

SUPPORTIVE HOUSING AND THE MENTALLY ILL HOMELESS

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Executive Summary

Mayor Bill de Blasio's \$2.6 billion supportive-housing plan is one of his administration's best ideas for combating homelessness. And yet because it proposes to try to serve more subpopulations than is truly feasible, the plan risks failing to accommodate those who need it most: the many New Yorkers who are both homeless and mentally ill.

Supportive housing has long been central to New York City's efforts to address homelessness, particularly among the single-adult population. Combining subsidized rents with services, supportive-housing units number more than 30,000 citywide, with at least 15,000 more planned to open in coming years. When the government first began building supportive housing on a broad scale in the early 1990s, the principal beneficiaries were individuals suffering from both homelessness and serious mental illness. But the perceived success of those efforts has caused supportive housing's focus to broaden in recent years to include other populations, such as those recovering from substance abuse and youth aging out of foster homes. While each of these groups is clearly in need of, and deserving of, assistance, that help should not necessarily be supplied through supportive housing.

Supportive housing's ability to reduce overall homelessness has been shown to be modest. Studies have demonstrated that placing the homeless in supportive housing reduces expenditures on other government services but that such cost savings are truly significant only in the case of the seriously mentally ill. The de Blasio plan risks devoting an even smaller share of total units toward the seriously mentally ill than the Bloomberg administration did. Based on a review of the literature, analysis of city data, and interviews with providers, advocates, and current and former government officials,* the following report recommends that *city government dedicate two-thirds of the total units from the "New York City Supportive Housing" plan to homeless individuals diagnosed with a serious mental illness, such as bipolar depression or schizophrenia*. This would leave city government better positioned, over the next two decades, to address untreated mental illness and still leave 5,000 units available to serve other needy populations.

*Acknowledgments: Thanks to the many city officials and supportive-housing advocates and providers who provided data and insight. Nearly all interviews were conducted on background.

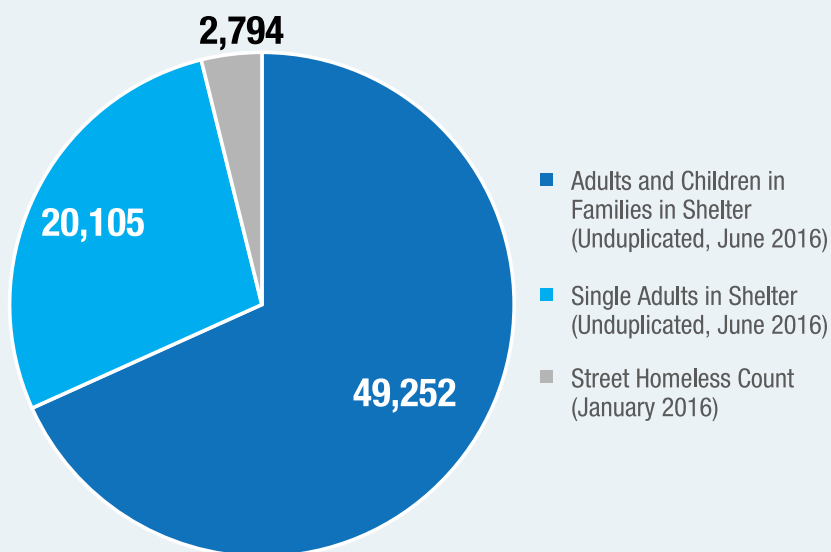
SUPPORTIVE HOUSING AND THE MENTALLY ILL HOMELESS

I. Introduction

Despite operating what is likely the most sophisticated and expensive homeless-services system of any American city, New York has so far failed to stop the unremitting rise of its homeless population. In June 2016, about 70,000 New Yorkers experienced homelessness (**Figure 1**).

FIGURE 1.

Current Composition of New York City's Homeless Population



Source: New York City Department of Homeless Services

Between FY14 and FY17 (the current fiscal year), spending increased by \$700 million, to reach \$1.89 billion, more than the sanitation department (\$1.65 billion) and nearly as much as the fire department (\$1.93 billion).¹ (The federal government as a whole spends slightly more than \$5 billion annually on “homeless assistance”).² New York’s homelessness policy is implemented across several city agencies and through many government-funded nonprofits. Its functions include street outreach, rental subsidies, legal services to prevent eviction, and temporary housing (shelter).

