with a local Community Action Agency which was the owner and developer. Community Action Agencies (CAAs) are nonprofit private and public organizations established under the Economic Opportunity Act of 1964 to fight America's War on Poverty. The goal of Community Action Agencies is to help people to help themselves in achieving self-sufficiency. The West Central Missouri CAA has developed and manages 399 units of multifamily housing in eleven properties in Cass County, Jackson County, Henry County and several other rural counties. Over 80% of the units are senior housing and 12 are for people with special needs. WCMCAA is also a partner in three other multi-family developments with a total of 72 units

Staff of DMH provided consultation and support in responding to the HUD NOFA. The CAA operates the facility and Pathways keeps it full and provides the services primarily through the Community Psychiatric Rehabilitation Program.

There was some initial community resistance but this was met by one-on-one meetings. The advantage of meeting people one-on-one is that there is less likely to be an adversarial atmosphere that is built up and individual concerns can be addressed directly.

In terms of design or building changes that staff would recommend for the future:

- Stay with one-bedroom units
- Create more units in the building to benefit from the economy of scale in providing services

In the future, Pathways is interested in pursuing funding to develop and own themselves and will be looking to DMH staff for help and technical assistance.

# 'PATH' to Independence for Young Adults

## Ozark Center, Joplin

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Child custody care systems provide safety, shelter, and guidance for children. Once old enough to live on their own, youths oftentimes exit foster care or the mental health placement system with nowhere to go and no knowledge of how to succeed in adult society.

### Ozark Center PATH to Independence

Ozark Center PATH to Independence provides long-term housing options for young adults age 17-22. There is no arbitrary time limit on how long people may stay as every situation is viewed individually, with the exception that age 22 is the upper limit. To qualify, participants must have a serious emotional disturbance determined through an assessment. PATH teaches effective coping skills and offers a transitional housing opportunity and services that ease the adjustment to adult life.

Those accepted into the program must seek and secure employment. Until the person finds a job, PATH provides a fully furnished apartment and living expenses. Once the young man or woman secures a job and learns necessary independent living skills, he or she pays rent and expenses on a sliding scale.



Ozark Center

Services include:

- Safe, stable housing
- Basic life-skill building
- Consumer education, including budgeting, using credit, and housekeeping
- Interpersonal-skill building, including establishing positive relationships with peers and adults, managing stress, and making decisions

- Educational opportunities (GED preparation, postsecondary training, or vocational education)
- Career counseling and help finding a job
- Help obtaining a driver's license, Social Security card, and birth certificate
- Education, information, and counseling to prevent, treat, and reduce substance abuse
- Mental healthcare, including individual and group counseling and in-home community support services
- Help securing Medicaid health benefits, physical healthcare, health assessments, and emergency treatment by referral

The PATH complex has eight fully furnished individual apartments. There is a common laundry facility and storage unit.

All residents are CPRP eligible and community support services are funded through that program. While there is no on-site staff, CSSs meet individually with clients in their homes and in the community on a regular basis. (An adjacent property does have 24-hour staffing, and residents have access to that staff if needed.) There is also a crisis hotline that can be reached 24 hours a day. Ozark Center staff are exploring options for bringing on additional security/support staff.

## Capital and Operating Financing

Ozark Center came up with the original design and concept for the program and arranged for all the construction and program services.

Ozark Center received stimulus money made available through the federal government. These funds paid for the construction of the apartment complex, and private grants and donors helped with gap funding and buying furniture.

Some SCLP dollars are used to help support resident living expenses and MHDC Trust Fund dollars help subsidize rents. Trust fund money must be applied for and renewed annually.

This project is another good example of a provider working in partnership with a number of funders to fill a critical need.

# Community Housing Network

The Community Housing Network, serving the Kansas City region, was established in 1992 as a non-profit community development corporation to create long term housing opportunities “for persons on limited incomes receiving mental health services and their families.”

Working on the theory that mental health providers know best about services and developers or housing providers know best about housing, the CHN worked with providers in the Kansas City region to create housing that best met the identified needs of those providers and their consumers. This is a model that is of particular relevance in metropolitan areas that have multiple providers in the same region.

The CHN developed and owns six HUD 811 projects and partners with providers who deliver the services. CHN also processes housing vouchers for DMH and HUD.

