

A Description and History of The New York/New York Agreement to House Homeless Mentally Ill Individuals



A Companion Piece to:
*The New York/New York Agreement Cost Study:
The Impact of Supportive Housing on Services
Use for Homeless Mentally Ill Individuals*

Written by Ted Houghton



CORPORATION *for* SUPPORTIVE HOUSING



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Dear Colleague:

We are pleased to share *A Description and History of The New York/New York Agreement to House Homeless Mentally Ill Individuals* by Ted Houghton. This chronicle of the precedent-setting 1990 city/state pact is intended as a companion piece to the summary of a study of the impact of NY/NY housing on homeless mentally ill New Yorkers' use of seven service systems conducted by the University of Pennsylvania. These two publications, when read together, provide an in-depth portrait of the historic initiative and its impact on NY/NY tenants' utilization of shelter, health, mental health and corrections systems.

Houghton's history of the New York/New York Agreement is the first comprehensive look at the single largest government initiative to house homeless mentally ill people. It chronicles both the beginnings of widespread homelessness and the pioneering efforts initiated to combat it. It first provides detailed descriptions of the various types of housing created by the Agreement and then offers an in-depth history of mental health housing in New York. Finally, it summarizes the events leading up to the historic 1990 Agreement and gives a brief update on the current status of public funding for mental health housing in New York City.

The summary of the NY/NY Cost Study findings encapsulate the first large-scale attempt to quantify the cost of homelessness for people suffering from severe mental illness across multiple publicly funded systems, as well as its solution: service-enriched housing. The findings include:

- the average annual cost of maintaining a mentally ill person in homelessness is more than \$40,000;
- once NY/NY tenants had access to housing-plus-services, their cost to the public across seven systems decreased dramatically even after controlling for system-wide reductions;
- the public cost of homelessness for mentally ill people is about equal to the cost of ending homelessness for this population through supportive housing.

These two publications will inform public-policy makers and private funders about the most effective approaches to ending homelessness for mentally ill individuals, so that we can invest the resources necessary to end chronic homelessness in this country.

Sincerely,

Carol R. Davis
President

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Credits and Thanks

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Ted Houghton is a writer and consultant to nonprofit organizations working in homelessness, employment and related human services. Previously, he oversaw housing placement at the New York City Department of Homeless Services and worked for the Coalition for the Homeless. He dabbles in music and film.

The Corporation for Supportive Housing

Founded in 1991, the Corporation for Supportive Housing (CSH) is a national financial and technical assistance intermediary dedicated to helping nonprofit organizations develop and operate service-enriched permanent housing for homeless and at-risk families and individuals with special needs, including mental illness, HIV/AIDS and substance use issues. CSH currently carries out its programs in eight states and localities with offices in: California, Connecticut, Illinois, Michigan, Minnesota, New Jersey, New York City and Ohio. As a local intermediary, CSH convenes community-based stakeholders, brings relevant research and data to the table, works with networks of providers and government from planning through implementation and makes grants and loans. Its goals are to expand the supply of supportive housing, build new constituencies and local capacity for reform, help networks take advantage of funding opportunities, and provide assessment of the efficacy of new initiatives. For more information on CSH, visit the CSH Web site at www.csh.org.

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I. The NY/NY Agreement

The accompanying study by the University of Pennsylvania's Center for Mental Health Policy and Services Research shows how placing homeless mentally ill individuals into service-enriched housing substantially reduces their use of other public services such as emergency shelters, hospitals, jails and prisons. While anecdotal evidence has long supported this assertion, the study greatly advances our understanding of this type of housing by measuring its effectiveness in terms of its associated costs and savings.

The study examined the 1990 New York/New York Agreement to House Homeless Mentally Ill Individuals, a historic joint effort by New York State and New York City that created 3,615 units of supportive and licensed, permanent and transitional housing for homeless mentally ill people in New York City. The New York/New York (NY/NY) Agreement remains the largest housing initiative for homeless mentally ill people to date, and provided the University of Pennsylvania researchers, Dennis P. Culhane, Ph.D., Stephen Metraux, M.A., and Trevor Hadley, Ph.D., an exceptionally large group of people on which to base their study. The resulting research shows for the first time exactly how much money placing homeless mentally ill individuals into NY/NY housing saves other publicly funded service systems, and how little it ultimately costs us to have people with psychiatric disabilities live in service-enriched, subsidized housing, rather than in hospitals, shelters, prisons or the streets.

Upon hearing of the study's economic analyses, one psychiatrist observed, "It's too bad it's not enough just to say that this housing is the most humane way to treat mental illness."¹ While the virtue of NY/NY housing may be obvious to those familiar with the program's success, deciding where to allocate scarce public resources is never a straightforward endeavor. Economic arguments for more supportive housing may be ignored as easily as moral ones when it comes time to adopt a state or municipal budget. But the enormous number of people tracked by the study, the rigorous standards of the research, and the unprecedented cooperation of government agencies may all help finally to convince policy makers of the value of expanding the NY/NY Agreement's housing program to a size more reflective of the enormous need.

All the same, the monetary justifications for providing housing with services to homeless mentally ill individuals become secondary when one visits a NY/NY residence in person. The study's persuasive cost analyses can only hint at the extraordinary improvement in the quality of life experienced by the individual who has moved into NY/NY housing. And these cost analyses don't even begin to measure how the NY/NY Agreement has helped to improve the quality of life for every citizen who has shared their neighborhood park with a shantytown, or had to cross the street to avoid an obviously confused mentally ill homeless person. The following account is a brief history of the efforts to shelter and house mentally ill people in New York City, and an attempt to describe how and why the housing programs created by the NY/NY Agreement are so effective for the homeless mentally ill individuals they serve.

Del Hendricks: One New Yorker's Story

One person housed by the NY/NY Agreement is Del Hendricks.² The first part of Del Hendricks' sad life story is all too familiar to anyone who has worked with homeless mentally ill people. A Korean War veteran hospitalized with schizophrenia for over six years in an upstate psychiatric center, Del was released to live in the community in the early 1960s. He returned to the city, and after years of living without services or medication, Del had one psychotic outburst too many and lost his messenger job. Without money to pay his modest weekly rent, he lost his room in a commercial single room occupancy (SRO) hotel soon after. For the next 11 years, he remained homeless on the streets of New York City, his bizarre behavior and intense paranoia isolating him from any kind of help. His life became a dull, eventless blur punctuated by the occasional visit to the psychiatric emergency room and a quick discharge back to the anonymity of the streets.

In many ways, the story of Del Hendricks is the story of mental health care in New York. For centuries, care for mentally ill individuals was limited to containment in locked facilities with virtually no treatment. The invention of effective psychotropic medications allowed tens of thousands of mentally ill people to be released to more fulfilling lives outside of the hospitals. But even as the state budget reaped a windfall in savings as state psychiatric centers downsized or closed, adequate services and supports in the community for the former inpatients never materialized. Many of the newly released patients gravitated toward commercial SROs, where their eccentricities were tolerated and welfare or income from odd jobs paid their rent. Aging buildings and rising real estate values gradually eliminated this housing resource, leading to today's high rates of homelessness among mentally ill individuals.

Fortunately for Del, he survived on the streets long enough to benefit from the next and most inspiring chapter of this ongoing saga: permanent housing with on-site social services created by the landmark NY/NY Agreement. In 1993, Del followed an outreach worker to the 324 Lafayette Reception Center, operated by the nonprofit social service provider Bowery Residents' Committee (BRC). "The coffee was good, so I stayed," he shrugs, blithely discounting the months of readjustment he went through at the Reception Center, where mentally ill homeless residents relearn the skills and habits necessary to live independently in housing. While many homeless mentally ill people are able to move directly into supportive housing, in Del's case, it took almost a year in a transitional program for him to become stable enough to try living in an apartment of his own again. But when he did, he became one of the first people to move into Clyde Burton House, a supportive single room residence on the Lower East Side of Manhattan built and operated by BRC under the auspices of the NY/NY Agreement.

What Did the NY/NY Agreement Accomplish?