The homelessness challenge is often divided up between single adults and families. Though no variety of homelessness is purely a housing problem, family homelessness is generally assumed to be driven mainly by economic

factors (the gap between rent and income). Family homelessness is also more often a temporary situation. Homeless single adults, however, are in much poorer health, in a mental as well as a physical sense, than the family population, and certainly society in general. Several studies have documented the high rates of mental illness, substance addiction, HIV/AIDS, and other physical ailments present among homeless single adults in New York City.³ Though single adults currently constitute 32% of all homeless

New Yorkers, HUD data show that they compose 56% of the number of “chronically” homeless individuals in the city.⁴ Single-adult homelessness is growing in New York. Between January 2014, when Mayor de Blasio took office, and June 2016, the number of single adults who entered the city’s shelter system increased from 16,230 to 20,105.⁵

One solution that city officials offer for noneconomic homelessness is supportive housing. To its recipients, supportive housing provides permanent rental subsidies along with social services beyond those made available to all poor New Yorkers. The character and intensity of services offered varies. “Congregate” supportive-housing units are part of a single building that employs onsite 24/7 support staff. “Scatter-site” units offer a more independent form of living in leased or sublet apartments with regular check-ins by caseworkers. Scatter-site is much easier to site (e.g., it raises fewer objections from neighborhood groups) and is cheaper because it entails no capital costs. Scatter-site is also seen as preferable, in a normative sense, for homeless individuals whose service needs are more modest. By helping tenants with their medical, financial, psychological, and economic needs, the services component of supportive housing helps maintain tenants in an independent, as opposed to institutionalized, living situation. All supportive-housing tenants pay 30% of their income toward rent. Participation in services is not a condition of receiving the underlying rental subsidy but is, rather, voluntary. At present, most supportive-housing units in New York are in Manhattan.⁶

II. Policy History

The history of supportive housing in New York City unfolded in three phases. In the 1970s, private groups began taking control of decrepit old hotels and single-room-occupancy (SRO) buildings, rehabbing them, and working out an arrangement with government to provide targeted services for residents. This was the early stage of the “modern” homelessness crisis, when more and more poor single adults who had been formerly institutionalized for a mental condition and/or had obtained accommodations in an SRO residence found themselves left with increasingly few housing options.⁷ Between 1949 and 1965, the number of beds in Bowery lodging houses had declined from 11,219 to 9,797 and would reach a low of 2,400 by 1993.⁸ Estimates of the decline in SRO stock citywide are equally dramatic.⁹

Housing the serious mentally ill homeless was not, initially, the sole focus of supportive housing. That became the case during the second phase, which began with the “New York / New York” agreement signed in 1990 by the Dinkins and Cuomo administrations. It developed 3,615 units for the benefit of homeless adults who were diagnosed with a serious mental illness (the formal title was “The New York / New York Agreement to House Homeless Mentally Ill Individuals”).¹⁰ New York / New York I was followed in 1999 by “New York / New York II,” a smaller agreement signed by the Giuliani and Pataki administrations to jointly develop 1,500 units, also for the seriously mentally ill.¹¹

The signing of a New York / New York III agreement in 2005 initiated the third phase of supportive housing in New York City. New York / New York III differed in two important ways from the two prior city-state agreements. First, at 9,000 units, it was far larger than both of them combined; second, it expanded the program’s reach to other populations beyond the seriously mentally ill, such as current and former substance abusers, as well as youths aging out of foster care (see **Appendix I** for the full list of populations served by New York / New York III).

New York / New York III has built, on average, 281 scatter-site and 435 congregate units per year. New York / New York III’s initial completion date was originally June 2016, but all units won’t be available until 2018 or 2019.¹² New York / New York I and II were also not fully built out until years after their original deadlines.