The organization is currently in transition as there was a loss of revenue for staffing, and DMH housing staff are assisting the board as they plan for the future of the organization. There was a clear message from several mental health services providers that this was a model that has worked for them and they would like to see it continued. As stated earlier in this document, the behavioral health providers do not all have the resources and staff to stay on top of changes in the housing development and funding arena so having a specialty organization whose mission is to do that was a great help.



# Glossary of Housing and Financing Terms

## Affordable Housing

HUD defines affordable housing as housing for which a person pays 30% or less of income towards rent.

## Bond Financing

A municipal bond is an interest-bearing debt obligation issued by a state or local authority which may support general government needs or fund a public works project.

## BOS

Balance of state (BOS) refers to those areas not considered entitlement communities (generally population under 50,000). In the cases of block grant funding or SHP funding, BOS areas do not generally have their own allotment or allocation and the funds are administered by a state-wide entity like MHDC or Department of Economic Development.

## Cash Flow

The income remaining to a project after all operating expenses and debt service are paid

## CDBG

Community Development Block Grants are provided to communities from HUD for a range of eligible activities.

## CHN

Community Housing Network based in Kansas City, Missouri, acts as a clearinghouse and housing developer for mental health provider agencies in that region.

## Chronic Homelessness

Defined by HUD as individuals who have been homeless continuously for a year or more or who have experienced four or more episodes of homelessness over three years. This was amended in the 2010-2011 Continuum of Care funding cycle to include families with children.

## Construction Loan

This is generally a bank loan to finance construction of a project. Funds are disbursed as needed and the loan is repaid on completion of the project.

## Draw

Withdrawal or distribution of funds from an account established for a specific purpose, e.g., construction

## Environmental Assessment

Lenders and funders will generally want to see a report clearing a site of any potential environmental hazards.

### Environmental Survey

An assessment of a site identifying physical characteristics of the site

### Equity

The amount an owner actually holds in a property or the difference between the market value and the debt

### Errors and Omissions Insurance

Insurance carried by architects and engineers to cover claims based on faulty design

### Escrow

Money held by third party until conditions of contract are met

### Fair Market Rate (FMR)

HUD-determined amount to be the reasonable cost of decent housing in a specific area. Acts as a cap for many federal housing subsidy programs.

### Forgivable Loan

A loan with no repayment obligation as long as certain requirements are met over a period of time

### General Contractor

The main construction contractor who oversees all aspects of construction including hiring and overseeing sub contractors

### HAP (Housing Assistance Payment)

Funds paid to landlord as rental assistance for person enrolled in rent subsidy program, generally the difference between actual rent and tenant share

### HCVP (Housing Choice Voucher Program)

Generally known as Section 8. Local Public Housing Agencies administer these rent vouchers to income-eligible people who then have the responsibility to find landlords who will rent to them using this voucher.

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

This reauthorization of the McKinney-Vento Homeless Assistance Act made changes in the program, including HUD's definition of homeless and chronically homeless.

### Hard costs

Those costs directly associated with constructing a building (bricks and mortar) as opposed to legal, architectural, accounting, consultant, etc.

### HTC (Historic Tax Credits)

Both federal and state tax credits which can be used to renovate a building designated as historic by the Department of Natural Resources State Historic Preservation Office.

### HUD (Housing and Urban Development)

A federal program created to administer government programs providing assistance for housing and development

### LIHTC (Low Income Housing Tax Credits)

A tax credit available to investors in low income housing production administered in Missouri through MHDC

### MHDC

Missouri Housing Development Commission

### MHTF

Missouri Housing Trust Fund, administered by MHDC

### Master Leasing

A legal contract in which a third party (not the tenant) enters into a lease agreement with the owner and then becomes responsible for tenant selection and rent collection from sub-lessees

### Net Operating Income (NOI)

The amount of income left after all operating expenses, excluding mortgage, have been paid

### NOFA

Notice of Funding Availability

### Operating Expenses

The usual cost of operating and maintaining a rental property including taxes, insurance, repairs, utilities, administration, preventive maintenance, etc.

### Operating Reserve

Money set aside for unexpected expenses or loss of revenue. Many lenders will require some kind of reserve.

### Option

The right to purchase or lease a property if certain conditions are met within a certain time frame

### Pre-development Financing

Funding to cover initial planning costs to develop an application for funding or plan for project before funds for project actually come in. In many cases, much of this cost can be recovered when full project is funded.