Clyde Burton House is just one of 87 residences and 20 scattered site housing programs created by the NY/NY Agreement. From the Agreement's beginning until October 1998, when the last residence opened, the Agreement funded the new construction or substantial renovation of 3,112 new units of housing for homeless mentally ill people in all five boroughs of New York City, as well as subsidizing the rent of an additional 503 existing apartments scattered across the city's neighborhoods. The creation of these 3,615 units, bolstered by the vacancies generated by residents' departures, have allowed 7,774 homeless mentally ill individuals to be placed into NY/NY housing as of December 31, 2000.³

At the time that the Agreement was signed, City and State mental health and social service agencies had already begun to address some of the service needs of homeless mentally ill individuals by establishing transitional residential mental health programs, both within and outside of the municipal shelter system. And both the New York City Department of Housing Preservation and Development (HPD) and the New York State Division of Housing and Community Renewal (DHCR) had funded some pioneering nonprofit groups to renovate housing with services for elderly and homeless individuals, many of whom also had psychiatric disabilities. But these disparate, often innovative efforts tended to be inadequately funded and often directed their services at low-income and special-needs populations that only incidentally included people who were both homeless and mentally ill. Even with improved coordination between programs, the already overwhelming need for affordable housing and mental health services easily outstripped the resources allocated.

The NY/NY Agreement was a belated admission by the City and State that a more urgent and comprehensive effort was necessary. Prior to the Agreement, the New York State Office of Mental Health (SOMH) had never funded the construction of permanent housing for mentally ill people, nor paid for on-site services to keep mentally ill people in permanent housing. Allocating capital money to build housing reversed years of SOMH policy and signaled a historic change in the agency's mission by acknowledging that the provision of stable, affordable housing was an integral part of mental health treatment. City officials answered this concession by agreeing for the first time to issue municipal bonds to construct permanent housing for individuals with psychiatric disabilities, something they had heretofore maintained was the responsibility of the state and federal governments.

Identifying and Applying Resources

Together, the city and state allocated a total of \$194.7 million in capital funds to build the Agreement's housing. For its share, the city funded the construction of 1,423 units of new housing and subsidized the rent of three additional units, mostly in permanent supportive single room residences. The state responded to that effort by building 1,689 new units and subsidizing the rent of 500 more in a variety of permanent and transitional housing models. The city and state each contribute half of a modest operating subsidy for the supportive SRO

units built by the city, and reflecting the state's traditional responsibility for mental health care, SOMH paid for the cost of ongoing clinical and social services in all 3,615 housing units.

Both the city and the state used federal funds to supplement their commitments. Some of the city's capital costs were paid with funds from the United States Department of Housing and Urban Development (HUD). The state used a combination of federal Stewart B. McKinney funds and state general budget money to pay for services. Finally, the city applied a significant portion of its allocation of federal Section 8 rental subsidies to cover almost all of the supportive housing units it built.

To realize the NY/NY Agreement's ambitious development targets, the city and state embarked on two separate and parallel efforts. The city was already in the midst of an unprecedented ten-year, \$5.1 billion housing development initiative, a small percentage of which would be spent on housing for single adults with special needs. It made sense for the NY/NY Agreement's development to be managed from the same city office that oversaw the financing and construction of other supportive housing projects, the SRO Loan Program in the New York City Department of Housing Preservation and Development (HPD), which has been headed by Timothy O'Hanlon since shortly after the Agreement began. The New York City Human Resources Administration (HRA) augmented HPD's production by providing capital funding for five of the largest supportive residences, each with 150 to 200 units, just under a third of which are designated NY/NY units.

The state had funded the rehabilitation of some of the earliest residences for homeless single adults through its Division of Housing and Community Renewal (DHCR), which later funded two buildings through the NY/NY Agreement. But because a majority of the state residences would be licensed—and all of the mental health services funded—by the State Office of Mental Health, SOMH's Bureau of Housing and Rehabilitation Services was chosen to manage the NY/NY development initiative, expanding on its previous experience building licensed transitional housing.

Despite these agencies' collective development expertise, delays in identifying, financing and rehabilitating properties extended the term of the Agreement long past its initial length of three years. Development finally concluded more than nine years after the Agreement's start. Despite these not inconsiderable delays, the Agreement's separate city and state development targets were finally achieved, in part because the dual tracks of development created a competitive dynamic between the two levels of government. The high public profile of the NY/NY Agreement, and the mutual obligation it represented, allowed the city and state to challenge and prod one another to make good on its promise.

The Role of Nonprofits

Perhaps most important to the Agreement's success, the city and the state made an early decision to depend on the evolving expertise of the nonprofit organizations serving homeless and mentally ill populations. SOMH worked closely with mainstream mental health providers that

it had previously licensed to operate clinical treatment and transitional housing programs, as well as some community-based agencies serving homeless people that had advocated for the creation of permanent housing models for mentally ill individuals. In the first years of the Agreement, SOMH concentrated on creating beds in its time-tested transitional treatment model, the Community Residence, but expanded development to include growing proportions of permanent housing as well. The city managed the construction of five large residences itself, turning operation over to nonprofits upon completion, but met most of its development share by funding nonprofit organizations to build an unlicensed model of permanent housing with which they had had much recent success, the supportive single room residence, or supportive SRO.⁴ At the conclusion of the Agreement's development, over 50 different nonprofit organizations had become involved in constructing, operating and providing services in NY/NY housing.

These groups brought with them a range of experience serving special needs populations such as homeless and mentally ill people, but also people with AIDS, the elderly, people with physical disabilities and substance abusers. By harnessing their diverse knowledge and skills, the city and state created homes for homeless mentally ill people that could also answer the multiplicity of other service needs often presented by members of this population. The nonprofits' experience serving people with dual diagnoses of mental illness and substance abuse was especially crucial to the development of a new transitional treatment model, the MICA (Mental Illness and Chemical Abuse) Community Residence.

In some cases, a NY/NY project has involved more than one nonprofit, with one organization skilled in housing development and management teaming up with another expert in providing social or clinical services to the tenants.⁵ Whether in partnership with another nonprofit or on their own, most nonprofit providers building supportive housing residences with the city used NY/NY funding to pay for the construction and operation of only a portion of the units in their buildings. By identifying and securing other funding streams that subsidized units for the formerly homeless, the elderly, people living with AIDS and low-income working people, these providers were able to create a diverse milieu that more closely resembled the housing in the surrounding neighborhood. The 1,276 supportive SRO units funded by the NY/NY Agreement share their buildings with 2,149 units intended for these other populations. Although these units were not funded directly by NY/NY, the capital financing and ongoing service subsidies of the Agreement helped bring these units into existence.

Almost all of the city and state projects rehabilitated dilapidated, mostly vacant or abandoned buildings, replacing neighborhood eyesores and dangerous stretches of shuttered no-man's-lands with vibrant, well-kept residential buildings that fit in with their surrounding communities. Some of the later residences built under the Agreement included attractive, newly constructed buildings that greatly enhanced the blocks they joined. Even so, some projects encountered resistance by people fearful of the effect the presence of mentally ill individuals might have on their communities. By using locally based nonprofits with a history and presence in New York City's neighborhoods, both the city and the state were able to minimize many (if not all) of the siting problems encountered when government agencies propose the establishment of social service programs directly. Siting issues diminished further as the public

became more savvy about the differences between emergency shelters and the services-enriched, mostly permanent housing of the NY/NY Agreement.

Housing: The Essential Component

In some ways, the NY/NY Agreement only represented the continuation and codification of the many efforts already under way to alleviate homelessness among the psychiatrically disabled. Without the visible success of these early efforts, both in creating effective service models and in identifying new funding sources and affordable financing, the NY/NY Agreement would have never been proposed. But the Agreement did more than just consolidate disparate development initiatives; it substantially accelerated the development of housing for mentally ill individuals in New York City.