In May 2014, two years before New York / New York III’s formal date of completion, the Supportive Housing Network of New York and the city’s advocacy community for the homeless launched “Campaign for New

York / New York IV.”¹³ But when negotiations between the de Blasio and Cuomo administrations faltered, the city announced¹⁴ plans for 15,000 units citywide in November 2015. Shortly thereafter, Governor Cuomo pledged 20,000 statewide.¹⁵ (Advocates doubt Cuomo’s commitment; but assuming that these units do get built, a large portion will presumably be located in New York City.)¹⁶

The de Blasio “New York City Supportive Housing” program is a continuation and expansion on New York / New York III in that it increases both the total units and variety of populations served (see **Appendix II**). Though the easier-to-build scatter-site units compose a larger share (50%, 7,500) of the de Blasio plan than New York / New York III (30%, 2,750), a much tighter rental market will slow the plan’s progress. Mayor de Blasio does not project that these 15,000 units will be complete until 2030. The city is currently focused on bringing 500 scatter-site units online by December.¹⁷

Demand for existing units is high. According to city government, there is a 5.5:1 ratio between eligible applicants and available units,¹⁸ up from 4:1 in 2013.¹⁹ Occupancy of New York / New York III units now stands at 91%; more than 184,000 applications were received for 9,000 units. The Corporation for Supportive Housing, whose research formed the backbone of the push for a NY/NY IV agreement and the de Blasio plan, claimed in 2015 that the city needed 24,155 more units.²⁰ The Supportive Housing Network of New York pegs the city’s current stock at more than 32,000 units.²¹ (Over the years, many units have been developed through sources other than the “New York / New York” agreements, such as the federal government’s Veterans Affairs Supportive Housing program.) Supportive-housing units thus outnumber traditional rent-controlled units (27,000).²² Collectively, the de Blasio and Cuomo plans could increase the stock by three-fourths in coming years.

III. Evidence on Costs and Benefits

Supportive housing is one of the least controversial elements of homelessness policy in New York City. Going back to the first New York / New York agreement, it has enjoyed broad support from politicians of both parties as well as from homeless-policy researchers. Nonetheless, it is a scarce resource, which means that city government must be scrupulous in gauging need. Questions of eligibility and access to supportive housing have become more complicated as New York has expanded the focus beyond the seriously mentally ill. The best way to evaluate how supportive housing should be used is to evaluate the three arguments for why governments should make it a priority in the first place. These arguments have to do with cost-efficiency, reducing homelessness, and moral obligation.

“It’s a deal”

Supportive housing, because it entails not only up-front capital costs but ongoing annual costs for rental subsidies and services, is very expensive. Mayor de Blasio’s plan projects that its 7,500 new congregate units will cost \$350,000 each in capital costs. The annual average cost of the initial 500 scatter-site units is \$25,000.²³ New York / New York III’s per-unit rental subsidy-services package exceeds \$35,000 in the case of seriously mentally ill youth, with the standard range for most other populations being \$15,000–\$25,000.²⁴ Just to put these figures in perspective, the average cash assistance–food stamps grant for a family of three in New York City is \$14,800 per year.²⁵ As permanent housing, the grant of a supportive-housing unit authorizes what may be a multi-decade spending commitment. (Advocates and city officials understand the opportunity cost involved in granting a permanent rental subsidy to someone who, a decade later, may need the benefit less than someone else, but they prefer to handle such challenges through administrative processes rather than by placing formal time limits on units.)²⁶

In response to these cost concerns, supportive-housing advocates argue that the spending is offset, all or in part, by the reduced demand on other heavily used public services for the homeless, such as jail, shelter, and hospitalization. Two highly influential New York City–specific studies have advanced a version of this claim.²⁷

Using a randomized-control model, they found that populations placed in supportive housing were generally less of a burden on the taxpayer than those found eligible for supportive housing but left unplaced.

But the greatest cost savings were associated with reduced expenditures on psychiatric hospitals for the seriously mentally ill cohort. The landmark 2002 study done by the University of Pennsylvania's Dennis Culhane and his colleagues was of New York / New York I and thus could examine only the fiscal advantages of supportive housing for the seriously mentally ill. A 2013 assessment of New York / New York III, which served nine different populations, found that three groups—substance abusers; heads of family with a substance abuse disorder, disability, or HIV/AIDS diagnosis; and youths aging out of foster care—were more expensive to place in supportive housing than not place. By contrast, placing single adults in supportive housing who were exiting state psychiatric hospitals generated \$77,425 in annual savings. Mental hospitals are extremely expensive to run, so it is not surprising to learn that a community-care model for treating mental illness, such as supportive housing, would save money. If the bottom-line consideration is how to address homelessness in the most cost-effective manner possible, government should restrict supportive housing only to the seriously mentally ill, not expand it to other populations.

