Background

High Acuity: High acuity homeless men are men usually with chronic mental illness or chemical dependency who have been homeless for a long time or with numerous episodes; these men, while a small portion of those homeless, eat up at least half of all resources in the homeless system (as well as in health care, law enforcement etc…); they tend to create destruction when they concentrate in significant numbers, in part because of their own behaviors but also because of those who prey upon them, often drug dealers; they are the hot potatoes in most regions as communities do whatever they can to push them somewhere else; it is not accident that there is not a single emergency shelter bed for high acuity homeless men outside of the City of St. Louis or more than 1 mile from Downtown

Medium Acuity: Medium acuity individuals are people who typically don't have chronic mental illness or chemical dependency though they may have a transient episode; they are people who typically have not been homeless before, or at least recently, who have become homeless for a reason, like a job loss, divorce, medical bankruptcy, or otherwise; they cluster around good service providers like St. Patrick Center as they are looking for help to escape their situation; they typically don't create huge problems around them; though, medium acuity men to the general public tend to look a lot like high acuity men and are often lumped with them for service provision, such as at NLEC and The Bridge

Regional, Scattered Site Facilities: There are homeless services scattered throughout the City of St. Louis and parts of the St. Louis region; however, these almost exclusively serve those who are not perceived to create problems, including women and children, abused women, men with diseases like AIDS, those with long term non-violent mental illness, kids exiting foster care, and medium acuity individuals in rapid re-housing

Centralized Downtown Services: Since high acuity, and many medium acuity men, are viewed as toxic to the surrounding suburbs and most urban neighborhoods, they are sent Downtown via police car, private vehicle, mass transit, taxi and otherwise; services for these men (other than some permanent supportive housing and rapid re-housing beds) are almost exclusively clustered Downtown or very close to Downtown; in the last 5 years, the only facilities that provided overnight shelter to significant numbers of high and medium acuity men have been NLEC, Sunshine Mission (just north of Downtown), Peter and Paul (Soulard), Harbor Light (Midtown but now closed) and the City's 125 bed shelter at Park and Tucker (just south of Downtown)

Off The Grid Shelters: Some overnight shelter operate "off the grid as they know their business model is not a best practice and would not be funded by government; typically, their funding comes through their religious organizations; these shelters often do not participate in the regional coordinated continuum of care, in a centrally managed homelessness database, or the annual HUD mandated point in time courts to determine the total population of homeless individuals in an area; HUD hates off the grid shelters because they undermine the implementation of the Housing First model, prevent identification of many homeless individuals in the system, and enable many homeless individuals to stay homeless under the guise of providing comfort to the homeless, typically for religious reasons

The Old Best Practice Model: When homelessness showed up in large numbers in the 1970's, a overnight shelter based model was created to deal with this assumed temporary condition; as the problem stayed around, the system added "transitional" housing to help people transition out of homelessness; the combined shelter / transitional housing model involved people starting in overnight shelter and earning their way into transitional housing by checking various boxes such as sobriety, job skills training, life skills training, treatment of mental illness etc… this model helped perpetuate chronic homelessness as many of those who were homeless simply were not willing or able to comply with the rigid service provider preferred model

Housing First: The federal best practice model that was adopted by the federal government in the early 2000's is called Housing First; it is supported by extensive evidence as the best way of helping people escape homelessness; it abandons the shelter / transitional housing model to a large degree (there is very little federal money for shelter anymore) and replaces it with housing, meaning apartments that people live in; the idea is that if people are housed in apartments that they control 24/7 as the first intervention after they have been identified, and escape the incredible stress of life on the street, it is much easier to deal with their other issues like chemical dependency

Permanent Supportive Housing: PSH was the first federally mandated Housing First approach; PSH targets high acuity individuals, typically men, and involves providing sometimes permanent apartments for them while service providers work to address their underlying issues; some men can successfully graduate out of homelessness; some men will spend the rest of their lives in PSH units; but, it is much cheaper for the system, from a homeless service, health care and law enforcement perspective, to keep these men housed rather than on the street; estimates are that men in PSH units tend to cost the overall system $15-20,000 per year while high acuity men on the streets cost the system $40-100,000, mostly for health care costs

Rapid Re-Housing: RR was innovated under the Obama administration in about 2009 to counteract the excessive resources being directed to the high acuity, which costs a lot more per individual served; RR is targeted at medium acuity individuals who are looking for help to escape homelessness but can't do so immediately or without help; RR provides free or subsidized apartments for 3-6 months while people deal with their issues, look for jobs, reconcile with families etc…; these units are typically widely scattered in the community

