COLORADO
Department of Local Affairs

John W. Hickenlooper
Governor

Irv Halter
Executive Director

FY 2017-18 Funding Request | November 1, 2016

Department Priority: R-03
Request Detail: Permanent Supportive Housing for Behavioral Health Consumers

Summary of Incremental Funding Change for FY 2017-18	Total Funds	General Fund
Permanent Supportive Housing for Behavioral Health Consumers	$4,000,000	$0

The Department is requesting the Joint Budget Committee sponsor a bill to expand the use of marijuana funds for housing for individuals within the behavioral health system or at risk of entering the behavioral health system. The annual funding request is $4 million from the Marijuana Tax Cash Fund with roll forward authority for each subsequent year.

Problem or Opportunity:

The State of Colorado spends $666[1] per day or $243,090 per year for a bed at the Colorado Mental Health Institute at Pueblo, one of Colorado's state-operated inpatient psychiatric hospitals. The average length of stay at the Pueblo hospital is 192 days compared to the Fort Logan average stay of 101 days, according to Colorado's Office of Behavioral Health. The State's lack of supportive housing for behavioral health consumers prolongs these costly stays rather than offering more cost efficient supportive environments for people to transition to in their home communities. Additionally, state and local governments spend as much as $175 per day or $63,808[2] per year for a high cost homeless person living on the street, over 60% of which are struggling with a significant mental illness and/or substance use.[3,4] This cycle is compounded by the State's shortage of crisis beds which results in individuals in crisis remaining in less than ideal housing, like jails or homelessness, while awaiting an appropriate placement.

Governor Hickenlooper's 2013 Strengthening Behavioral Health Initiative: *a Plan to Safeguard All Coloradans* had the following goals:

- Expand early access to support and services for individuals with behavioral health needs and their families
- Promote ongoing recovery through linkage with community resources
- Decrease the number of unnecessary involuntary civil commitments, hospital emergency room visits, jail stays, and reduce episodes of homelessness for individuals experiencing a behavioral health emergency

[1] Figure received from the Colorado Department of Human Services, Office of Behavioral Health

[2] Getting_Home_2013 study conducted by the Economic Roundtable

[3] Allday, Erin. *The streets' sickest, costliest: the mentally ill.* San Francisco Chronicle, June 29, 2106.

[4] Substance Abuse and Mental Health Services Administration (SAMHSA). Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States. http://homeless.samhsa.gov/ResourceFiles/hrc_factsheet.pdf

- Increase the availability of community and natural supports to prevent behavioral health crisis.

This budget request builds on the Governor's 2013 plan and the ongoing work of various stakeholder groups, by aiming to reduce the length of hospitalization and reduce readmission rates. In addition, the funding will target behavioral health consumers exiting the Department of Corrections (DOC) and county jails, as well as individuals with severe mental illness who lack adequate housing. The Department proposes to do this by creating 354 affordable supportive housing units within the first five years of this funding for Colorado's most vulnerable citizens, matched with 300 State Housing Vouchers.

Just this year, there are approximately 3,850 people with severe mental illness reported through sources such as annual Point in Time homeless counts (1,877 people), exiting DOC into homelessness (1,800 people) and in the State's Mental Health Institutes (MHI) (180 people) ready to transition to community living but lacking a supportive home.

Safe, decent and stable housing improves individual's well-being and productivity, while also reducing chances for incarceration, hospitalization or homelessness.[5] Specifically, in a 2014 study "The Relationship Between Community Investment in Permanent Supportive Housing and Chronic Homelessness," within 372 communities studied between 2007 and 2012, the mean number of permanent beds with rental assistance and services rose by 57% while the mean rates of people languishing in homelessness decreased 35%.[6] Certain chronic medical and behavioral health conditions, as well as limited income, make it difficult for individuals to maintain a stable home without additional assistance. Repeated studies show the evidence-based practice that a home is the first step in obtaining adequate treatment and that it is essential to start on the path toward recovery.