“It reduces homelessness”

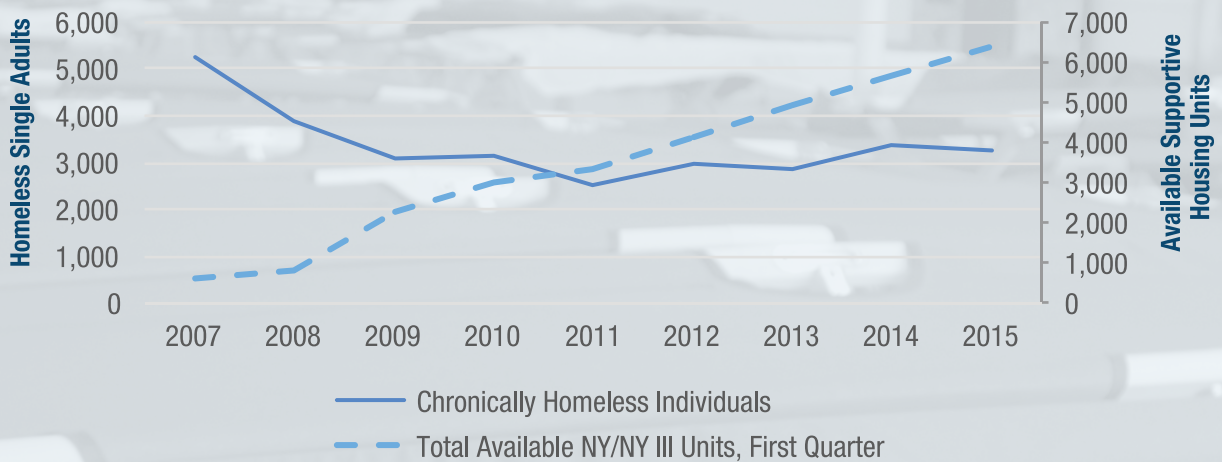
More important than questions over the cost of supportive housing is “What has it bought?”²⁸ The New York City government is not officially committed to “ending” homelessness, but responding to the public's perception over rising levels of street homeless was one motivation for the de Blasio supportive-housing plan. Public order as a whole stands to benefit from removing mentally ill homeless people from city streets and other public spaces.²⁹ New York / New York III was signed in November 2005, but the city did not begin placing individuals in units until February 2007, or after the annual 2007 count of the unsheltered homeless (January 29, 2007). Most of the units were reserved for chronically homeless individuals (**Appendix I**). As **Figure 2** shows, the first four years of New York / New York III did indeed see a noticeable decline in the number of chronically homeless individuals, but the effect had leveled off by 2011, even as the city added several thousand more units.

As for the effect on single-adult homelessness overall, **Figure 3** shows that, though there was a sharp decline in the street and sheltered single-adult homeless during the program's first two years, the homeless population and the number of available supportive-housing units have been growing simultaneously since 2009. Almost 10 years into New York / New York III, the street count is now below where it was in 2007. However, the quality of New York's data on street homelessness has been doubted by many, including the de Blasio administration.³⁰ Assuming that the street homelessness decline is real, it is also hard to know if it has more to do with supportive-housing stock or the number of single adults in shelter, both of which have increased in recent years.

Individuals placed in supportive housing are very likely to stay housed in the near-term: an 80% “housing retention” over two years is a common finding of researchers.³¹ Evidence about supportive housing's effectiveness in reducing levels of homelessness in a given community is, however, far less compelling. An evaluation of New York / New York I estimated that it reduced the average annual daily shelter census of single adults from 1990 to 1999 by 0.4%–4.3%.³² More methodologically precise empirical studies have found that supportive housing comes far short of reducing homelessness on a one-to-one basis. A 2014 study of 372 jurisdictions over six years came to the conclusion that “the observed relationships between community investment in Permanent Supportive Housing (PSH) and chronic homelessness are fairly modest in strength.”³³ A 2015 study of supportive housing's effect of overall homelessness across hundreds of jurisdictions found that, at best, it would require 12.6 more supportive-housing units to reduce the local homeless population by one person.³⁴ Under the de Blasio program, New York is poised to spend \$2.6 billion in capital costs plus hundreds of millions in operating funds to effect what will likely be a 1%–5% decrease in the street and sheltered census.

