

Addressing the Homelessness Crisis in New York City: Increasing Accessibility for Persons With Severe and Persistent Mental Illness

LeeAnn Shan and Matt Sandler

Homelessness continues to be a persistent and highly visible public health issue in New York City. New York/New York III, the current initiative that aims to expand supportive housing services for New York City's chronically homeless mentally ill population, will expire in June 2016. In the context of shifting policies reflecting the growing popularity of the Housing First model, the authors of this paper call attention to the unique needs of the severely and persistently mentally ill (SPMI) homeless population. The authors propose that the current and future states of homelessness initiatives are inadequate in their levels of funding, coordination, and regulation, thereby negatively affecting New York City's most vulnerable residents. Drawing on evidence from the literature, we compare the Housing First and traditional housing readiness models in New York City, the latter of which has become increasingly controversial in recent years. The authors provide suggestions for bridging the current gaps in research, policy, and practice in hopes of increasing accessibility and prioritizing housing for this population.

Homelessness continues to be a persistent and highly visible public health issue in New York City. In 2013, the number of people sleeping in city shelters each night reached its highest level since the Great Depression, with homeless families and children making up 78% of this population (Markee, 2013). Approximately one-third of all homeless individuals suffer from at least one serious mental illness, and 50% to 70% of homeless mentally ill individuals also suffer from concurrent substance use disorders (Groton, 2013). Homeless shelters are projected to cost New York City close to \$1 billion in 2015, a 62% increase in the last eight years (Bekiempis, 2015). These numbers reflect a serious problem in current service delivery and homelessness prevention methods.

New York/New York III, the current initiative that aims to expand supportive housing services for New York City's chronically homeless mentally ill population, will expire in June 2016. On January 13th, 2016, Governor Andrew Cuomo issued a new initiative to create 20,000 new supportive housing units in New York State over the next 15 years. This initiative adds to Mayor Bill de Blasio's prior commitment to fund 15,000 units in the city over the same time period (Rought, 2016). In the context

of these new developments and shifting policies reflecting the growing popularity of the Housing First model, the authors of this paper call attention to the unique needs of the severely and persistently mentally ill (SPMI) homeless population. The authors propose that the current and future states of homelessness initiatives are inadequate in their levels of funding, coordination, and regulation, thereby negatively affecting New York City's most vulnerable residents. Drawing on evidence from the literature, we compare the Housing First and traditional housing readiness models in New York City, the latter of which has become increasingly controversial in recent years. In doing so, the authors provide suggestions for bridging the current gaps in research, policy, and practice in hopes of increasing accessibility and prioritizing housing for this population.

A Brief History

Modern homelessness in New York City has roots in two important historic events: the deinstitutionalization movement and the decline of the single-resident occupancy housing market (Baxter & Hopper, 1982; cite: Coalition for the Homeless). The deinstitutionalization movement, which began in New York State in the 1950s, facilitated the discharge of thousands of psychiatric patients from state hospitals and other inpatient facilities into the general community. This policy stemmed from new psychopharmacological developments and studies advocating for less restrictive, community-integrated approaches to treatment (Durham, 1989; Talbot, 2004). Over the next few decades, negative public opinion toward inpatient treatment strengthened the movement, largely shaped by popular media depicting abhorrent hospital conditions (e.g., the 1962 novel *One Flew Over the Cuckoo's Nest*).

As a result of deinstitutionalization, the number of resident patients in New York State psychiatric centers fell by 68% between 1965 and 1979 (Coalition for the Homeless, 2015). Lack of follow-up services meant that many newly released individuals were left without any treatment or community support. With limited resources and inadequate follow-up services, the patients sought housing in low-cost, single-resident occupancy (SRO) units. During this era, from 1955 to 1975, restrictive zoning ordinances and changes in New York City housing regulations essentially prevented the creation of any new SROs (Dennis et al., 1991). In addition, gentrification and property tax policies financially incentivized owners of existing SRO buildings to convert SRO units into higher-priced rental housing, cooperatives, or condominiums (Coalition for the Homeless, 2015). These events led to a rapid decline in the

SRO housing stock, which continued for several decades and severely limited both access to and availability of housing.

Adverse political, economic, and social contexts perpetuated modern homelessness. For individuals who struggle with mental illness, the impact of homelessness is especially consequential. Compared with their non-mentally ill counterparts, such individuals generally remain homeless for longer periods of time, have fewer social supports, poorer health outcomes, and experience more barriers to employment (Tessler & Dennis, 1989). Homelessness impedes continuity of care, which further exacerbates these problems.