It is the intent of this funding request to allocate in year one $820,000 for housing vouchers which will be paired with the creation of approximately 125 new housing opportunities for people that are exiting or at risk of entering state hospitals or mental health institutes, and other individuals with special needs such as behavioral health or substance use disorders. In subsequent years, the number of created units will decline as more funding will be allocated to ongoing housing stability through vouchers. Because people with mental illness and other severe disabilities are more likely than others to be incarcerated or to enter long-term healthcare institutions like nursing homes or psychiatric hospitals, or to cycle between institutionalization and homelessness, housing is a vital solution.[7] People with histories of incarceration or institutionalization significantly reduce their use of those systems after moving into supportive housing. Many studies show that supportive housing successfully interrupts this cycle. For example, one of the largest studies to date that documents these reductions, conducted in New York City, found that individuals placed in supportive housing spent, on average, 115 fewer days per person in homeless shelters, 75 fewer

[5] Jocelyn Fontaine et al., "Supportive Housing for Returning Prisoners: Outcomes and Impacts of the Returning Home Ohio Pilot Project," Urban Institute, August 2012, http://www.urban.org/sites/default/files/alfresco/publicationpdfs/412632-Supportive-Housing-for-Returning-Prisoners-Outcomes-and-Impacts-of-the-Returning-Home-Ohio-PilotProject.PDF.

[6] Byrne, Thomas; Fargo, Jamison; Montgomery, Ann Elizabeth; Munley, Ellen;and Culhane, Dennis. *The Relationship Between Community Investment in Permanent Supportive Housing and Chronic Homelessness*. Social Service Review 88.2, 2014.

[7] Metraux and Culhane (2004) found that 45 percent of those leaving jails or prisons with a prior history of homeless shelter use reentered shelters, mostly within the first month of release. People who had contact with the mental health system had more shelter stays and re-incarcerations than those who had not. Similarly, Culhane, Metraux, and Hadley (2002) found that, among people experiencing homelessness entering supportive housing in New York City, 26 percent had stayed in a state run psychiatric hospital in the two years prior to moving into supportive housing. Hopper et al. (1997) conducted in-depth interviews with 36 people experiencing homelessness. They identified a sub-set of these individuals who lived in an "institutional circuit" — they spent some time homeless, but they spent about 40 percent of their time cycling between hospitals, psychiatric institutions, and prisons and jails.

days in state-run psychiatric hospitals, and almost eight fewer days in prison or in jails, in the two years after entering supportive housing, compared to a similar group without supportive housing.[8]

Most studies recruit people from homeless shelters or off the streets, but a few small studies use supportive housing to help people move out of nursing homes or other institutions.[9] One found that a group in supportive housing recruited from psychiatric hospitals moved quickly out of the institutions and avoided subsequent homelessness, while a group without supportive housing exited institutions much more slowly and experienced higher rates of homelessness two years later.[10]

Additionally, preliminary findings from the Western Interstate Commission for Higher Education (WICHE) 2016 Behavioral Health Study completed for the Office of State Planning and Budgeting (OSPB) shows statistically significant differences in cost of outpatient care among homeless individuals that can also be classified as "indigent" under the OBH qualifications, which is defined as those who earn less than 300% of the Federal Poverty Level and who have no other source of funding (e.g., Medicaid) to pay for behavioral health services. The mean cost of care was found to be $3,355 for an indigent client experiencing homelessness, while only $2,396 for an indigent client who is not experiencing homelessness. Homelessness, as an isolated variable, had a greater effect on cost of care than did unemployment and diagnosis of a serious mental illness/serious emotional disturbance. The study states, "Services to reduce homelessness and unemployment are critical for the indigent population as data indicate a significant proportion of the indigent population is struggling with homelessness and unemployment, and homelessness in particular appears to be associated with poor functioning and a higher cost of care."

HOUSING MARKET:

To understand the shortage of affordable units in Colorado, you need only pick up the newspaper or listen to the news. Behavioral health consumers who are homeless or who want to return to the community after receiving care in an institution face particular barriers without assistance finding housing. According to the Denver Metro Apartment Vacancy and Rent Report[11], vacancy rates in market rate apartments have hovered at or below 5% for the past four years (with the exception of the past two quarters, due to a normal seasonal increase and construction of new, expensive apartments). As a result, market rents have increased from just under $1,000 to just over $1,300. In comparison, vacancy rates in affordable housing are typically below 3% simply allowing for unit turnover, and they tend to have long waiting lists.