And by identifying this housing as a priority of both the city and state governments, the Agreement validated and sometimes spurred the creation of other transitional and rehabilitation programs for mentally ill people. Many of the transitional mental health programs established in the municipal shelter system could be effective only with the creation of permanent housing in which they could place their graduating participants. No one claimed that the 3,615 housing units built by the NY/NY Agreement would end homelessness among the psychiatrically disabled. But without the permanent housing initially made available by the Agreement, and the approximately 700 vacancies a year that turnover in the housing continues to provide, the entire system of outreach teams, drop-in centers, shelters and transitional programs that comprise what is now referred to as “the continuum of care” for homeless mentally ill people would have most likely collapsed years ago.

New York/New York II

Well before NY/NY development was concluded, it was apparent that more permanent housing was needed for the homeless mentally ill population. As residences opened their doors during the first five years of the Agreement, the municipal single-adult shelter census steadily declined, falling by more than a third until it began rising again in 1995.⁶ And as the need for more NY/NY housing became evident, a broadly based, well-orchestrated campaign for a second NY/NY Agreement began to coalesce in early 1997. Providers and advocates were heartened when the administration of Mayor Rudolph W. Giuliani voiced support for a second Agreement that would have the city and state create 10,000 additional units of supportive housing. But Governor George E. Pataki was reluctant to make such a substantial commitment, even for such a well-documented need, and it wasn't until April 1999 that the city and state announced a second initiative.

Despite the demonstrated success of the first NY/NY Agreement, NY/NY II was a decidedly more modest effort, committing funding for 1,500 units of permanent supportive housing. As in the preceding Agreement, the city and state are each funding the construction of half

of the units, with the state paying for services and operating costs. Unlike the first Agreement, the SOMH decided against building additional Community Residences, relying predominantly on supportive housing. The City is meeting its target by constructing more supportive SRO residences.

As the units funded by this second effort begin to open, the single-adult shelter census has resumed its upward trajectory. Providers have long observed that mentally ill shelter residents appear to stay in shelter beds more frequently and for longer periods of time than the general homeless population at large. Mentally ill shelter users who consistently refuse services often remain in the same shelter every night for years at a time. And while shelter residents engaged in nonprofit transitional housing programs within the municipal system may be headed toward permanent housing, program participation requires staying every night during the three to twelve months it may take before placement occurs. The ongoing expansion of these shelter-based transitional programs, coupled with a reduction in access to both long-term and acute psychiatric beds, has made the need for additional housing units for homeless people with psychiatric disabilities only more apparent.

Del Hendricks knows firsthand how scarce housing is, and how lucky he is to have a room in a NY/NY residence. He now lives independently with the occasional but regular help of an on-site case manager at Clyde Burton House. At 73 years of age, he's a voracious reader and an avid watercolorist who has become a leader in his building. While Del usually remembers to take his medication and has learned to cook healthy meals for himself, BRC's three social service staff at Clyde Burton help him keep a budget, and from time to time help him to clean his room and wash his clothes. With their help, Del hasn't been hospitalized for psychiatric reasons for over six years, and when he developed diabetes last year, it was quickly diagnosed and brought under control before he suffered any long-term effects.

The benefits to the public of having Del live in a supportive SRO are obvious. He no longer menaces passersby on the streets, and the on-site social services provided at Clyde Burton have so far eliminated his past need for expensive acute psychiatric and emergency medical care. The research of the accompanying report shows just how much of the public's money this reduced use has saved. But Del doesn't have to see a cost-benefit analysis to tell him what he already knows: the years he's spent in supportive housing have been the calmest, safest and happiest years of his life.

II. What Does Home Look Like?

Nothing guaranteed that Del Hendricks would thrive in a supportive SRO. He might have found the presence of BRC's social services staff at Clyde Burton House heavy-handed, their attentions intrusive. BRC is well known for its programmatic emphasis on fostering independence among its residents, however, so it would have been more likely for Del instead to have missed the structure of the transitional residential program that had helped prepare him for a return to housing. As it turned out, the match between Del and Clyde Burton House was successful. But whether he had required a higher level of care or even more independence, the NY/NY Agreement was intentionally designed to offer him a range of housing options.

In fact, part of the NY/NY Agreement's success serving such large numbers of people with widely varying levels of disability comes from the conscious decision of its signatories not to depend on just one service or housing model. The city concentrated on constructing supportive single room residences for more independent mentally ill individuals, but it also created 147 beds in more structured congregate care models for individuals with more intensive service needs. And the diverse missions of the community-based nonprofit providers contracted by the city to operate the supportive SROs have created both subtle and substantial differences in their service philosophies. With NY/NY housing units in most cases making up only a portion of the total units in each of the city's supportive residences, the presence of other groups of tenants, with and without special needs, imbues each supportive residence with its own character.

The state divided its NY/NY development among an array of both transitional and permanent housing models. More than 600 units in Community Residences and scattered site Apartment Treatment Programs are licensed by SOMH to provide transitional congregate care for up to two years to individuals with secondary diagnoses of substance abuse, long histories of institutionalization or other barriers to independence. The 15 licensed NY/NY residences containing 713 units that follow the CR/SRO model more closely resemble the City's supportive single room residences, with the addition of on-site meal plans and augmented clinical services. Permanent supported housing apartments created by SOMH provide fewer clinical services than the licensed models, and emphasize ongoing case management rather than treatment. Located together in one building or scattered throughout a neighborhood, supported housing apartments are visited a few times a week by case managers and require tenants to maintain a high level of independence. Together, the Agreement's diversity of housing models, providers and service philosophies combine to form a system that can effectively serve a heterogeneous population with a multiplicity of needs. And by providing this range of models, the Agreement offers choices to a group of people who are rarely consulted about how or where they would like to live.⁷

The Supportive Single Room Residence

For most mentally ill individuals, the supportive single room residence, or supportive SRO, offers a flexible balance of services and independence, socialization and privacy, structure and freedom. The model evolved out of early attempts by social workers and psychiatrists to engage and stabilize mentally ill and substance abusing tenants of privately owned SRO hotels in the 1960s and '70s. Without any institutional authority or power over the commercial SRO tenants, these pioneers were compelled to develop a service philosophy that allowed the tenant to exercise more control over his or her interactions with staff—and participation in treatment—than other clinical settings that existed at the time.

Today's supportive SRO housing model provides services to tenants in single room residences operated by nonprofit organizations. Ownership of the residences greatly increases the service providers' power in the provider-tenant relationship, but today's practitioners continue to try to afford the tenant a significant amount of control over how, and how much, he uses services. Done correctly, the supportive housing provider constantly adjusts services to respond to the present needs of the tenant. When the tenant is psychiatrically stable, occupied and interested, "on-site services" may mean no more than a case manager's open door and a greeting to the tenant as he enters and leaves the building. When a crisis occurs, "on-site services" may mean daily interventions, intensive engagement and counseling, even involuntary hospitalization. Whatever the degree of assistance, a safety net is created that protects the tenant from the most destructive aspects of his illness, while allowing him the autonomy to learn and grow, and sometimes even to fail. One supportive housing provider said it best when he described his organization's service philosophy as "low demand, high expectations."⁸

Providers attempt to make the physical layout of the supportive SRO conducive to this kind of service delivery. When the building's floor plan allows it, most groups choose to locate social service offices and group activities space on the ground floor to maximize tenant-staff interactions in semipublic areas. Larger supportive residences often offer a communal lounge area on each floor when possible. But because the NY/NY Agreement relied predominantly on rehabilitating abandoned or underutilized buildings, the floor plan of each residence has been dictated to some extent by the preexisting physical configuration of the building it occupies. Some supportive SROs built under the Agreement were purchases and renovations of the last surviving commercial SRO hotels; many of these had some portion of their rooms still occupied by longtime tenants. In these instances, the housing developer normally renovated one side of the building at a time, moving all tenants to the other side until work was completed, at which time the procedure would be reversed.

The floor plans of supportive SROs built in this way, such as the West Side Federation for Senior & Supportive Housing's Euclid Hall on Broadway and 86th Street in Manhattan, tend to resemble their commercial antecedents, with floors of small, sometimes oddly shaped rooms sharing bathrooms and communal kitchens. Following original floor plans and having residents share facilities helped keep construction costs down, and retaining a building's quirky layouts and original design motifs helped prevent the housing from appearing institutional. Having four rooms share one bathroom and kitchen saved enough money that the city

even experimented with this configuration in the five supportive residences it built that were completely new construction.