Past supportive housing plans in New York were a response to the ubiquity of conspicuous homelessness on city streets. The origins of city and state coordination on supportive housing date back to 1990, when Mayor David Dinkins and Governor Mario Cuomo entered an agreement called New York/New York to create 5,000 supportive housing units for chronically homeless New Yorkers. The agreement has since been renewed twice, first in 1999, when 2,000 units were added [New York/New York II], and again in 2005, when the city and state agreed to create 9,000 units over a 10-year period through the New York/New York III initiative (Office of the Public Advocate, 2015).

Housing First

As a way of tackling homelessness for this most vulnerable and chronic mentally ill population, Sam Tsemberis, the founder of the New York-based organization Pathways to Housing created the Housing First model in 1992 (Tsemberis & Asmussen, 1999). The model's philosophy states that access to housing integrated with appropriate and ongoing support services is of immediate concern and should not be contingent on commitment to mental health and/or substance abuse treatment. Housing First aims for harm reduction, in contrast to a housing readiness approach, which emphasizes that psychiatric treatment and/or sobriety should be a precondition to stable housing (Tsemberis, Gulcur, & Nakae, 2004).

Evidence of Housing First's effectiveness has been demonstrated in multiple research studies, set within a variety of contexts (Goering et al., 2011; Tsai, Mares, & Rosenheck, 2010; Stefancic et al., 2013; Stefancic & Tsemberis, 2007). It is important to note, however, that most studies investigating the effectiveness of the Housing First model have had a strong research affiliation with the agencies being evaluated (Groton, 2013). Thus, it is possible that this bias could have influenced more favorable study outcomes.

In a 5-year longitudinal study, Tsemberis and Eisenberg (2000) compared

housing retention rates among New York City individuals housed through the Pathways to Housing program with those who were housed through standard care, treatment-first programs. As predicted, Housing First tenants maintained significantly better housing tenure over the duration of the study—88% remained housed, compared with 47% of the control group (Tsemberis & Eisenberg, 2000). Housing stability has also been linked to positive health outcomes for individuals with mental illness, as evidenced by lower rates of hospital utilization (Kyle & Dunn, 2008), and improvements in overall neuropsychological functioning (Seidman et al., 2003).

In addition to individual benefits, the Housing First approach also promises improvements on a macro scale. In terms of cost effectiveness, increased access to permanent housing and services means decreased risk of contact with the criminal justice system and lowered use of costly acute care services such as emergency shelters and hospital emergency rooms (Dennis et al., 1991; Gulcur, Stefancic, Shinn, Tsemberis, & Fisher, 2003). In a 2013 randomized controlled trial on five major Canadian cities that adopted the Housing First program, it was found that the approach was both effective in reducing homelessness and economic impact—“government savings were even greater for those who used services the most, with three dollars saved for every two dollars spent” (Tsemberis & Stergiopoulos, 2013, p.1).

Continuum of Care

The Continuum of Care was first implemented by the United States Department of Housing and Urban Development (HUD) in 1995 and prescribed a housing readiness model (O’Connell, 2003). Unlike the Housing First approach, the housing readiness approach used in the Continuum of Care system centered on the idea that homeless individuals, including those diagnosed with mental illness, must pass through a series of temporary residential programs (e.g., emergency shelters, transitional housing) with varying levels of care prior to attaining permanent, independent housing (Gulcur et al., 2003). As a result, HUD allocated funding to those housing organizations that followed such a model. For the subset of SPMI individuals who may not be equipped to care for themselves in an independent setting, the requirements of this kind of graduated model—which often include psychiatric medication compliance, participation in psychotherapy, and/or psychosocial rehabilitation—offer the structure and support not necessarily emphasized in Housing First programs.

Although the majority of SPMI adults report a preference for living in as independent and normative a setting as possible (Yamada, Korman,

& Hughes, 2000), and consumers that live under these conditions report higher levels of satisfaction (Wilson, 1992), it is important to remember that subjective satisfaction alone does not eliminate the risk of returning to homelessness. In fact, Yamada and colleagues (2000) found that consumers who were placed in group homes or supported housing with “appropriate structure and support” (p. 36) were able to remain in the community for twice as long as those living independently.