There are 272,250 Colorado low-income households who are "severely cost burdened," paying more than 50% of their income for housing. Currently, 108,970 renter households spend more than 50% of their income for rent and earn less than 30% of the Area Median Income (AMI), which is $24,300 for a four-person household Denver Metro area. Affordable housing options are scarce, often causing those that could be served in the community to remain institutionalized. In order for clients to live in the community, they must first have access to safe, affordable and suitable housing options. In Colorado, there are 128,000 more households than available units.

[8] Culhane, Metraux, and Hadley, 2002.

[9] Studies include between 25 and 80 people

[10] Leyla Gulcur et al., "Housing, Hospitalization, and Cost Outcomes for Homeless Individuals with Psychiatric Disabilities Participating in Continuum of Care and Housing First Programmes," Journal of Community & Applied Social Psychology, April 2003, Vol. 13, pp. 171-186.

[11] The Denver Metro Apartment Vacancy and Rent Report for the First Quarter of 2016. Ron L. Throupe, Ph.D, Daniels College of Business, University of Denver & Jennifer L. Von Stroh, Colorado Economic and Management Associates. https://www.colorado.gov/pacific/dola/node/105576/

A 2015 study recently released by the Public and Affordable Housing Research Corporation (PAHRC)[12] indicates the need for rental assistance is growing as rents rise nearly three times as fast as household incomes. At the same time, the supply of federal rental assistance is inadequate to meet the mounting need. Although the total number of units nationally in the primary housing assistance programs has increased less than 3% since 2007, there has been an increase of approximately 21% in the number of extremely low-income households over the same time period further exacerbating the housing crisis.

HOUSING FOR PEOPLE WITH SPECIAL NEEDS:

➔ **People Exiting and at Risk of Entering Colorado Mental Health Institutes**

The Colorado Department of Human Services (DHS) reports that it has a need for additional housing for clients that are exiting the Colorado Mental Health Institutes, exiting other institutional settings into homelessness, or clients who are at high risk of hospitalization. On any given month, there are a number of state hospital patients that could be discharged if they had adequate housing. For example, on July 1st, 2016, there were 15 individuals at the Mental Health Institutes who could have benefited from stepping down into a lower level of care if the Department had available housing. This equates to approximately 150 annually. In addition, DHS reports that in August there were 1,500 behavioral health consumers reporting as currently homeless. Supplying permanent affordable housing to these individuals can end the revolving door between state institutions and homelessness.

➔ **Ex-Offenders or Diversions from Incarceration**

In addition to mental illness, incarceration is strongly associated with housing instability and homelessness, and individuals with mental illness have a stronger likelihood of being incarcerated and/or homeless and have longer stays in facilities or on the streets. According to the Justice Center at the Council of State Governments, more than 10% of people entering prisons and jails are homeless in the months before their incarceration. The rates are even higher at nearly 20% for those with mental illness. Individuals with a history of shelter use prior to incarceration were almost five times as likely to have a shelter stay after release from incarceration.[13] According to a qualitative study by the Vera Institute of Justice, individuals released from prison and jail to parole who entered homeless shelters were seven times more likely to abscond during the first month after release than those who had some form of housing.[14] According to DOC, approximately 150 individuals exit Colorado's state prisons into homelessness each month (1,800 annually), and the majority (70%) have high service needs.

➔ **Homeless Individuals with Severe Mental Illness:**

Additionally, the U.S. Department of Housing and Urban Development's (HUD) report on the 2015 Point-in-Time survey indicates that there were a total of 9,953 homeless individuals in Colorado. Of these, 1,877 were chronically homeless. Additionally, 1,800 of these individuals self-reported chronic substance abuse disorders and 1,877 individuals self-reported that they were severely mentally ill. The Substance Abuse and Mental Health Services Administration (SAMHSA) has found that over 60% of people who are chronically homeless have experienced lifetime mental health problems and over 80% have experienced alcohol and/or

[12] "Value of Home" a 2015 Public and Affordable Housing Report. HAI Group. http://www.pahrc.org/studies/2015PAHRCReport.pdf

[13] Metraux, S. & D.P. Culhane. "Homeless Shelter Use and Reincarceration Following Prison Release: Assessing the Risk." *Criminology & Public Policy* 3, no. 2 (2004): 201-22.