### PRA

Project Based Rental Assistance (subsidies attached to unit or building)

### Permanent Housing

Housing in which the tenant may stay as long as they fulfill requirements of tenancy and lease

### Pro Forma Income and Expenses

A financial statement, generally over an extended period of several years, showing the expected income and expenses of a project. Applications for development will generally require a pro forma showing the project is viable into the future.

### SCP

Supported Community Living Program of the Missouri Department of Mental Health which has provided a range of financial assistance to help individuals live in a variety of community settings.

### SPC

Shelter Plus Care

### Soft Costs

Costs other than bricks and mortar, including things like legal, architectural, financing fees

### Super NOFA

The annual HUD NOFA covering a wide range of housing programs

### Supportive Housing

Housing that is both affordable for low-income people and comes with the necessary services and supports to allow people with significant support needs to remain in housing they have chosen

### TRA

Tenant-based rental assistance; subsidy is held by tenant not the unit

### Tax Credits

Tax reductions or benefits subtracted dollar for dollar from taxes owed; usually provided to investors to encourage them to participate in some activity for the public good, e.g., affordable housing, economic development in depressed area

### Vacancy Allowance

Income not received (or lost) over one year when units are empty or not rented

### Very Low Income

Income that does not exceed 50% of area median income

## **appendix B**

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# Key Websites

Corporation for Supportive Housing  
[www.csh.org](http://www.csh.org)

Missouri Department of Mental Health Housing Unit  
<http://dmh.mo.gov/housing/HousingDevelopment.htm>

MHDC Missouri Housing Development Commission  
[www.MHDC.com](http://www.MHDC.com)

HUD in Missouri  
<http://portal.hud.gov/hudportal/HUD?src=/states/missouri>

Rural Development in Missouri  
<http://www.rurdev.usda.gov/MO-Home.html>

DESC Downtown Emergency Services  
[www.DESC.org](http://www.DESC.org)

Homeless Resource Center  
<http://www.homeless.samhsa.gov/Channel/View.aspx?id=17>

National Low Income Housing Coalition  
<http://www.nlihc.org/template/index.cfm>

Pathways to Housing  
[http://www.pathwaystohousing.org/content/our\\_model](http://www.pathwaystohousing.org/content/our_model)

# Working with Landlords

## Preparation

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Many people with mental illness qualify for rental assistance vouchers through federal and state housing subsidies. While living in the community is an important goal for most people, navigating successful relationships with landlords can be challenging.

It is important to have as much information as possible before the first encounter with the landlord. Know the answers to these questions:

- Does the person have any outstanding amounts on utility bills that would prohibit service connections?
- What are the terms of the rental subsidy the tenant receives?
- What information will the landlord find in a background check?
  - Check the Sex Offender Registry and state court database online
- Does the person have any outstanding judgments or warrants?

If there are outstanding utilities (or fraudulent usage), it is important to get those paid off as soon as possible or locate rental units where the utility is not required to be in the person's name. Contact local Community Action Agencies, United Way affiliates, or other nonprofits that may be able to provide utility assistance.

Know the terms of the subsidy program. It is helpful if you and the landlord have a clear understanding of responsibilities (who is paying application/inspection fees, security deposits, and monthly rent.)

When locating units, it is important to take into consideration environmental aspects: location to grocery, retail, transportation and safety of the neighborhood. Drive or walk around the neighborhood and talk to neighbors. Be aware of presence of addiction triggers. Landlords who manage a lot of property may have the resources to make repairs quickly, but may have stricter rental policies. Use [www.socialserve.com](http://www.socialserve.com)—a free online rental listing site that connects landlords and people searching for affordable housing.

## Making Contact and Disclosing Information

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Disclosure of personal information presents a lot of challenges in leasing a rental unit. There is a fine line between educating the landlord about the agency and achieving the primary goal of securing a rental unit. Many rental subsidies have specific eligibility criteria (disability, homelessness). It is usually good to disclose terms and eligibility of the subsidy. If the landlord asks more specific information, it is up to the individual to determine the level of disclosure. The prospective tenant might diplomatically explain that they prefer to keep their personal

medical history private. The primary thing the landlord wants to assure is that rent is paid and the tenant can follow the requirements of the lease.