Consumer self-determination is a key component of the Housing First Model that should not be negated. However, social isolation—a significant predictor of psychiatric relapse (Hultman, Wieselgren, & Öhman, 1997)—continues to be a reality for SPMI adults, as community integration can prove extremely challenging. Individuals with severe mental illness living in independent housing report significantly more social isolation than those living in group settings or supportive housing with on-site visits by staff (Friedrich et al., 1999). For these reasons, the New York/New York supportive housing agreements successfully created different levels of supportive housing to include custodial and therapeutic services to meet the variety of needs for chronically homeless individuals and families. In addition, ensuring housing in beneficial neighborhoods with well-maintained buildings has been linked to lower costs of mental health services for SPMI adults (Harkness et al., 2004).

Housing First has evolved to satisfy these unique needs of the populations it serves through different levels of supportive housing. In 2013, HUD changed its Continuum of Care guidelines and began prioritizing funding for localities whose service providers use the Housing First model (U.S. Department of Housing and Urban Development, n.d.) to address chronic homelessness. This change in policy is a major step forward in recognizing the efficacy of providing housing stability as the cornerstone to successful treatment for SPMI and other chronically homeless populations. This prioritization, though, while supported by many service providers, also came with unintended consequences. Service providers in New York City provide mostly transitional housing services in the form of emergency shelter. Given the number of homeless in the city, shelter remains an important safety net. Under the new Continuum of Care guidelines that prioritize Housing First,

“This change in policy is a major step forward in recognizing the efficacy of providing housing stability as the cornerstone to successful treatment for SPMI and other chronically homeless populations.”

service providers that run shelters stand to lose some HUD funding.

New York/New York IV: A Lost Opportunity

The lost funding opportunities and increased number of homeless individuals in shelters and on the street made an updated New York/New York supportive housing agreement even more crucial. What should have been a matter of course—an agreement between city and state to fund a new crop of supportive housing units—turned into a political tug-of-war between Mayor de Blasio and Governor Cuomo over cost sharing.

Under previous New York/New York supportive housing agreements, the state paid 50% of capital expenses while covering 80% of service costs (Stewart, 2015). The mayor began negotiating an agreement by seeking 12,000 units in New York City. The governor responded by offering 3,900 units and changing the previous funding scheme from the state covering 80% of service costs to an even 50-50 split (see: Editorial Board). The impasse resulted in the mayor and governor each announcing his own independent plan for creating more supportive housing; New York City will create 15,000 units of supportive housing over the next 15 years, and the State will create 20,000 units in the same time. On a positive note, the political spat resulted in a one-upmanship that created more supportive housing than either city or state initially offered.

The independent announcements from the mayoral and gubernatorial administrations demonstrate a significant increase in resource allocation to supportive housing. However, these plans function independently of one another and are not a coordinated New York/New York IV agreement. This is significant, as the independent initiatives abandon the efficiency of previous coordinated efforts between the city and state. Past agreements allocated resources and processes for capital financing and service delivery in concert. Now, with two separate initiatives, nonprofits charged with creating new units of supportive housing will likely encounter administrative hassles. A new coordinated New York/New York agreement would be a more efficient strategy to reduce chronic homelessness, as well as a more financially responsible approach. The New York City Department of Health and Mental Hygiene estimated in 2013 that the New York/New York agreements resulted in public savings of \$10,100 annually per unit (Coalition for the Homeless, 2015) through decreased use of emergency services.

Conclusion

Supportive housing is appropriate for the chronically homeless and makes

financial sense for the city and state because of the high cost of care otherwise associated with individuals and families who use emergency services at a high rate. It is important, though, to consider that the chronically homeless are a subpopulation of a larger whole. Nearly one-third of individuals and heads of household in the New York City Shelter system have earned income (Iverac, 2015), and would not qualify for supportive housing. The city and state can partner to make rental subsidies, such as the Living in Communities (LINC) subsidy introduced in 2014, viable options for these individuals and families. The two can also work together to help prevent homelessness by working together to increase funding for the Solutions to End Homelessness Program (STEHP).

These issues must be tackled in a partnership between the city and state, and this requires a coordinated effort between the mayor and governor. Although it is encouraging that more supportive housing will be created over the next 15 years, it is disappointing that these units could not build upon the legacy of a New York/New York agreement. The success of Housing First supportive housing under the banner of a New York/New York IV housing agreement could be monumental. A robust housing plan to curb chronic homelessness in the country's largest city would certainly be a notable achievement. A plan of this nature would signal the joint commitment to providing stability and services to the vulnerable subpopulation of SPMI individuals and families. In the meantime, we welcome the independent plans and look forward the city and state's commitments to addressing chronic homelessness.