[14] Metraux & Culhane; David Michaels et al., "Homelessness and indicators of mental illness among inmates in New York City's correctional system." *Hospital and Community Psychiatry* 43 (2002): 150-55.

drug problems.[15] It would be safe to assume that both untreated mental health and substance abuse problems are leading contributing factors to homelessness for many individuals.

So intertwined are homelessness and mental health that it is impossible to resolve one without addressing the other. The HUD defines chronic homelessness as "an individual or family with a disabling condition who has been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years." Chronically homeless individuals present serious challenges for service providers and the community at large. This group utilizes a disproportionate share of shelter beds and emergency services (especially hospital emergency room visits and criminal justice system encounters). Further, their substance use, mental health, incidents of trauma, and medical/physical disorders create significant barriers to successful transition from the streets to permanent housing and long-term housing sustainability.

NEED FOR SUPPORTIVE HOUSING IN COLORADO:

Permanent Supportive Housing (PSH) is an evidence-based model and highly effective strategy that combines affordable housing with intensive coordinated services, and it is a proven solution to the problem of finding safe, stable housing for people with behavioral health issues. In August 2014, a study titled Recommendations for Increasing the Supply of Supportive Housing in Colorado completed by the Governor's Office found that Colorado's existing inventory of PSH units was inadequate to meet the current need. It is estimated that in order to meet the needs of Colorado's most vulnerable citizens, an additional 5,800[16] new affordable units, many with supportive services, were needed at the time of the study. Additionally, the study found that there are two main components to filling the affordability gap:

- ➔ Larger grant-like investments in the construction of additional new supportive housing units, such as grants, equity investments provided in exchange for tax incentives, and "soft" debt that is only repaid to the extent that there are net revenues from the projects.
- ➔ More rent vouchers to house homeless people in: (1) scattered-site supportive housing programs, and (2) new affordable rental projects, where project-based vouchers are essential to bridge the large gaps between affordable rents and operating costs.

Rental Assistance Voucher use in Colorado:
The Department has 7,015 housing vouchers leased with an additional 456 individuals with vouchers searching for an available unit across the state under a variety of federal and state programs. On average, people who receive a voucher have a 74% success rate – in other words, 26% of them are unable to find appropriate housing even with rental assistance. Of those that are eventually successful, they need an average of 67 days to find a suitable unit. This process is even more challenging for people with behavioral health issues, which is why increasing the supply of PSH units designed to support them is so important.

Capacity to Create Permanent Supportive Housing units in Colorado:
The Department has partnered with the Governor's office to offer the PSH Toolkit, an intensive series of classes designed to help local non-profit agencies learn to develop PSH projects. Although the state has made great strides towards increasing the PSH stock, with 282 units funded two years ago and 134 in the

[15] Substance Abuse and Mental Health Services Administration (SAMHSA). Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States. http://homeless.samhsa.gov/ResourceFiles/hrc_factsheet.pdf

[16] Recommendations for Increasing the Supply of Supportive Housing in Colorado. A report to the Colorado Governor's Office, by Werwath Associates, August 20, 2014

pipeline currently, Colorado still needs over 5,000 units to meet demand. Colorado has the need for PSH units and the talent to develop them, but we lack the funding to make them a reality.

Proposed Solution:

Beginning in FY 2017-18, the Department, in collaboration with the DHS, requests $4 million in cash funds from the Marijuana Tax Cash Fund (MTCF) to support the development of approximately 354 new units and State Housing Voucher rental assistance for approximately 300 supportive housing (SH) units for behavioral health consumers who are exiting institutions or who are homeless and/or in jeopardy of becoming institutionalized. The request includes 1.0 FTE to administer the funding through the underwriting of projects and programs, and the long-term management of the housing vouchers. Additionally, the Department will contract with a Housing Navigator that will connect clients with services, agencies and housing providers to ensure client needs are being met and clients are achieving the goal of housing stability rather than cycling through hospitals, jails, detox and possibly homelessness.