It is important for the landlord to develop a rapport with the tenant. The prospective tenant should lead the conversation as much as they are comfortable with. The first contact (usually a phone call) with the landlord should be brief, confirming unit availability, price, amenities, and setting up an appointment to view the unit. If the support worker makes the call, they should keep the explanation of their role brief.

Use the face-to-face visit to build rapport with the landlord. On viewing the unit, the case manager and prospective tenant can explain the terms of the program. Communicate the benefits of the subsidy to the landlord: (1) The subsidy pays a portion of the rent every month. (2) The agency is providing a variety of ongoing support and may be able to assist with concerns before they become problematic.

Most landlords will not approve tenants with recent evictions\* or criminal history if they have occurred in the last 2-3 years. Landlords will usually discover this information in the background check. It is usually wise to disclose this information up front and give the landlord an assurance that past problems are being resolved. Many landlords will appreciate this good-faith disclosure and may relax their leasing policy. Some landlords may refuse to rent to the tenant, but disclosing ahead of time may prevent the delay of finding a unit and save the cost of finding a unit.

Try to establish good relationships with landlords. As they get to know the people at your agency, they may be important resources in the future.\*

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*\*Please note that the tenant has not been “evicted” unless the landlord has been awarded a legal judgment. Simply being asked to move is not an eviction.*



# Entitlement Cities, Counties in Missouri

## Entitlement Cities

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City of Columbia  
Department of Planning and Development  
P.O. Box 6015  
Columbia, MO 65205  
Phone: 573-874-7239

City of Independence  
Dept. of Housing and Community Services  
P.O. Box 1019  
Independence, MO 64051  
Phone: 816-325-7396

City of Joplin  
Dept. of Community Development  
321 E. Fourth St.  
Joplin, MO 64801  
Phone: 417-624-0820  
Fax: 417-625-4738

City of Lee's Summit  
Department of Administration  
207 S.W. Market St.  
Lee's Summit, MO 64063  
Phone: 816-969-7520

City of St. Charles  
Department of City Development  
200 N. Second St.  
St. Charles, MO 63301  
Phone: 636-949-3222  
Fax: 636-949-3557

City of St. Louis  
Community Development  
1015 Locust St.  
Suite 1100  
Saint Louis, MO 63101  
Phone: 314-622-3400

City of Springfield  
Department of Planning and Development  
840 N. Boonville Ave.  
Springfield, MO 65802  
Phone: 417-864-1038

City of Florissant  
Department of Community Development  
1055 Rue St. Francois  
Florissant, MO 63031  
Phone: 314-839-7680

City of Jefferson City  
320 E. McCarty St.  
Jefferson, MO 65101  
Phone: 573-634-6305

City of Kansas City  
Dept. of Housing and Community Dev.  
414 E. 12th St.  
City Hall, 14th Floor  
Kansas City, MO 64106  
Phone: 816-513-2823 (Lois Christian)

City of O'Fallon  
Department of Administration  
100 N. Main St.  
O'Fallon, MO 63366  
Phone: 636-379-5438

City of St. Joseph  
Division of Community Development  
1100 Frederick Ave.  
City Hall, Room 101A  
St. Joseph, MO 64501  
Phone: 816-271-4646

City of St. Peters  
Dept. of Engineering & Development  
P.O. Box 9  
St. Peters, MO 63376  
Phone: 636-477-6600

# Entitlement Counties

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County of Jefferson  
Department of Economic Development  
P.O. Box 623  
Hillsboro, MO 63050  
Phone: 636-797-5336

County of St. Louis  
Office of Community Development  
121 S. Meramec Ave.  
Suite 444  
Clayton, MO 63105  
Phone: 314-615-4427



Service Descriptions  
for Intensive CPR in  
Specific Residential  
Settings



**MISSOURI DEPARTMENT OF MENTAL HEALTH  
Comprehensive Psychiatric Services Division**

The Division of Comprehensive Psychiatric Services is proposing 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. 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 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 interventions. Those tiers include – Clustered Apartments (I-CPR RES/CA), Intensive Residential Treatment Settings (I-CPR RES/IRTS), and Psychiatric Individualized Supported Living Environments (I-CPR RES/PISL).