“These issues must be tackled in a partnership between the city and state, and this requires a coordinated effort between the mayor and governor.”

References

- Barr, H. (1999). Prisons and jails: Hospitals of last resort. New York: Correctional Association of New York and the Urban Justice Center.
- Barrow, S., Soto, G., & Cordova, P. (2004). Final report on the evaluation of the closer to home initiative. Retrieved from <http://www.csh.org/index.cfm?fuseaction=page.viewPage&pageID=3834&nodeID=81>
- Baxter, E., & Hopper, K. (1982). The new mendicancy: Homeless in New York City. *American Journal of Orthopsychiatry*, 52(3), 393-408.
- Bekiempis, V. (2015, October 16). New York City homeless shelter costs near \$1 billion. *Newsweek*. Retrieved from www.newsweek.com
- Campaign 4 NY/NY Housing. (2015). Campaign Platform. Retrieved from <http://www.nynycampaign.org/platform/>.
- Carmiel, O. (2015, December 10). Manhattan Apartment Vacancies Rise to Highest in Nine Years. *Bloomberg Business*. Retrieved from <http://www.bloomberg.com/news/articles/2015-12-10/>

manhattan-apartment-vacancies-rise-to-the-highest-in-nine-years.

- Coalition for the Homeless. (2015). New York City Homelessness: The Basic Facts. Retrieved from <http://www.coalitionforthehomeless.org/basic-facts-about-homelessness-new-york-city/>
- Dennis, D.L., Buckner, J.C., Lipton, F.R., & Levine, I.S. (1991). A decade of research and services for homeless mentally ill persons: Where do we stand? *American Psychologist*, *46*(11), 1129-1138.
- Durham, M.L. (1989). The impact of deinstitutionalization on the current treatment of the mentally ill. *International Journal of Law and Psychiatry*, *12*, 117-131.
- Friedrich, R.M., Hollingsworth, B., Hradek, E., Friedrich, H.B., & Culp, K.R. (1999). Family and client perspectives on alternative residential settings for persons with severe mental illness. *Psychiatric Services*, *50*(4), 509-514.
- Goering, P.N., Streiner, D.L., Adair, C., Aubry, T., Barker, J., Distasio, J., Hwang, S.W., Komaroff, J., Latimer, E., Somers, J., & Zabkiewicz, D.M. (2011). The At Home/Chez Soi trial protocol: A pragmatic, multi-site, randomised control trial of a housing first intervention for homeless individuals with mental illness in five Canadian cities. *BMJ Open*, *1*(2), 1-18.
- Gaetz, S., Scott, F., & Gulliver, T. (2013). Housing First in Canada: Supporting Communities to End Homelessness. Toronto: Canadian Homelessness Research Network Press.
- Groton, D. (2013). Are housing first programs effective? A research note. *Journal of Sociology and Social Welfare*, *40*(1), 51-63.
- Hultman, C.M., Wieselgren, I., & Öhman, A. (1997). Relationships between social support, social coping and life events in the relapse of schizophrenic patients. *Scandinavian Journal of Psychology*, *38*(1), 3-13.
- Iverac, M. (2015, December 15). Homeless, But Determined to Reclaim Her American Dream. WNYC News. Podcast retrieved from <http://www.wnyc.org/story/long-way-home-part-one/>.
- Kyle, T., & Dunn, J.R. (2008). Effects of housing circumstances on health, quality of life and healthcare for people with severe mental illness: A review. *Health and Social Care in the Community*, *16*(1), 1-15.
- Larimer, M.E., Malone, D.K., Garner, M.D., et al. (2009). Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. *The Journal of the American Medical Association*, *301*(13), 1349-1357.
- Markee, P. (2013). State of the Homeless 2013. *Coalition for the Homeless*. <http://www.coalitionforthehomeless.org/pages/state-of-the-homeless-2013>.
- Martinez, T. & Burt, M. (2006). Impact of permanent supportive housing on the use of acute care services by homeless adults. *Psychiatric Services*, *57*, 992-999.
- NYC Department of Homeless Services and Human Resources Administration and NYCstat shelter census reports. Retrieved from [Coalitionforthehomeless.org](http://www.coalitionforthehomeless.org)
- O'Connell, M.E. (2003). Responding to homelessness: An overview of US and UK policy interventions. *Journal of Community and Applied Social Psychology*, *13*, 158-170.
- Office of the Public Advocate of New York City. (2015). *New York/New York I, II, and III*. Retrieved from <http://archive.advocate.nyc.gov/housing-guide/C/1>.
- Rought, C. (2016). Advocates applaud Governor Cuomo's plan to create 20,000 new state funded supportive housing units [Press release]. Retrieved from <http://www.nynycampaign.org>.
- Salit, S.A., Kuhn, E.M., Hartz, A.J., Vu, J.M., & Mosso, A.L. (1998). Hospitalization costs associated with homelessness in New York City. *The New England Journal of Medicine*, *338*, 1734-1740.
- Seidman, L.J., Schutt, R.K., Caplan, B., Tolomiczenko, G.S., Turner, W.M., & Goldfinger, S.M. (2003). The effect of housing interventions on neuropsychological functioning among homeless persons with mental illness. *Psychiatric Services*, *54*(6), 905-908.
- Srebnik, D., Livingston, J., Gordon, L., & King, D. (1995). Housing choice and community success for individuals with serious and persistent mental illness. *Community Mental Health Journal*, *31*(2), 139-152.
- Stefancic, A., Henwood, B.F., Melton, H., Shin, S., Lawrence-Gomez, R., & Tsemberis, S. (2013). Implementing housing first in rural areas: Pathways Vermont. *American Journal of Public Health*, *103*, 206-209.