State dedicated resources for both development and rental assistance are needed given Colorado's high-cost, low-vacancy housing market. Affordable units must be developed to create more opportunities for the pairing of units to vouchers for supportive housing. Existing voucher programs throughout the state have extensive waiting lists that have been closed for years due to the high demand and limited vouchers. Furthermore, many of Colorado's highest utilizers of emergency and behavioral health systems without stable housing are not able to access federally funded rental assistance due to narrow federal eligibility and definitions. State funded vouchers will enable the state to resolve housing and thereby reduce utilization for a wide range of individuals.

The Department envisions using the $4 million for rental assistance and the acquisition and/or rehabilitation of existing units. The Department, in cooperation with DHS, will work to identify individuals who are in need of both supportive housing and rental assistance and connect them quickly to safe, stable housing. Also due to the acuity of client needs, the budget below includes a housing navigator to assist clients throughout the housing placement.

The Department will work with affordable housing developers and behavioral health providers across the state to identify buildings and leverage funding for the acquisition and/or rehabilitation of the identified units. The Department leveraged its state funds 23:1 in FY 2015-16. This high leveraging is largely due to the number of new construction projects. Because the resources available for new construction are limited, particularly with the highly competitive 9% Low Income Housing Tax Credit (LIHTC) program, the Department anticipates the majority of funds will be used for the acquisition and rehabilitation of existing units.

Funding awards under this program will be dependent on match dollars from local community sources such as:

- Federal block grants to local governments
    - Community Development Block Grants (CDBG)
    - HOME Investment Partnership Program
- Local resources
    - City/County General Fund Dollars
    - Housing Vouchers
    - Behavioral Health Agency Funds
    - Foundations, fundraising
    - In-Kind Services

- Fee Waivers

Funding awards will also be dependent upon the incorporation of services for the tenants directly by the agencies or by partner agencies in the community. Agencies will need to ensure that tenants have access to behavioral and medical health care, as well as vocational and education services when appropriate, to support individuals to maintain housing, improve well-being and ultimately live as independently and productively as possible, including reducing chances of recidivism. The proposed housing navigator will work with clients, landlords and their respective service agencies to ensure housing needs are being met. Similar to the current model of the Department's various supportive housing vouchers, agencies are required to engage tenants to encourage participation in services and to ensure housing stability. However, tenancy is not predicated upon treatment or program participation. Community mental health agencies are key partners in offering and provider existing treatment and services within their current programs both on site at the residences and within each community mental health center site. Currently providers have existing sources of funds to cover services, including funding through the Office of Behavioral Health as well as some portion through Medicaid reimbursement. Services to support housing stability have not historically been covered fully by Medicaid, but many providers are working to improve billing rates for tenancy supports beyond traditional mental health treatment.

Permanent Supportive Housing Model:
As mentioned above, PSH is a proven and efficient model of affordable housing with intensive services that aids people struggling with disabilities to maintain stable housing and receive care. PSH is considered evidence-based by Results First standards. Most of the studies reviewed by the Washington State Institute for Public Policy looked at Housing First programs, which provide independent apartments where participants hold the lease but receive subsidies to pay rent. These programs don't have specific requirements for abstinence or treatment; however, these programs typically provide intensive case management and services. PHS targets several outcomes to varying degrees of effectiveness, but its largest impact is on reducing homelessness. Although the program significantly reduces homelessness, homelessness is not an outcome that can be monetized through the Results First model.

PSH housing features:

Permanence and affordability
Tenants generally pay no more than 30% of their income for rent through the use of rental vouchers. They have the same rights and responsibilities as other renters, such as having the lease in their name and the right to privacy in their unit, which means they cannot be evicted for reasons unrelated to being a good tenant.