It is difficult to underestimate the attractiveness of a private bathroom to prospective tenants, especially those who've been sharing facilities with hundreds of other shelter residents. Providers' experiences soon showed that, while it was important to provide common spaces that encouraged social interactions with staff and among residents, supportive SRO tenants also benefited from the privacy afforded by self-contained studio apartments with individual baths and kitchenettes. Tenants who do not have to share bathrooms and kitchens have less altercations and disputes, convincing nonprofits and government funders to build self-contained efficiency apartments in all of the later NY/NY-funded supportive residences. Despite the added cost of placing a kitchenette and bathroom in each single room apartment, the city's supportive SRO remains one of the most economical NY/NY housing models to build.⁹

Service Funding

To pay for the on-site clinical and social services to NY/NY residents in the supportive SROs built with city capital funds, SOMH allocates funding to the New York City Department of Mental Health, Mental Retardation and Alcoholism Services (DMH), which enters into contracts with nonprofits to provide on-site services. This funding, ranging approximately from \$6,500 to \$9,000 per unit per year, allows on-site SRO staff to provide NY/NY tenants with case management and crisis intervention services, as well as medication monitoring, money management, group meetings, individual counseling, socialization activities and psychiatric consultations.

But the state's NY/NY service funding is just one of the typical supportive residence's funding sources. Tenants are issued leases and contribute approximately one-third of their incomes toward rent (usually between \$180 and \$450 a month), supplemented by federal Section 8 rent subsidies for at least the first five years of the building's operation. The state and city also evenly share the costs of an annual payment of \$1,800 per unit to help defray the costs of 24-hour front desk coverage and other regular operating expenses. In addition to these resources, most groups operating supportive housing have supplemented services with grants from other government agencies and private philanthropies, as well as operating reserves generated from the federal Low Income Housing Tax Credit. Depending on the source, these funds can often be used for the benefit of all the tenants, providing such services as vocational rehabilitation and on-site employment, legal aid, benefits advocacy, escorts to medical and service appointments and linkages to off-site community-based programs.¹⁰ And because supportive residences usually house people with other kinds of special needs alongside NY/NY-eligible tenants, they normally receive additional funds to serve those populations, whether it comes in the form of housing and service subsidies for people living with AIDS, or meal and activity programs for elderly tenants.

Supportive Housing in Action: The Times Square

One of the most elaborate and celebrated examples of a supportive single room residence with a mixed tenancy is The Times Square on 43rd Street and Eighth Avenue in Manhattan. Using loans from HPD, federal Low Income Housing Tax Credits, and grants from several foundations, the nonprofit organization Common Ground Community completed rehabilitation of the once-notorious welfare hotel in 1994 and now manages the massive 652-unit building, the largest supportive housing residence in the nation. The Center for Urban Community Services (CUCS), one of the nonprofit organizations most responsible for refining supportive housing service delivery, provides on-site social services to tenants, 130 of whom reside in rooms built and supported by funding from the NY/NY Agreement. Another 53 of The Times Square's units house formerly homeless people without mental illness, while 50 units house people living with AIDS and receive service funding from the New York City Human Resources Administration's Division of AIDS Services (DAS). Almost 200 tenants (many of them mentally ill) lived in The Times Square Hotel when Common Ground Community first purchased the building. The remainder of the units house elderly and low-income actors, artists, musicians and other low-income working people who had resided in substandard or overcrowded housing in the surrounding community.

By limiting tenants with special needs to about a third of The Times Square's studio apartments, Common Ground Community and CUCS enhance the diversity of the building without overwhelming the staff's ability to maintain a safe and stable residence of this size. No one group of special needs tenants dominates the social services staff's time or inordinately influences the character of the residence. And the presence of other tenants with dissimilar strengths and weaknesses can be inspiring and instructive: many residents with AIDS have expressed a preference for a living situation integrated with a more healthy populace, and mentally ill residents may be more willing and capable of maintaining employment if surrounded by working neighbors. Perhaps most importantly, the diversity of The Times Square's tenants emulates that of typical private apartment building and prevents it from looking like other, more institutional, residential settings.

In fact, after three years and \$36 million of renovation work,¹¹ The Times Square resembles nothing less than the luxury hotel it was when it opened in 1923. Once the residence of the deposed leader of the Dominican Republic, Joaquin Balaguer, a stopping point for Lee Harvey Oswald and the Beatles favorite place to drink after their appearances on the Ed Sullivan Show, The Times Square has been painstakingly rehabilitated by local craftspeople. The building's landmark façade and massive lobby boast huge chandeliers and a flowing circular staircase; colossal stone angels rescued from the nearby Helen Hayes Theatre look down over a grand piano and comfortable lounge areas. A balcony encircles the entire room, creating a mezzanine that contains social services offices and an exhibition area for regularly rotating community art shows. A medical clinic on the mezzanine employs part-time nurses and medical professionals who provide regular morning hours, as well as house visits to tenants in their rooms.

Common Ground Community and CUCS both stress employment and The Times Square offers multiple opportunities for vocational training and paid work, including a fully equipped computer lab, and an agency-wide employment program called the Common Ground Jobs Training Corporation. Because of its prime location in a recently rejuvenated neighborhood near tourist hotels and attractions, The Times Square has been able to rent all of its sizeable storefront space to businesses such as a Ben & Jerry's ice cream parlor and a Starbucks coffee shop, among others. Common Ground Community has been able to use this geographic advantage to generate employment and training opportunities for The Times Square's tenants. All of the building's storefront businesses are required to employ residents as part of their lease obligations, and a rooftop conference facility regularly rented to outside groups doubles as the site for a new culinary arts training program that graduated its first class in April this year. Common Ground Community and CUCS have also emphasized the creation of training and employment opportunities for tenants in the day-to-day operation of the building, such as front desk, maintenance and administrative support positions.

Supportive Services

Much has been written about supportive services in housing, but it continues to be difficult to convey to the uninitiated how supportive services delivery differs from other service programs. Providers often become tongue-tied when asked to articulate what makes supportive housing exceptional. "Soul." "Concern." "It's not just a job." Each attempt does not fully describe this professional relationship that seeks to address and improve all aspects of a resident's life.

Fortunately for us, a particularly insightful and articulate social worker named Joan Hatch Shapiro endeavored to depict her experience providing services to residents of commercial SROs in the 1960s. This seminal 1969 work, *Communities of the Alone*, provided a foundation for supportive housing service delivery and remains relevant more than 30 years later.¹²

In her book, Shapiro explained how social workers serving commercial SRO residents tended to build two different kinds of relationships with the tenants. The first relationship was as a case manager, assisting tenants one-on-one to resolve everyday issues and crises as they arose. This unique, confidential relationship could be very effective at resolving specific problems like securing and maintaining benefits or gaining access to medical care. But sometimes the workers found they had difficulties understanding tenants' problems in the isolated forum of the case conference.

Shapiro identified a second relationship that developed between the social worker and the groups of tenants that existed within the milieu of the residence. In their forays into the commercial SROs, these early forebears of supportive services found that, "The lives of all but a few of the tenants [were] actively intertwined, a finding which sharply contradict[ed] the stereotype of the single, unattached individual as reclusive."¹³ The social workers sought out existing groups of tenants or attempted to gather tenants into groups using communal meals and other social activities. Once the relationship with a group was established, individual emergencies occurred in which the worker could be useful to the tenants.

The social worker would solve these individual issues using case management strategies, with a slight, but consequential, difference. Having observed the individual as a member of a group, the social worker was privy to more contextual information. For example, while case conferences tended to focus on what was bothering the tenant, group activities tended to bring out more positive feelings. By interacting in both settings, the social worker was able to evaluate more accurately the extent of a tenant's problems and identify more effective strategies for dealing with them.

The casework role changed in another way that would be critical to the development of the supportive residence. The social workers could use their knowledge of the group's dynamics to make use of the "system of mutual aid" that already existed among the group members. By enlisting other sympathetic tenants in solving their neighbor's problem—asking one to accompany another on a medical appointment, for example—the social worker "formalized the giving-helping impulse"¹⁴ among the tenants, increased confidence in their own abilities, and supplemented the social services staff with a small cadre of case aides.