FIGURE 2.

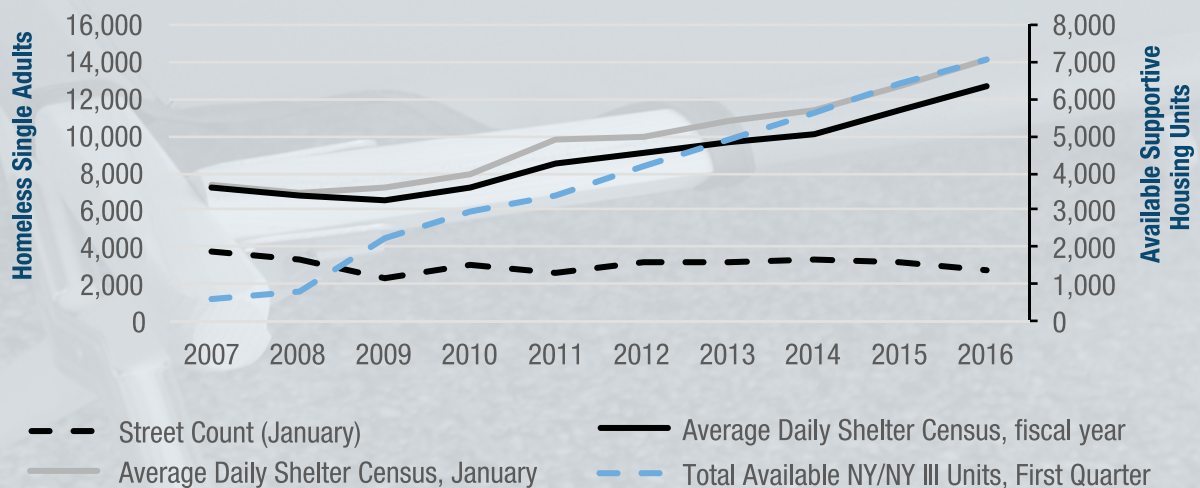
Available Supportive Housing Units and Trends in Chronic Single Adult Homeless in New York City, 2007–16



Source: New York City Department of Health and Mental Hygiene and U.S Department of Housing and Urban Development

FIGURE 3.

Available Supportive Housing Units and Trends in Overall Single Adult Homeless in New York City, 2007–16



Source: New York City Department of Health and Mental Hygiene and New York City Department of Homeless Services

“It’s a moral obligation”

Advocates and city officials also argue that supportive housing is a moral obligation. This is particularly convincing in the case of the seriously mentally ill homeless. According to HUD data, 9,840 homeless New Yorkers in early February 2015 were “severely mentally ill,” making up 13% of the total sheltered and unsheltered population (adults and families) at that time. The equivalent rate for the city’s adult population as a whole is below 4%.³⁵ Deinstitutionalization’s central promise was that the mentally ill could receive a more superior level of care in communities than they had been receiving in psychiatric hospitals.³⁶ In light of how many Americans received a less effective level of care as a consequence of deinstitutionalization, some have argued that government should now increase the role of inpatient psychiatric care in our efforts to treat severe thought and mood disorders.³⁷ But the involuntary commitment of large numbers of seriously mentally ill individuals is not practical from a fiscal or legal standpoint. The prospect of saving money on mental hospitals—during the 1940s, near the peak of the institutionalization era, one-third of New York State’s budget was devoted to mental institutions³⁸—was a major factor in creating bipartisan support for deinstitutionalization.³⁹ Furthermore, new legal barriers erected in the wake of the 1960s “rights revolution” have made involuntary commitment possible only in the case of “dangerous” individuals, a high standard to meet.⁴⁰ The Supreme Court’s ruling in *Olmstead v. L.C.* (1999) positively mandated treatment of mental illness in the “least restrictive setting.” Upon winning the case, the plaintiffs in *Olmstead* were placed by the state of Georgia (the defendant) in supportive housing.