- Services are housing-oriented- Services aim to help tenants remain housed. Service providers help people find suitable housing, build relationships with their landlords, and understand their rights and responsibilities as renters. Providers also intervene to prevent evictions.
- Services are multi-disciplinary- Service providers also help tenants address physical health, mental health, and substance use conditions, and help with other needs. Teams of professionals such as mental health and substance use specialists, nurses or doctors, and case managers provide care.
- Services are voluntary but assertive- Services are voluntary although providers offer supportive services *assertively*, which means that they will continue to show up and check on someone even if tenants don't request help.

Integration
Individuals and families are able to live independently in apartments in residential neighborhoods. Tenants in supportive housing should have access to public transportation, grocery stores, parks, and other neighborhood amenities common to all other residents. Services are usually provided in the client's unit or building, or at a place of their choosing in the community.

Emphasis on choice
Supportive housing maximizes client choice, in clients' housing options and the services they receive. For instance, tenants can generally come and go as they please and have control over their daily schedule, like mealtimes and visitors. They also can direct the types of services they receive and the goals they set with the service provider. This investment furthers Colorado's efforts to comply with the requirements of the Olmstead Act by offering housing choice to persons with a disability.

Low barriers to entry
Supportive housing providers do not require clients to hit benchmarks before moving into housing or put other screening barriers in the way. Blanket bans on people with criminal histories or bad credit, for example, or requirements to meet goals, like employment or completing a course of treatment, before entering supportive housing would screen out the very people supportive housing aims to help.

Based on the acuity of client needs and the gap in regional resources for serving people with mental illness, there are other supportive housing options that may also be considered:

- **Rural Respite beds for Coloradans in Crisis**
  The Communities Coming Together for Mental Health (CCTMH) pilot resulted in the creation of rural respite rooms to provide shelter and care for rural community members in mental health crisis rather than incarceration, hospitalization or homelessness. Although no rent is charged for the respite beds, the alternative is the regional mental health center to pay $666 per day per client for a bed in the state psychiatric hospital. In 2012, the Department provided funding to Centennial Mental Health Center (CMHC) in Logan County for six respite beds. The Department funded the rehabilitation of 11 units owned by CMHC for adults with severe and persistent mental illness and the new construction of six respite beds to serve community members in mental health crisis. The estimated cost saving of CMHC having six respite beds is $250,000 annually.

- **Group Homes/Congregate Living**
  Congregate housing is a type of housing in which each individual has a private bedroom or living quarters but shares with other residents a common dining room, recreational room, or other facilities. This type of housing allows for supportive services to be delivered in an efficient and effective way for people with addictions and/or disabilities. In 2010 the Department provided funding to Mesa Developmental services for the purchase of three six-bedroom group homes. Although this example is for group homes for persons with intellectual and developmental disabilities, congregate living may also be an option for behavioral health consumers.

Anticipated Outcomes:

The additional housing placements will reduce utilization of state psychiatric hospitals, as well as recidivism to state prisons, county jails and homelessness. The study of the cost of homelessness provides several tools for analyzing the potential for cost avoidance associated with providing supportive housing for people with severe and persistent mental illness. It is also important to note that over 60% of chronically

homeless people are struggling with significant mental illness and/or substance use.[17,18] The first study to quantify the public costs associated with homeless people before and after supportive housing placement was published in 2001. Dozens of studies have since quantified the ways homeless people with disabilities utilize various public systems, including hospitals, emergency rooms, psychiatric hospitals, shelters, jails and prisons.