These strategies remain indispensable in today's supportive residence. Social services team members provide assistance, but also teach tenants how to assist themselves and each other. Tenants may become so adept at many of the caseworker's duties that the worker is able to recede into a backup role. Instead of imparting the learned helplessness so often found among shelter residents, the supportive services worker increases the tenant's self-sufficiency and socialization. And if the tenant chooses not to adopt these new responsibilities, that's okay, too. The worker continues to proffer assistance and generate opportunities for increased self-sufficiency, in the expectation that, one day, the tenant will choose to assume added responsibilities.

Medication and Money Management

Two less general, more pragmatic, elements of supportive housing service delivery are medication and money management. Known more familiarly as "M & Ms," tenants' ability to take their psychotropic medications and to budget money is absolutely critical to their ability to maintain housing. "The art program enhances life to a great extent, as do other activities, but our tenants won't benefit from any of it if they don't take their meds," says Father John McVean of the St. Francis Residence. In a less immediate, and somewhat less critical, way, the same could be said for money management. While supportive SRO providers are by and large quite forgiving as landlords, tenant rent payments form a crucial part of a supportive residence's budget, and a tenant who regularly lacks money for food, transportation and other necessities will have a much harder time maintaining her housing than one who sticks to a budget.

As self-evident as this may sound, it is difficult to convey the emphasis most supportive housing providers put on these two services, although every provider differs slightly in their application of the "M & Ms." Most NY/NY supportive SRO providers anticipate that some tenants will need little help with medication and money, taking their meds unprompted, paying

rent on time and eating regularly. But these same staffs know that many tenants need to be reminded to take their meds, and a tenant who is independent and compliant today may decide tomorrow to stop taking his or her meds, with disastrous results. While Directly Observed Therapy (DOT), or watching residents take their pills each day, is avoided in the supportive SRO as much as possible, many tenants will receive reminders from staff to take meds and will often work with clinical staff to prepare packages containing their daily doses at the beginning of each week. In a similar way, few supportive housing providers besides the St. Francis Residence are willing to be a tenant's "Rep Payee" (Rep Payees receive directly a tenant's monthly SSI payments, then manage the money to make it last the month). Usually supportive housing tenants manage their own money, or enter into a voluntary budgeting agreement with the provider. Some tenants on welfare get their rent checks paid directly to the landlord.

Other Supportive Housing Models

Until the NY/NY Agreement, the State Office of Mental Health (SOMH) had limited its housing development to transitional licensed treatment facilities. While these residences played an important role in smoothing state psychiatric center inpatients' transitions to life in the community, residents often had nowhere to go upon completing treatment, remaining in the enriched and expensive treatment beds long after they should have graduated to more independent living situations. Advocates, providers and city officials had long pressured SOMH to address the dearth of affordable permanent housing for people with psychiatric disabilities. SOMH responded by developing three permanent housing models for NY/NY: its own version of the supportive SRO, a scattered site apartment program known simply as "supported housing," and a hybrid model of licensed permanent housing called the CR/SRO.

The supportive SRO residences funded by the state closely follow the housing and service model established and refined by the city, although in the state supportive SRO model, the residential population is completely comprised of persons with psychiatric disabilities. Two of these SRO residences did not require capital financing, the providers instead renting and serving blocks of rooms in existing, previously unserviced, single room occupancy buildings.

A sizeable portion of the state's NY/NY development involved subsidizing the rent of 643 apartments clustered or scattered in privately owned buildings throughout the city. Nonprofit organizations managing these supported housing apartments receive funding for staff to visit and provide services to residents in their homes. Slightly more than 200 of these apartments required substantial capital rehabilitation before they could be occupied. Although the implementation of this housing model varies widely among providers and programs, the scattered site configuration of SOMH supportive housing can make it the NY/NY model that most closely resembles private housing.

Some providers chose to use supported housing subsidies to rent a cluster of apartments in the same building, sometimes opening a social service office on-site as well, when possible. Others use the subsidies to house one to three persons each in apartments rented in buildings

scattered throughout a neighborhood. One program uses supported housing to reunite and house homeless mentally ill individuals with their families. Supportive services staff offers case management to residents during business hours, and expects to visit each resident in their home about three times a week. Residents must be psychiatrically stable, clean and sober, and able to take their medications independently. Many mental health providers use supportive housing apartments as the final placement for individuals graduating from their transitional mental health treatment residences. And though the 436 rent-subsidized supportive housing units did not increase the overall supply of affordable housing in New York City, they remain one of the most popular options for people eligible for NY/NY housing.

The CR/SRO

The CR/SRO is another housing model created by SOMH for the NY/NY Agreement. Though the CR/SRO is licensed, like SOMH's transitional Community Residences, it is considered permanent housing and there is no limit to a resident's length of stay. Similar to the city's supportive SROs, the 15 CR/SROs have 24 to 78 individual rooms each with shared baths and common areas. All residents have psychiatric disabilities, and services are more intensive than in purely supportive housing. These include 24-hour staff coverage, meal planning and cooking, training and assistance in learning Activities of Daily Living (ADL) skill, and medication management.

Unlike other licensed facilities, residents of CR/SROs are not required to participate in any structured activities. Residents hold occupancy agreements, but have their rents paid directly by Supplemental Security Income (SSI) Level II, a federal benefit considerably enhanced by the state. Although the CR/SROs offer more services to their tenants than do supportive SROs, they are considerably less expensive to operate than Community Residences, allowing the provider to share a larger portion of the SSI Level II payment with the tenant. This larger living allowance, about \$500 per month (as opposed to slightly more than \$100 per month in a Community Residence), must be used to pay for food, although most CR/SROs offer meal plans to their residents. The CR/SROs' high levels of support combined with this extra spending money have proven understandably popular among NY/NY-eligible individuals who may not be independent enough to maintain themselves in other supportive housing options.

The Community Residence

The traditional Community Residence (CR) model is a 10- to 24-bed transitional housing residence with shared bedrooms and bathrooms and 24-hour staff coverage. Residents are required to participate in a treatment program or some kind of structured activity during the day, and are expected to move on to more independent living situations within two years. Residents of CRs do not hold leases, must obey a curfew and relinquish control of all but a small portion of their finances to the provider. The Community Residence model was originally designed to help former psychiatric center inpatients accomplish the transition to more

independent living situations. Residents of the CR model today usually require extensive ADL training, although participation in the CR program presumes that the individual is capable of improving their independent living skills.

The physical layout of Community Residences varies from 24-bed supervised congregate care programs that provide intensive, around-the-clock services, to Supported Community Residences, scattered site apartments with visiting case managers and beeper coverage. Sometimes referred to as “Apartment Treatment Programs,” or “Intensive Supportive CRs,” scattered site CR apartments usually house three to four individuals in an apartment. Both the supervised and scattered site CR programs require residents to share bedrooms. Many providers operate both Supervised CRs and Apartment Treatment Programs, placing graduates of the former into the latter, less structured program as they become more capable of living independently. Ultimately, successful graduates of CR programs tend to be placed into supported housing apartments.

The MICA Community Residence

Studies of the homeless mentally ill population in the years leading to the NY/NY Agreement reported growing numbers of individuals with serious and persistent mental illnesses complicated by secondary diagnoses of drug and alcohol abuse. Most providers continue to agree that approximately half of homeless mentally ill New Yorkers also have substance abuse problems. But at the commencement of the NY/NY Agreement, few mental health programs could effectively treat people with these dual diagnoses, and traditional substance abuse treatment providers were even less well-equipped to serve individuals suffering primarily from mental illness. To address this mounting need, SOMH modified the design of its Supervised Community Residence model to provide a treatment program that focused on both the resident’s mental health and sobriety in a more holistic way than the traditional Community Residence.