The average monthly benefit payment for Social Security Disability Insurance for someone disabled by virtue of “schizophrenic and other psychotic disorders” is \$884.⁴¹ In New York State, 35,478 are receiving Social Security Disability Insurance for this condition.⁴² At this level of income, an “affordable” rent would be \$265 a month, an entirely unrealistic rate for New York’s market. One reason for the connection between mental illness and homelessness is that living with roommates, which is how many New Yorkers adjust to the city’s high rents, is not practical for those with an untreated mental illness.

Thus, supportive housing should be seen as one among several policy approaches for treating mental illness. Others include Assisted Outpatient Treatment (AOT), which has also been found to substantially reduce the use of expensive government services⁴³ and, where appropriate and legally feasible, involuntary commitment. In 2015, 2,058 New Yorkers were, at some point, under a court-ordered AOT plan.⁴⁴ A 2005 study of 2,745 AOT recipients in New York State found that while 19% experienced homelessness in the three years prior to being put under court-ordered treatment, only 5% did so during participation in AOT.⁴⁵ According to a recent analysis by the Department of Health and Mental Hygiene, about 45,000 were hospitalized in psychiatric institutions in 2013, for an average stay of 16 days.⁴⁶ High-quality supportive-housing providers, such as Fountain House in New York City, likely meet a standard of care for the seriously mentally ill superior to any found throughout U.S. history.⁴⁷ To be sure, the overwhelming majority of the near-240,000 seriously mentally ill New Yorkers are not homeless.⁴⁸ But for the minority who are, government needs to provide them with housing stability to ensure adequate treatment.⁴⁹



IV. Conclusion

In January, Mayor de Blasio appointed a task force to determine the precise allocation of units among sub-populations. Though their recommendations have not yet been issued, debate has centered on moving away from a “diagnosis-centric” approach to eligibility determinations to a “whole person” approach.⁵⁰ This idea, which would likely deemphasize the importance of a serious mental illness in making eligibility determinations, has significant support among the supportive-housing community (city officials, providers, researchers, homeless advocates).

However, New York would be unwise to completely abandon the diagnosis-centric approach. Instead, the city should reserve 10,000 units for those diagnosed with a serious mental illness, leaving the other 5,000 for the “whole person” approach, with high priority granted to the substance-addicted and HIV/AIDS sub-populations. The figure 10,000 would be almost exactly the count of “severely mentally ill” individuals in New York City’s HUD data. Maintaining and refocusing the diagnosis-centric approach in this manner would give assurances to the public of the de Blasio administration’s commitment to addressing serious mental illness–related homelessness. Though mental health in general has been a priority of the de Blasio administration, through its “Thrive NYC” plan, critics have challenged the degree to which this helps the schizophrenic and bipolar populations.⁵¹ Dedicating two-thirds of units to the seriously mentally ill would arrest the “mission creep” that, for over a decade, has been diverting scarce supportive-housing resources away from the seriously mentally ill.

With each successive wave of supportive-housing units, more non–mentally ill populations are added as well as more units for those populations. For example, the New York City Department of Health is currently piloting a supportive-housing program for prisoner reentry.⁵² Though small-scale now and restricted to “justice-involved individuals” with a mental illness and/or substance addiction, its focus may very well be expanded to the ex-offender population more broadly. The Corporation for Supportive Housing has recommended that at least 15% of all units from the de Blasio supportive-housing program be devoted toward “individuals and families with criminal justice histories.”⁵³

Mission creep has caused supportive housing to assume almost panacea status in social-policy circles and to blur the line between affordable and supportive housing. If rental subsidies without fixed time limits must be part of the solution to addressing homelessness among populations such as domestic-violence survivors, ex-offenders, former substance abusers, and youths aging out of foster care, the de Blasio administration should create carve-outs for those populations within the mayor’s “Housing NYC” plan, not divert supportive-housing units away from the seriously mentally ill. Alternatively, some of these populations could be just as well served by transitional housing, as has been suggested by Dennis Culhane, the nation’s leading homelessness-policy researcher.⁵⁴

The history of mental illness policy has been characterized by a drift in focus and resources away from those suffering from severe mental illness.⁵⁵ At a time when the local economy is expanding, and city and state governments claim that they have the financial capacity to fund 35,000 new units statewide, the description of supportive housing as a “scarce” public resource may seem exaggerated. Nonetheless, the fiscal and administrative challenges of building supportive housing in New York create a condition of de facto scarcity even for a plan as large as de Blasio’s. Fifteen years, the official time frame for the mayor’s plan, is a very long time for a homeless policy. Over the last 15 years, New York’s homeless population has doubled.