Below are summaries of several relevant studies and their findings:

- In 2006, the Colorado Coalition for the Homeless' Cost Benefit Analysis Study[19] focused on examining the actual health and emergency service records of a sample of participants in Denver, CO for the 24 month period prior to entering the program and the 24 month period after entering the program. The findings document an overall reduction in emergency services costs for the sample group. The total emergency related costs for the sample group declined by 72.95%, or nearly $600,000 in the 24 months of participation in the program compared with the 24 months prior to entry in the program. The total emergency cost savings averaged $31,545 per participant.
- In 2013 A Pilot Study of the Impact of Housing First Supported Housing for Intensive Users of Medical Hospitalization and Sobering Services[20] was completed in Seattle. Participants showed a significantly greater reduction in emergency department and sobering center use relative to the comparison group. At a trend level, participants had greater reductions in hospital admissions and jail bookings. Reductions in estimated costs for participants and comparison group members were $62,504 and $25,925 per person per year—a difference of $36,579, far outweighing program costs of $18,600 per person per year.
- In 2014, The Cost of Long-Term Homelessness in Central Florida[21] studied a cohort of 107 chronically homeless individuals. The study calculated that the average annual cost to be homeless and cycling in and out of incarceration, emergency rooms and inpatient hospitalizations was $31,065 per person per year. Housing for this same group would similarly cost an average of $10,051 per person per year for a savings of $21,014.

In Colorado, the Department's successful "Shelter Plus Care" program serving people experiencing homelessness with intensive service needs, which includes rental assistance paired with case management, mental health, and substance abuse services achieved a 93% housing stability rate in the 2014 grant fiscal year. Additionally, 83% of Shelter Plus Care participants increased or maintained their total non-earned income, 9% maintained or increased their earned income, and 91% had mainstream benefits upon exiting the program.

Similar housing stability outcomes are anticipated for this effort as well, which will result in reduced usage of the limited state psychiatric hospital beds. Specifically, housing will reduce the length of time individuals reside in the hospital due to lack of stable discharge plans and will reduce the return to hospitals as housing assists in stabilizing individuals' mental health status. As a result, the state psychiatric hospitals will have reduced lengths of stay, creating additional capacity to serve those on the extensive waiting lists.

[17] Allday, Erin. *The streets' sickest, costliest: the mentally ill.* San Francisco Chronicle, June 29, 2106.
[18] Substance Abuse and Mental Health Services Administration (SAMHSA). Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States.
http://homeless.samhsa.gov/ResourceFiles/hrc_factsheet.pdf
[19] http://www.coloradocoalition.org/!userfiles/housing/denver_housing_first_study.pdf
[20] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3558756/pdf/AJPH.2012.300867.pdf
[21] http://shnny.org/uploads/Florida-Homelessness-Report-2014.pdf

Assumptions and Calculations:

The Department estimates that $4 million annually from the MTCF will support the development of approximately 354 supportive housing units which will be paired with 300 State Housing Vouchers rental assistance over the first five years of this program. The Department expects to fund the acquisition and rehabilitation of existing units and also new construction of units. Although leveraging is better for new construction, the funding sources are highly competitive and limited, which necessitates a balance with existing units.

New Construction: Supportive housing for people with behavioral health issues can take many different forms, depending on client needs and available resources. The typical PSH toolkit project consists of 30 to 100 new constructed apartments and utilizes LIHTC equity, gap funding, conventional debt when possible, and project-based housing choice vouchers to cover operating costs that exceed the tenants' contributions toward rent. In 2015, the Department provided gap funding to five of these PSH projects for a total 234 units and $9.35 million in the Department's funding. In FY 2015-16, the average investment by the Department to develop PSH projects was approximately $8,700 per unit.

An example of a PSH toolkit project is Sanderson Apartments by the Mental Health Center of Denver (MHCD). MHCD was awarded a $320,100 grant and a $450,000 loan from the Department for the development. Sanderson Apartments will consist of 60 one bedroom apartments in a three story elevator serviced building. The development was awarded 9% LIHTCs by CHFA and has a commitment from the Denver Housing Authority and the Department for 30 project-based vouchers each for a total of 60 project-based vouchers. MHCD will provide services to the community's "Front End Users", those repeat offenders who, as a result of their homelessness, have frequently committed low-level offenses and relied heavily on local service agencies such as medical and psychiatric hospitals, jails, courts, shelters, and detox facilities. Located in Metro Denver, the project includes offices and amenities designed to facilitate the delivery of case management services. Sanderson Apartments was selected to receive Social Impact Bond (SIB) funding to assist in funding the supportive services for the first five years. This is a "pay for success" model of funding based on the cost savings to the city. The Department funding of $770,100 was leveraged by $14.4 million in other development financing.