Many NY/NY programs expect residents to have six months of sobriety prior to move-in, but these new “MICA (Mental Illness Chemical Abuse) Community Residences” require only that applicants complete detoxification before entering. Some MICA Community Residences require that newly arrived residents remain on-site for the first 30 days of their stay, as a traditional residential substance abuse treatment facility would. Residents are required to attend a dual-diagnosis day treatment program; many MICA CRs provide these programs on-site. Many of the programmatic elements are similar to that of a regular Supervised Community Residence, with an added substance abuse treatment component. In addition, MICA CR residents receive vocational preparation in anticipation of some level of employment.

Other NY/NY Housing Models

The state also constructed 135 NY/NY-designated beds in three residences following another residential treatment model, the Residential Care Center for Adults (RCCA). The RCCA offered

less services but more structure to people thought to be too low-functioning to benefit from the transitional programs of the Community Residences. The RCCA model was expensive, however, and in 1996 was merged into the Community Residence program under the new rubric "Congregate Treatment." In one other permanent housing model, three providers received capital funding, first from the state and then the city, to construct 132 NY/NY beds serving an elderly and more psychiatrically disabled population. These residences are the most structured of the city's NY/NY housing, and are perhaps best exemplified by the West Side Federation for Senior & Supportive Housing's Frederick Fleming House at 443 West 22nd Street in Manhattan.

An Experiment in Choice

The varied range of residential models developed under the NY/NY Agreement represents the culmination of the best efforts to date to house homeless mentally ill individuals. Indeed, the Agreement most likely would have been decidedly less effective if it had depended on only one or two housing models. The housing's responsiveness to the needs of its residents was increased further with the participation of such a large number of nonprofit providers who developed their own programmatic variations within the different housing models.

One innovative provider, Pathways to Housing, has had considerable success forgoing licensed housing and moving homeless mentally ill individuals from shelters and the streets directly into supported housing apartments. This Manhattan-based provider helps its residents complete the transition to independent living without having to move from one facility to another each time they show improvement in their ADLs. In today's mental health continuum, a homeless mentally ill individual can spend nine months in a shelter-based transitional mental health program, followed by a year in a Supervised CR, a year in an Apartment Treatment Program, and then finally move into a permanent supported housing placement. While this can be an effective course of treatment and support, Pathways to Housing tries another approach by instead placing homeless individuals directly into supported housing, surrounding them with social services, then gradually removing support as the individual becomes able to maintain his apartment more independently. By allowing this transition to occur in one place, Pathways to Housing minimizes the disruption in services and the opportunities for relapses that can occur when mentally ill people move from one residence to another.

The extraordinary housing retention rates shown by Pathways to Housing's tenants are impressive. But it's likely that some significant subset of the homeless mentally ill population will continue to benefit from transitional services before they can move into permanent housing. One person may have had little experience living outside an institutional setting; another may have a recent history of self-destructive behavior that warns against leaving her unsupervised right now; still another may just be unable to get a provider to accept him for supportive housing because of his recent drug use. Even if a vast increase in the number of available

supportive housing units caused providers to be less selective in accepting new tenants, some number of individuals will benefit from time in a transitional program before they're able to secure and maintain an apartment in supportive housing.

When More Structure and Services Are Necessary

Gina Madison is a good example of someone who needs a higher level of care than what she would receive in a supportive SRO. In the 1960s, Gina was an actress, with small parts in Hollywood movies supplemented by more avant-garde roles as one of Andy Warhol's "Superstars." Even then, Gina was unconventional, but her eccentricities meshed with the countercultural scene in which she traveled. As she got older, however, her mental illness caught up with her and in 1987 she entered the municipal shelter system. She languished there for seven years, where her outlandish costumes, aggressive neediness and constant irrational chatter fomented constant conflicts with other shelter residents. Gina's memories of her glamorous past bolstered her independent self-image and thwarted any attempts to engage her in mental health treatment.

When the shelter in which she lived was closed, Gina was convinced to go to Valley Lodge, a transitional housing program operated by the nonprofit West Side Federation for Senior Housing. Arriving in a silver lamé miniskirt, raving about an abusive boyfriend from long ago, Gina instantly alienated everyone on her floor. The next morning, the six other women in her room petitioned to have her moved out. Transferred to a general shelter in the municipal shelter system, Gina's behavior became even more psychotic and aggressive, until she was involuntarily committed to Roosevelt Hospital.

Gina might have soon been discharged back to a general shelter if not for the intervention of the Valley Lodge staff, who offered her a chance to return to the program once she was moderately stable on psychotropic medication. It was the first time in her life that she had been on meds, and the difference in her personality was profound. Nonetheless, Valley Lodge required her to attend an intensive psychiatric day treatment program at Roosevelt for her first 12 weeks back at the residence. After an additional six months living at Valley Lodge, where she relearned how to socialize, how to dress more appropriately, and how to manage her new Supplemental Security Income (SSI), Gina was ready for housing.

But it was obvious that Gina was going to need more help than what she would get at a supportive SRO. She understood that the meds helped her think more clearly, but they also made her gain weight, so she often would conveniently "forget" to take them on weekends and other times when staff wasn't around to monitor her. Also, she needed to continue to work on her interactions with others. Knowing her weaknesses, the Valley Lodge staff placed her into an Intensive Supportive Community Residence operated by the Postgraduate Center for Mental Health on West 98th Street.

Now referred to as the Apartment Treatment Program or Supported Community Residence, the Intensive Supportive CR model provides two- to four-bedroom shared apartments for people deemed unready for supportive housing. Case managers visit five to seven times a week, closely monitoring the residents' medication and leading socialization activities, ADL skills training, counseling, crisis interventions and budgeting. Once in the residence, Gina's SSI benefits were increased to "Level II," and are now sent directly to Postgraduate staff, who give her a weekly stipend for spending money. Gina now supplements this with income she earns working 25 hours a week for a Postgraduate Center. While she doesn't always want to participate in all of the activities at the CR, Gina loves her room and the privacy it gives her—something she hadn't experienced in years. And when she has a bad day and feels stressed out, she knows there's always someone who will help her "keep it together."

If things continue to go well for Gina, she'll probably move on to a less structured residence someday—most people in Community Residences do. And once approved for NY/NY housing, residents remain eligible to move on to other NY/NY residences with increased or reduced services, depending on their needs. Supportive CRs and supported housing both offer scattered site apartments in the community that are visited less often by case managers than where Gina is now. Or she might better benefit from the CR/SRO model, which can offer Gina some on-site psychiatric care, some meals, and more varied services in which participation is optional, without losing 24-hour on-site staff coverage. Whatever she eventually chooses, Gina knows she'll get the care she needs without having to give up the independence of having a room of her own.

III. A History of Mental Health In New York

In retrospect, the NY/NY Agreement looks like a reasonable, almost inevitable, policy response to the crisis of homelessness that first appeared in the late 1970s and early 1980s. But its success was by no means assured. It took years of extraordinary effort and persistent advocacy by a broad alliance of innovative social service providers and housing developers, creative government administrators and interested politicians to turn the obvious need for this housing into a viable political achievement. Even then, the NY/NY Agreement would never have been as effective as it has proven to be, if not for these trailblazers' more than 30 years of experimentation devising the service and development models that have kept mentally ill people housed so successfully. So many contributed to the efforts leading to the NY/NY Agreement that it's impossible to give proper credit to them all. The following is only an attempt to identify the larger trends and significant developments that made this housing a reality.

Deinstitutionalization

In 1955, a federal commission headed by former President Herbert Hoover called mental illness America's greatest health problem. It was certainly the most expensive: mental health patients occupied over half of all the hospital beds in the United States at the time.¹⁵ In New York State, the census of the psychiatric hospital system topped 93,000, the highest ever.¹⁶

That year also marked the first in which doctors in psychiatric centers widely distributed recently approved psychotropic medications, with miraculous results. Over the ensuing decades, the state's psychiatric census dropped sharply, as tens of thousands of mentally ill inpatients were stabilized with the new drugs and released. Most returned to live with and be cared for by their families. But a significant number of them gravitated to commercial single room occupancy (SRO) hotels in New York City, where rents were low and landlords tolerated tenants' idiosyncrasies. Most of the SROs offered small rooms with a shared bathroom down the hall, although a broader definition of the SRO included "flophouses" that provided no more than a 4-by-8 cubicle containing a cot, a light bulb and chicken wire forming a low ceiling to keep out thieves.