The point is not that the schizophrenic deserves exclusive access to supportive-housing units. Providers and city officials attest that it can be impractical to distinguish between the substance-addicted, HIV/AIDS-infected, and mentally ill populations, since so many homeless individuals are afflicted by more than one of these conditions. Someone in the grip of a mental illness less severe than schizophrenia—such as anxiety—and addicted to heroin may need supportive housing, both from a therapeutic and public-order standard,

just as much as someone who is “only” bipolar or schizophrenic. But one unit provided to a youth leaving foster care, a domestic-violence victim, a former substance abuser who has gone through treatment, or a former felon is one fewer that could go toward someone with schizophrenia. All these populations need the government’s assistance; but with respect to the distribution of scarce permanent housing resources, our obligation to them does not equal our obligation to the seriously mentally ill. In a policy landscape defined by powerful legal and financial constraints against institutionalization, supportive housing is one of the best options for stabilizing the lives of some seriously mentally ill individuals. New York should never be in a position where it needs to place a seriously mentally ill individual and does not have a unit for him or her.

Appendix I. Populations Served by the New York / New York III Agreement

Population	Congregate	Scatter-Site	Total
Chronically homeless single adults who suffer from a serious and persistent mental illness or who are diagnosed as mentally ill and chemically addicted (MICA)	3,200	750	3,950
Single adults who are presently living in New York State-operated psychiatric centers or State-operated transitional residences and who could live independently in the community if provided with supportive housing and who would be at risk of street or sheltered homelessness if discharged without supportive housing	500	500	1,000
Young adults, ages 18-24, who have a serious mental illness being treated in New York State licensed residential treatment facilities, state psychiatric facilities or leaving or having recently left foster care and who could live independently in the community if provided with supportive housing and who would be at risk of street or sheltered homelessness if discharged without supportive housing	200	0	200
Chronically homeless families, or families at serious risk of becoming chronically homeless, in which the head of the household suffers from a serious and persistent mental illness or a MICA disorder	400	0	400
Chronically homeless single adults who have a substance abuse disorder that is a primary barrier to independent living and who also have a disabling clinical condition (i.e. a medical or mental health condition that further impairs their ability to live independently)	250	500	750
Homeless single adults who have completed a course of treatment for a substance abuse disorder and are at risk of street homelessness or sheltered homelessness and now need transitional supportive housing (that may include halfway houses) to sustain sobriety and achieve independent living	250	500	750
Chronically homeless families, or families at serious risk of becoming chronically homeless, in which the head of the household suffers from a substance abuse disorder, a disabling medical condition or HIV/AIDS	750	0	750
Chronically homeless single adults who are persons living with HIV/AIDS (who are clients of the HIV/AIDS Services Administration or who are clients with symptomatic HIV who are receiving cash assistance from the City) and who suffer from a co-occurring serious and persistent mental illness, a substance abuse disorder, or a MICA disorder	600	400	1,000
Young adults (aged 25 or younger) leaving or having recently left foster care or who had been in foster care for more than a year after their 16th birthday and who are at-risk of street homelessness or sheltered homelessness	100	100	200

Source: City of New York, Office of the Mayor and New York State, Office of the Governor

Appendix II. Populations to be Served by Mayor de Blasio's Supportive Housing Program