10 Year Plans to End Homelessness: In 2004 or so, HUD mandated that cities and regions develop 10 year plans to end homelessness, targeted primarily at high acuity individuals using PSH; the City and County developed a joint plan that was finalized in 2005; the City has diligently been working to create PSH beds ever since; the County has done very little, as allowing homeless individuals to stay in the County is politically challenging

St. Louis' Unique Dysfunction: St. Louis has a unique dysfunction related to homelessness; the City-County divide, the reality of two states in the region, and many other factors result in a system where the model most non-urban areas follow to deal with homelessness is to not offer any services in their community, deny they have an homeless citizens, and export their homeless to the City of St. Louis; thus, the 300,000 person City is saddled with almost all of the homelessness for a 3 million person region; within the City, the aldermanic structure results in individual alderpersons being able to veto pretty much any facility for the homeless they don't like, which are typically facilities for medium and high acuity men

Proposed Biddle House Model

The City's Biddle House Plan is not that far off from federal best practices related to everyone but medium and high acuity men. However, the the hot potatoes are medium and high acuity men combined with the impending changes at NLEC (that have been housing most of them).

The City's approach of ignoring Best Practices combined with the unique dysfunction of the region, has resulted in this plan for Biddle House. Biddle House has 3 components:

- A 125 – 140 bed overnight shelter for medium and high acuity men to replace what NLEC provides
- A facility for meal service and day shelter for 180 or so medium and high acuity men, to replace what The Bridge provides
- A single location for intake and assessment for homeless men throughout the region, something that does not exist today

The City has tried and failed to locate this facility in other neighborhoods of the City, as the alderpersons have vetoed the facility in their wards; after much frustration trying to find another location, they moved to jam it into Downtown. They are vehement to put this in Downtown because it is highly unlikely they can find another location for it due to the regional dynamics

There are a host of problems with the plan for Biddle House beyond the devastating impact it would have upon the community, particularly in light of its proximity to St. Patrick Center, Sunshine Mission, Gateway 180, the surrounding high poverty neighborhoods etc…

- HUD, per Iain de Jong and Phillip Mangano, does not support emergency shelter for high acuity men except in conditions of cold weather when lives are in jeopardy; the appropriate intervention for high acuity men is direct placement into permanent supportive housing; assertive community treatment teams should locate high acuity men in place in the community and push them to accept PSH; emergency shelter for high acuity men 1) enables men to live on the streets where they become more damaged by the day, 2) undermines the willingness of men to escape their lives on the street which may be attractive to them in the short term, 3) does nothing to actually end homelessness for individuals in the best case, and 4) diverts resources from housing which it the ultimate solution to homelessness.
- Low demand meal service and day shelter for high acuity men shares the same basic flaws as emergency shelter
- Centralized intake and assessment is a really bad idea as many who need to be identified and assessed will either not be able to or unwilling to make it to the centralized location, thus staying "off the grid" and missing out on help the system can offer

Replacing Biddle House

There are alternative models to replace Biddle House that 1) comply with the federal best practice model, 2) will be much easier to find a home for, 3) won't devastate the areas around those homes, stopping the cycle of generating NIMBYism which is justified in light of the devastation the larger facilities cause

A key dynamic for developing an alternative model involves thinking more critically about the need for shelter.

- High acuity men are highly transient, with many moving around the country constantly; due to the fact that the City has been using emergency shelter as a primary intervention for high acuity men, enabling them to stay on the streets, many high acuity men have chosen to stay in St. Louis rather than depart for other places they would normally go to; this has artificially inflated the number of people in shelter beds, distorting the system

- The number of required shelter beds in a region is a function of both the number of people seeking shelter and their length of stay in shelter (which you want to be as low as possible since staying in shelter is damaging and unfruitful); if you can cut the average length of stay in half, you cut the required number of shelter beds in half; the way to reduce the length of stay in shelter is to create housing, both PSH and RR, that people can move to after a short stay (or no stay) in shelter; that is why the best practice model is what it is.

A much better, HUD best practice compliant model for replacing Biddle House, which can be physically implemented elsewhere, is the following:

- Establish a Downtown 50-75 bed emergency shelter for medium acuity men who comply with the services they are being offered and agree not to cause problems in the community; invest resources in accelerating the creation of Rapid Re-Housing beds to create throughput in the system and keep the length of shelter stay down to 30 days or less; creating additional RR beds will also likely allow some medium acuity individuals who are in PSH to move to RR, freeing up PSH beds

- That new shelter would also provide day shelter and meals to the men staying there

- Create ACT teams to locate and track high acuity homeless men and push them into PSH units; invest scarce resources in these ACT teams and additional PSH units

- Establish a "coordinated" intake and assessment process, using a single assessment tool and a centrally housed and managed database, but do the actual intake and assessment process on a scattered site basis at existing facilities