- Stefancic, A., & Tsemberis, S. (2007). Housing first for long-term shelter dwellers with psychiatric disabilities in a suburban county: A four-year study of housing access and retention. *The Journal of Primary Prevention, 28*, 265-279.
- Talbott, J.A. (2004). Deinstitutionalization: Avoiding the disasters of the past. *Psychiatric Services, 55*(10), 1112-1115.
- Tsai, J., Mares, A.S., & Rosenheck, R.A. (2010). A multisite comparison of supported housing for chronically homeless adults: "Housing first" versus "residential treatment first". *Psychological Services, 7*(4), 219-232.
- Tsemberis, S., & Asmussen, S. (1999). From streets to homes: The pathways to housing consumer preference supported housing model. *Alcoholism Treatment Quarterly, 17*, 113-131.
- Tsemberis, S., & Eisenberg, R.F. (2000). Pathways to housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities. *Psychiatric Services, 51*(4), 487-493.
- Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health, 94*(4), 651-656.
- Tsemberis, S., & Stergiopoulos, V. (2013, April 26). How the federal government plans to end homelessness in Canada. *The Huffington Post*. Retrieved from www.huffingtonpost.ca
- U.S. Department of Housing and Urban Development (n.d.). Retrieved from: http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/veteran_information/mayors_challenge/service_providers
- Walczyk, J., Branca, N., & Berhaupt, M. (2014). Taking Stock of New York/New York III Supportive Housing. *The Supportive Housing Network of New York*. February 2014.
- Wilson, S.F. (1992). *Community Support and Integration: New Directions for Client Outcome Research*. In S. Rose (Ed.) Case Management: An Overview and Assessment. White Plains, NY: Longman.
- Yamada, M.M., Korman, M., & Hughes, C.W. (2000). Predicting rehospitalization of persons with severe mental illness. *Journal of Rehabilitation, 66*(2), 32-39.

LeeAnn Shan is currently a second-year student at CUSSW and Executive Editor for the Columbia Social Work Review. She is concentrating in Advanced Clinical Practice, with a focus on Health, Mental Health, and Disabilities. She is currently placed at New York State Psychiatric Institute, where she works on the inpatient research unit with adults with severe mental illness. LeeAnn is also a research assistant at Columbia's Experimental Psychopathology Laboratory, where she studies the treatment and prevention of schizophrenia and schizophrenia-spectrum disorders. LeeAnn plans to apply to Ph.D programs after graduation, so she can continue to pursue research into these topics.

Matt Sandler is a senior editor at the Columbia Social Work Review and an MS candidate in his second year at the Columbia School of Social Work. His Field of Practice is in Public Policy, with an academic concentration on contemporary social issues related to poverty. Matt has worked extensively in homeless services, directly with clients, and in coalitions with providers.