The many success stories of recently discharged inpatients, combined with reformers' accounts of sometimes appalling conditions within the psychiatric hospitals, fomented growing public support for deinstitutionalization. Even without this support, states attempting to rein in the staggering costs of operating these institutions had ample incentive to discharge (and later to restrict admissions). The federal government hastened the process further by making psychiatric inpatients ineligible for Medicaid and federal disability benefits, giving states even more

reason to discharge. But the community mental health clinics, housing and services promised by the federal government didn't materialize, and many of the newly discharged were soon on their own in New York City's commercial SRO hotels and flophouses.

With housing relatively abundant in the 1960s, the run-down commercial SROs were not considered a valuable housing resource, and the supply quickly eroded. Landlords had long received substantial tax breaks to upgrade SRO properties into market rate apartments, but New York City's 1967 Housing Maintenance Code made this trend explicit by requiring the closure and conversion of all SRO housing by 1977. Some welfare advocates voiced concern about what the loss of these units might mean to the tenants presently occupying them, but most New Yorkers were more interested in dispersing the criminal element in the hotels than in maintaining what appeared to be a woefully inadequate housing resource.

Serving the Commercial SROs

And so the SROs became the center of a tug-of-war between development and preservation. Undeniably substandard, redolent of the 19th century, SROs were nevertheless indispensable for as many as 200,000 poor single adults in New York in the 1960s and early '70s.¹⁷ Most SROs accepted the daily rent rate paid by welfare, and an uneasy relationship between the welfare department and SROs was well established by the early '60s. In 1964, welfare case-loads were reorganized geographically so that one SRO location could be served by a single caseworker (or team of caseworkers, in the larger hotels).

Soon thereafter, workers from some of the New York City Human Resources Administration (HRA) welfare centers began lengthening their site visits at some of the welfare hotels, establishing regular daily hours in on-site offices provided by the hotel owners. One welfare office that served a large number of SRO residents, the Amsterdam Center on the West Side of Manhattan, permanently stationed caseworkers in some of the larger SROs. HRA workers at these on-site offices would help open and recertify welfare cases, issue referrals to detoxification services and, increasingly, provide basic case management services.

Along with HRA's early efforts, emergency room and psychiatric staff at local hospitals made some of the first attempts to serve mentally ill tenants in the SROs where they lived. From 1964 to 1967, the Community Psychiatry Division of St. Luke's Hospital sponsored an experiment to provide social services at an SRO at 207 West 85th Street. The program was eventually expanded by its founder, the aforementioned Joan Hatch Shapiro, to five-member teams in nine SROs on the Upper West Side. After the initial demonstration, supportive services were assumed by HRA caseworkers, with St. Luke's and the Visiting Nurse Service providing some auxiliary health and mental health services. The lessons learned from these first attempts at providing services to commercial SRO tenants would later form the basis for the supportive service philosophy employed in much of NY/NY housing.

The Aberdeen Provided a Model

In 1971, two priests at St. Francis of Assisi Catholic Church on West 32nd Street, Fathers John McVean and John Felice, noticed more and more people sleeping in front of the Church before eating their morning meal at the Parish soup kitchen. Many of them were mentally ill. "We got tired of stepping over people," says Father McVean, "We've always flown by the seat of our pants, and there was a hotel down the street with rooms available. So we asked the owners if they'd let us use a couple of rooms for an office and a space for activities."¹⁸

The Aberdeen Hotel, in the shadow of the Empire State Building on West 31st Street between Fifth and Sixth Avenues, was already renting rooms to families and single adults on welfare, but the owners were overwhelmed by the needs of their tenants. They readily agreed to the Franciscans' offer, and the first truly comprehensive model for providing supportive services to mentally ill individuals in permanent housing began to take shape.

Shortly thereafter, HRA workers responding to a brief shortage of SRO rooms placed a homeless family into the Waldorf-Astoria Hotel on an emergency basis. HRA scrambled to contain the resulting front-page scandal by moving all welfare families out of the SRO hotels, including the Aberdeen. However, the two priests convinced one of the HRA caseworkers to stay behind and work with the mentally ill tenants who were beginning to predominate at the hotel. In addition to helping with benefits and referrals, the HRA worker supervised tenants in the preparation of a daily meal made with industrial-sized tubs of food supplied by the city. A social worker from the Hudson Guild and a Visiting Nurse Service (VNS) nurse were also persuaded to provide their services, and Bellevue Hospital began to allow some third- and fourth-year residents and a social worker to provide part-time psychiatric care on-site at the hotel. The local clinic operated by the State Office of Mental Health (SOMH) also supplied some psychiatric time at the hotel.

"It seems so obvious now," says Father McVean, "but the thing that made the difference was having everything on-site." Dr. Carl Cohen, a psychiatrist who worked at the Aberdeen as a resident at Bellevue, recalls, "The environment encouraged participation. We were right there, so we could visit the rooms. Tenants begin to trust you if they see you every day. And when we needed to, we were able to intervene a lot earlier than we used to." The psychiatry residents wrote prescriptions at the hotel, but often filled them for the residents at the Bellevue Pharmacy. And though they were studying to be psychiatrists, the residents often provided medical treatment to tenants as well.

This piecemeal, part-time staff soon found itself offering a comprehensive menu of supportive services, from medication management and helping tenants make their welfare checks last until the end of the month, to leading socialization activities like art and news groups. Says Dr. Cohen, "Being there all the time, we learned the importance of social networks. If you understand the relationships between tenants, you become more attuned to the psychosocial dynamic. When you see someone acting out, arguing with somebody, you've got to be able to make an informed judgment. To the uninitiated it may look like psychosis, but it's just a disagreement."¹⁹ As the services at the Aberdeen grew more sophisticated, the local welfare

office began referring all psychiatrically disabled welfare recipients in need of housing to the hotel, until almost 150 mentally ill individuals occupied the Aberdeen's tiny rooms.

The Stratford Arms

With no knowledge of the Franciscans' work at the Aberdeen, Roosevelt Hospital's Department of Psychiatry designed a remarkably similar program at the Stratford Arms, a commercial SRO hotel on the Upper West Side. Roosevelt had already used multi-disciplinary "Neighborhood Care Teams"—consisting of medical and psychiatric nurses, social workers and case managers—to visit clients known to the clinic in their apartments in conjunction with the Visiting Nurse Service. Responding to a call for an involuntary hospitalization at the Stratford Arms, the team met an HRA caseworker stationed there who asked them to help serve a concentration of psychiatrically disabled individuals in need of supportive services.

Roosevelt Hospital applied for and received grants from the New York City Department for the Aging to create a multidisciplinary team inside the hotel. The team consisted of a psychologist, a psychiatric nurse, a social worker and three HRA caseworkers. The criminal element in the hotel was gradually nudged out and the team began providing counseling, groups, medical care, crisis intervention and other on-site support services to the mostly mentally ill tenants who remained. Psychiatric care was provided at the hospital. "We tried to keep the psychiatrists away from the hotel, because they were too traditional to condone what we were doing," says Dr. Steve Estrine, the psychologist at the program's inception. According to Dr. Estrine, one of the best aspects of the program was a small fund to pay stipends to the tenants for jobs, like cooking meals and cleaning rooms, as well as a neighborhood delivery service, and even a production of *The Fantasticks* put on by retired vaudevillians who lived in the hotel.²⁰

Crime Wave!

By 1972, the welfare department was referring about 2,500 single adults a month to commercial SRO hotels. Nearly half of the referrals were described by HRA as "drug addicts, persons with criminal records or discharged mental patients."²¹ Predictably, larger SROs full of single adult welfare recipients often had an adverse impact on their surrounding neighborhoods. Increases in muggings, panhandling, prostitution and drug dealing around the "welfare hotels," as they were now commonly known, led neighborhood groups to campaign actively against the SROs, pressuring owners to renovate to attract a more upscale tenancy. In a handful of instances, neighborhood groups were able to convert problem SROs into model residences for the elderly.