In addition, the CPS Division will begin using Intensive CPR in non-residential settings. A provider workgroup has been identified to assist in defining the settings, services/supports, and staffing requirements for I-CPR in non-residential settings, first meeting is scheduled for January 28.

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.

Intensive CPR procedure codes and rates for adults:

Intensive CPR (non-residential settings)

H0037 – IGT rate \$141.34/day, DMH pay rate \$122.54/day

Intensive CPR Residential – Clustered Apartments

H0037HK – IGT rate \$219.09/day, DMH pay rate \$189.95/day

Intensive CPR Residential – IRTS

H0037TF – IGT rate \$230.15/day, DMH pay rate \$199.54/day

Intensive CPR Residential – PISL

H0037TG – IGT rate \$241.21/day, DMH pay rate \$209.13/day

## I-CPR in a Clustered Apartment Setting

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.

<b>I-CPR Services in a Clustered Apartment Residential Setting (I-CPR RES/CA)</b>	
<b>Definition</b>	Medically necessary on-site services in a clustered apartment setting, because of a history of failure in multiple community settings and/or the presence of an ongoing risk of harm to self or others which would otherwise require long-term psychiatric hospitalization. Specific to this level of care - <ul style="list-style-type: none"> <li>• Consumers are often unable to tolerate congregate living arrangements in which the presence of others in the immediate living area tends to precipitate psychiatric relapse, aggression or other behaviors associated with a risk of re-hospitalization.</li> <li>• Consumers 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.</li> <li>• Services include the monitoring of points of ingress/egress, periodic room checks, and provision of support and rehabilitation activities around specific activities of daily living or when consumers are in crisis. However, the majority of rehabilitation activities are provided in the community.</li> </ul>
<b>Staff Qualifications</b>	All staff on-site are trained to provide the on-site services described above, and operate under the direction of a mental health professional
<b>Procedure Code</b>	H0037 HK
<b>Target Population/ Service Category</b>	Adults requiring Intensive Community Psychiatric Rehabilitation in a specialized residential setting as an alternative to long-term inpatient hospitalization.
<b>Utilization Rate</b>	Approximately 25 – 40 consumers in the 1 <sup>st</sup> year
<b>Unit Rate</b>	\$219.09 daily rate MHD, \$189.95 provider pay rate
<b>Limits</b>	Will be limited to Community Mental Health Centers which are contracted to provide I-CPR and other CPR services
<b>Place of Services</b>	Clustered Apartment Complex (POS 12 – Home)
<b>Fiscal Impact</b>	No new General Revenue is required
<b>Requested Effective Date</b>	November 1, 2010

## I-CPR in an Intensive Residential Treatment Setting

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.

<b>I-CPR Services in an Intensive Residential Setting (I-CPR RES/IRTS)</b>	
<b>Definition</b>	Medically necessary on-site services in an intensive residential setting, because of a history of failure in multiple community settings and/or the presence of an ongoing risk of harm to self or others which would otherwise require long-term psychiatric hospitalization. Specific to this level of care - <ul style="list-style-type: none"> <li>• Consumers have significant difficulties with activities of daily living and may require round the clock observation on site.</li> <li>• Services include the monitoring of points of ingress/egress, periodic room checks, and provision of support and rehabilitation activities around specific activities of daily living or when consumers are in crisis. It is expected that rehabilitation activities will be evenly distributed between on-site services and those obtained in the community.</li> </ul>
<b>Staff Qualifications</b>	All staff on-site are trained to provide the on-site services described above, and operate under the direction of a mental health professional
<b>Procedure Code</b>	H0037 TF
<b>Target Population/Service Category</b>	Adults requiring Intensive Community Psychiatric Rehabilitation in a specialized residential setting as an alternative to long-term inpatient hospitalization.
<b>Utilization Rate</b>	Approximately 25 – 40 consumers in the 1st year
<b>Unit Rate</b>	\$230.15 daily rate MHD, \$199.54 provider pay rate
<b>Limits</b>	Will be limited to Community Mental Health Centers which are contracted to provide I-CPR and other CPR services
<b>Place of Services</b>	Congregate Living Setting (POS 99 – Other )
<b>Fiscal Impact</b>	No new General Revenue is required
<b>Requested Effective Date</b>	November 1, 2010

## I-CPR in a Psychiatric Individualized Supported Living Environment

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.