Acquisition and Rehabilitation of Existing Units: Another supportive housing model is using small apartment buildings to create residential properties that combine housing and services for residents. These supportive housing communities typically consist of 10 to 20 units and can be transitional or permanent housing. Tenant-based rental assistance, sponsor contributions, or both can be used to cover the cost of operating the buildings. The Department will need to invest at a higher level in these projects due to the scarcity of other viable funding sources, particularly if the project involves acquisition in addition to rehabilitation, or new construction.

An example of a small supportive housing development is Karis Community in Denver. In 2011, the Department awarded a $300,000 grant for the rehabilitation of 17 units of transitional supportive housing for individuals recovering from serious and persistent mental illness. Residents are referred by social workers, private therapists, mental health workers, and family members. Residents earn up to 30-60% AMI, and they pay 30% of their income toward room and board. The average resident income at Karis Community is $8,719 annually. In addition to participating in on-site community activities and also receiving off-site therapeutic services, all residents at Karis must work, attend school or volunteer at least 20 hours per week. A typical resident lives at Karis for an average of 14 to 16 months and then moves on to more independent living.

Another example is Regal Apartments in Littleton operated by the Community Housing Development Association (CHDA) in partnership with Arapahoe Douglas Mental Health (ADMH), Arapahoe House and Developmental Pathways. In 2011, the Department awarded a $300,000 grant to CHDA for the acquisition and rehabilitation of this 12-unit rental community for persons with developmental disabilities, mental illness and/or drug or alcohol substance addiction. Residents at Regal Apartments earn up to 30 and 50% AMI.

Housing Production: The production of units is based on an average of $24,000 per unit. This average is based on the Department's work described above through new construction and the acquisition/rehab of existing structures. Based on these assumptions, the Department estimates 354 new units will be created over five years.

Housing Vouchers: Housing vouchers essentially pay the difference of the fair market rent and the rental amount a client cannot afford from his/her income. Voucher recipients pay 30% of their income, and the voucher pays the difference. The budget below assumes the subsidy amount for a voucher will be $650 per month. This is based on the Department's current average subsidy. Based on these assumptions, the Department estimates it will serve at least 300 households over five years.

Housing Navigator: The Department will contract with a Housing Navigator that will connect clients with services, agencies and housing providers to ensure client needs are being met and clients are achieving the goal of housing stability rather than cycling through hospitals, jails, detox and possibly homelessness. The need for a housing navigator is necessitated by the acuity of needs of the clients.

Department Administration: The request includes 1.0 FTE to administer the funding through the underwriting of projects and programs, and the long-term management of the housing vouchers.

Expenses	Year 1	Year 2	Year 3	Year 4	Year 5	Assumptions
Housing Production	$ 3,000,000	$ 2,000,000	$ 1,700,000	$ 1,400,000	$ 1,000,000	5% annual cost inflator
Units per Year	125	79	64	51	35	
Cumulative Units	125	204	269	319	354	40% Acquisitions 60% New Const
State Housing Vouchers	$ 820,000	$ 1,816,400	$ 2,112,728	$ 2,408,983	$ 2,805,162	$650/unit (5% annual inflator)
People served w/SHV	105	222	246	269	300	
Housing Navigator	$ 80,000	$ 81,600	$ 83,232	$ 84,897	$ 86,595	
Administrative	$ 100,000	$ 102,000	$ 104,040	$ 106,121	$ 108,243	
Total	**$ 4,000,000**	**$ 4,000,000**	**$ 4,000,000**	**$ 4,000,000**	**$ 4,000,000**	

The Department requests that funding for this request be approved in the Division of Housing, Affordable Housing Grants and Loans line item. That will provide the Department with flexibility to balance the program spending with the housing needs of behavioral health clients – whether it be grant or loan funding to produce new supportive housing stock, or housing vouchers when the housing stock is adequate to absorb vouchers efficiently. This market responsiveness allows the program to operate most efficiently. Pursuant to Section 24-32-721, the Department will spend up to 3% for the administration of the program.