Homeless families in which the head of the household suffers from a serious mental illness or a Mentally Ill Chemical Abuser disorder, a substance use disorder, a disabling medical condition, and/or HIV/AIDS
Homeless single adults with a serious mental illness, a substance use disorder, a disabling medical condition or HIV/AIDS
Homeless single adults with substance use disorders that are primary barriers to independent living and who also have a disabling clinical condition
Homeless single adults who have completed a course of treatment for a substance use disorder and are at risk of street homelessness or sheltered homelessness and who need transitional supportive housing to sustain sobriety and achieve independent living
Homeless single adults with HIV/AIDS, and who are clients of the HIV/AIDS Services Administration or who are receiving cash assistance from the City, and who suffer from a co-occurring serious mental illness, or a substance use disorder
Young adults (aged 25 or younger) leaving or having recently left foster care or who have been in foster care for more than a year after their 16th birthday and who are homeless or at-risk of homelessness
Homeless single veterans or families in which the head of the household is a veteran who suffers from a disabling clinical condition (i.e., a medical or mental health condition that further impairs their ability to live independently)
Domestic violence survivors at high risk for persistent homelessness
Street homeless individuals with behavioral health issues, including those in safe havens and stabilization beds
Individuals receiving nursing home care or medically frail individuals awaiting discharge from the public hospital system that can make the transition to independent living with medically appropriate supportive services

Source: City of New York, Office of the Mayor and New York State, Office of the Governor

Endnotes

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- ⁴ See U.S. Department of Housing and Urban Development, "HUD 2015 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations, NY-600 New York City CoC," Feb. 2015, https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_CoC_NY-600-2015_NY_2015.pdf. HUD's current official definition of a "chronically" homeless individual is someone with a disability who has been homeless for the last 12 months continuously or at least four times in the last three years, for a cumulative total of at least 12 months; see *Federal Register* 80, no. 233 (Dec. 4, 2015), Rules and Regulations, pp. 75791–806, <https://www.hudexchange.info/resources/documents/Defining-Chronically-Homeless-Final-Rule.pdf>.
- ⁵ New York City Department of Homeless Services, "DHS Local Law 37 report for the Month of July 2016," http://www1.nyc.gov/assets/operations/downloads/pdf/temporary_housing_report.pdf.
- ⁶ Transcript of the Minutes of the Committee on Housing and Buildings / Committee on General Welfare, Nov. 19, 2015, p. 63, <http://legistar.council.nyc.gov/LegislationDetail.aspx?ID=2506287&GUID=6565A1A5-F836-4D49-923A-BCC649B63CCD&Options=&Search>.
- ⁷ See Supportive Housing Network of New York, "History of Supportive Housing," <http://shnny.org/learn-more/history-of-supportive-housing>; Ted Houghton, "A Description and History of The New York/New York Agreement to House Homeless Mentally Ill Individuals," Corporation for Supportive Housing, May 2001, http://shnny.org/uploads/NY-NY_Agreement_History.pdf.
- ⁸ Brendan O'Flaherty, *Making Room: The Economics of Homelessness* (Cambridge, MA: Harvard University Press, 1996), p. 145.
- ⁹ See Brian J. Sullivan and Jonathan Burke, "Single-Room Occupancy Housing in New York City: The Origins and Dimensions of a Crisis," *CUNY Law Review* 17, no. 1 (Sept. 25, 2014): 901–32, n. 1, <http://www.cunylawreview.org/wp-content/uploads/2014/09/CNY109.pdf>.
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Abstract

Supportive housing, which combines subsidized rents with services, has long been central to New York City's efforts to address homelessness. When the government began building supportive housing on a broad scale in the early 1990s, the principal beneficiaries were individuals suffering from both homelessness and serious mental illness. In recent years the focus has broadened to include other populations, such as those recovering from substance abuse and youths aging out of foster homes. While each of these groups needs assistance, that help should not necessarily be supplied through supportive housing.

Key Findings

1. Supportive housing's ability to reduce overall homelessness has been shown to be modest. Studies indicate that placing the homeless in supportive housing reduces expenditures on other government services, but the cost savings are truly significant only in the case of the seriously mentally ill.
2. Mayor Bill de Blasio's \$2.6 billion supportive-housing plan is one of his administration's best ideas for combating homelessness. However, by trying to serve more subpopulations than is feasible, the plan risks failing to accommodate those who need it most.
3. Based on a review of the literature, analysis of city data, and interviews with providers, advocates, and current and former officials, New York would be better served by dedicating two-thirds of the total units from the mayor's plan to homeless individuals diagnosed with a serious mental illness, such as bipolar depression or schizophrenia. This would leave city government better positioned, over the next two decades, to address untreated mental illness and still leave 5,000 units available to serve other needy populations.