<b>I-CPR Services in a Psychiatric Individualized Supported Living Environment (I-CPR RES/PISL)</b>	
<b>Definition</b>	<p>Medically necessary on-site services in a psychiatric individualized living setting, because of a history of failure in multiple community settings and/or the presence of an ongoing risk of harm to self or others which would otherwise require long-term psychiatric hospitalization. Specific to this level of care -</p> <p>Medically necessary on-site services in a psychiatric individualized living setting, because of a history of failure in multiple community settings and/or the presence of an ongoing risk of harm to self or others which would otherwise require long-term psychiatric hospitalization. Specific to this level of care -</p> <ul style="list-style-type: none"> <li>• Consumers have intermittent difficulty tolerating the presence of others 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.</li> <li>• Consumers will have substantial difficulties with activities of daily living, and will require round the clock observation and oversight on site</li> <li>• Consumers will require daily redirection from on-site staff to avoid behaviors potentially harmful to themselves or others.</li> <li>• Services include the monitoring of points of ingress/egress, periodic room checks, and provision of support and rehabilitation activities around specific activities of daily living or when consumers are in crisis. It is expected that rehabilitation services received will be predominantly provided on-site, although some services will be obtained in the community.</li> </ul>
<b>Staff Qualifications</b>	All staff on-site are trained to provide the on-site services described above, and operate under the direction of a mental health professional
<b>Procedure Code</b>	H0037 TG
<b>Target Population/ Service Category</b>	Adults requiring Intensive Community Psychiatric Rehabilitation in a specialized residential setting as an alternative to long-term inpatient hospitalization.
<b>Utilization Rate</b>	Approximately 25 – 40 consumers in the 1st year
<b>Unit Rate</b>	\$241.21 daily rate MHD, \$209.13 provider pay rate
<b>Limits</b>	Will be limited to Community Mental Health Centers which are contracted to provide I-CPR and other CPR services

<b>Place of Services</b>	2 to 4 bedroom home (Psychiatric Individualized Supported Living Environment) (POS 12 – Home)
<b>Fiscal Impact</b>	No new General Revenue is required
<b>Requested Effective Date</b>	November 1, 2010

# Client Statements

## LT

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LT says she has been housed since 2002 after a long period of homelessness when she was literally living on the streets. She had the following to say about the benefits of having her own place to live:

“I appreciate to have housing, as it has given me stability and security. Being housed has taken away fears of being raped, robbed or killed. Stable housing has given me the strength and motivation to stay sober a good amount of time. Also, it has reunited me with my relatives. My life is drastically different from when I was homeless for many reasons. First off, now I have a meaningful routine. When I was on the street, all I thought about was where I lay my head and when I would eat next. Since I am housed I am able to take my medicine regularly, causing me to have less symptoms of my illness. I have been able to achieve many things that weren't possible when I was homeless. First off, I have lost 103 pounds. They have found finally the right combinations of medicine to stay stable. I have reconnected with my God and feel loved, appreciated and wanted and of worth and of value.”

She said it was important to her to add the following statement.

“I feel very appreciative for the services I have received and for the support with my medicine, doctor appointments, encouragement and vital information on my illness; and how to cope and deal with my illness successfully. I like and appreciate that support and that the help is ongoing. I try to do as much as I can myself.”

## Terry

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When Terry was referred for services, he was literally homeless, sleeping in bus shelters, car wash bays and shelters for months. He got his own apartment in February through a Shelter Plus Care voucher. This is what he had to say when asked how housing has made a difference in his life:

“It (the apartment) helps keep me sober and when I do drink it isn't in public places. I haven't gotten any tickets since I moved here. I don't have to sleep in the rain and cold. It makes me take things more seriously. My life makes a difference. I don't have as many useless friends as when I was on the street. I had to make friends with whoever was around when I was on the street so I didn't get taken. Now I have some ok friends and I can go home if I want. I don't get convinced to do things against the law for money and I have goals. I want to go to school so I can work. Now that I can take a bath and have a place to keep more than one set of clothes I can go to school and work.”

# Addenda







Missouri Department of Mental Health  
1706 E. Elm St., P.O. Box 687  
Jefferson City, MO 65101  
800-364-9687 ♦ 573-751-4122  
[www.dmh.mo.gov](http://www.dmh.mo.gov)