But little else was done to replicate or expand individual efforts to serve the commercial SRO tenants until 1973, when four murders in six weeks at the Upper West Side's Hotel Endicott confirmed the public's view of the SROs as harbors of violence, crime and unmentionable depravity. The tenants' disabilities and extensive service needs were overlooked as the public

interest focused on the grisly details, like the tenant who calmly ate a sandwich while showing police a dead body that had dangled outside his airshaft window for a week.

State Attorney General Louis J. Lefkowitz launched a drive on “the worst” of the commercial SRO hotels, vowing to shut them down, or at least disperse the criminal element within. Because so many of the SRO tenants had their rents paid by welfare, the Attorney General was especially critical of the city’s Human Resources Administration. HRA Commissioner Jule Sugarman’s initial response was to cut off some hotels from receiving welfare rent payments and to offer enhanced coordination with the police. But when the possibility of providing on-site social services to the SRO tenants was suggested, the Commissioner reiterated the commonly held view that SRO tenants were “a group of people with whom social service workers are not very effective.”²²

Asked for a more permanent solution than police actions and evictions, the harassed Commissioner said, “Frankly, I just don’t know of any,” although he did say that HRA would not build special housing for the “problem singles” far away from the city, as some elected officials were suggesting. Mayor John V. Lindsay was alarmed at the negative publicity, and Deputy Mayor Edward Hamilton was much more forceful than the Commissioner, saying that a solution “can and will be found” and calling for closing down the larger, more infamous hotels.²³ When asked if this might lead to a housing shortage, Hamilton reassured reporters that there was “no evidence that we will have too many people with no place to live” any time soon.²⁴

A few days later, Robert Jorgen, a social worker in the HRA Commissioner’s office who had been involved in placing some of the first caseworkers on-site at the SROs, found that City Hall was ready to listen to his ideas. In a newspaper interview, Jorgen suggested limiting SROs to no more than a hundred rooms apiece and providing on-site “supportive services, such as health, welfare and drug addiction counseling.” But Jorgen cautioned against high expectations for any program, saying there was no funding available. He was especially upset by attacks on the city’s SRO policies made by then-Congressman Edward I. Koch, saying the federal government had not provided any funding to house or serve the SRO population.²⁵

The Attorney General’s continued grandstanding and an almost daily string of SRO articles in the New York Times put pressure on Mayor Lindsay to take decisive action. One article quoted an internal study by the Bureau of the Budget that counted 60,000 SRO units that had already been renovated or demolished out of existence over the previous ten years.²⁶ The report proposed that the city fund the construction of a demonstration “voluntary home for adults” to be operated by a nonprofit organization, as well as a proprietary (for-profit) residence. The state was encouraged to do its part by constructing “halfway houses” for people discharged from state psychiatric institutions and prisons. The study also recommended that the City Council rescind an absolute ban on SROs due to take effect in 1977.²⁷

The SRO Housing Task Force and the Office of Special Housing Services

In January 1973, the idea of providing on-site support services to psychiatrically disabled and substance abusing tenants took a giant leap forward when Mayor Lindsay announced plans to create a multi-agency task force on the SROs. In his characteristically emphatic style, the Mayor confided to reporters, “If I had to pick two things that are driving me up the wall, I’d pick drug control and the maintenance of existing housing.”²⁸

Four months later, the Mayor’s Task Force on SRO Hotels (headed by Charles “Chip” Raymond, who would sign an addendum to the NY/NY Agreement 20 years later in his capacity as the first Commissioner of the new City Department of Homeless Services) announced an initiative to strengthen enforcement of city fire, building and health codes in the SROs, as well as the creation of three new city funded service programs to be operated by Roosevelt and St. Luke’s Hospitals. Building on their previous program models, the hospitals provided teams on-site at the SROs with staffs that included an addiction counselor, a nurse, an alcoholism counselor and an on-site supervisor.²⁹

In addition to these initiatives, HRA created a new Office of Special Housing Services and named Bob Jorgen Director. The new office significantly expanded the number of HRA workers in the SROs and improved their expertise. Three New York City Addiction Services Agency counselors were also assigned to the hotels. The new Office began its work in the ten hotels the Mayor’s Task Force had named as the city’s worst.

Noticeably absent from the Task Force plan was any housing construction, which had long been viewed as the province of the federal government. The Mayor, however, did heed Manhattan Borough President Percy Sutton and others who called for the establishment of a Mayor’s Office of SRO Housing. In this first incarnation, the Mayor’s Office focused mostly on monitoring code compliance in the commercial SROs and advocating for tenants at risk of eviction. Ten years later, the Mayor’s Office of SRO Housing would begin providing small loans to private landlords to upgrade their buildings. This would be the beginning of the SRO Loan Program that would later move to the City’s Department of Housing Preservation and Development (HPD) and fund the construction of many of the residences developed in the NY/NY Agreement.

New Funding, New Programs

Some officials within the State Office of Mental Health also began to push the idea that mentally ill people could benefit from social services located in their communities. In 1974, the state legislature passed laws that, for the first time, provided mental health and social service dollars for community-based services for former psychiatric center inpatients in need of support. But strict eligibility criteria limited the number of people served until 1978, when Senator Frank Padovan and Assemblymember Elizabeth Connelly of the New York State legis-

lature secured funding for what was designated the Community Support Services (CSS) program. Local agencies such as the New York City Department of Mental Health (DMH) used these new CSS funds to enter into contracts with nonprofits to provide a variety of community-based mental health services.

Assistant Commissioner Jim Rice of DMH's Bureau of Rehabilitation and Special Services chose to apply a significant portion of the new CSS funding to establish badly needed shelter-based rehabilitation programs that focused on preparing mentally ill municipal shelter users for housing. He also applied some of the money to shore up clinical services provided in some of the commercial SROs. Over the next 20 years, Rice and the Bureau he headed would harness a variety of funding streams to create an entire system of innovative outreach, transitional and permanent housing programs for homeless mentally ill people in New York City that would greatly influence the creation and design of the NY/NY Agreement.

Also in 1978, the state began funding the construction and operation by nonprofit mental health providers of the first Community Residences, the licensed treatment model that would be a significant part of the housing built by the NY/NY Agreement 12 years later. Intended to house people during their transition from the state psychiatric centers back into the community, the CR model often became *de facto* permanent housing as other appropriate housing options available to CR residents were limited mostly to returning to the care of their families. Psychiatric center referrals to the Community Residences had priority, making it difficult for mentally ill people already in the community to gain access to the new model. When they did, they often had problems adjusting to the CRs' constraints on personal freedom and privacy. Over the next six years, about 1,100 Community Residence beds would be opened, until inadequate funding and service gaps initiated a redesign of the model.³⁰

As the 1970s came to a close, property values began to rise and conversions of SROs to market rate apartments increased dramatically. While the blanket prohibition on SRO housing by 1977 had been repealed, the city did little else to address the disappearance of this housing stock. Some mentally ill individuals were able to move into Private Proprietary Homes for Adults (PPHAS) licensed by the state Department of Social Services, but others began to appear in train stations and the streets, and by the early 1980s, the word "homeless" had entered into New Yorkers' everyday lexicon.

The St. Francis Residence

Some of the first commercial SROs to be converted back to tourist hotels or into market rate housing were in the Murray Hill section of Manhattan, and when the owners of the Aberdeen began to convert SRO rooms back for use in the tourist trade, Fathers McVean and Felice realized that they would have to move to another location. Reluctant to relocate the 150 mentally ill Aberdeen residents to another SRO that could also be subject to sale or renovation, the Franciscans decided that the only way to provide the support and stability required by their residents was to own and manage the building themselves.

Says Father McVean, "When you own a building, you have greater control over everything. You eliminate the profit motive, so right there, you can do more. You can make sure the bathrooms are kept clean. If a wall needs to be painted you can get it painted. It's all very basic, but it makes an enormous difference in the environment of a place."³¹

In 1980, the two priests founded St. Francis Friends of the Poor and began a fund-raising drive to purchase the Beechwood Hotel, a half-empty SRO on East 24th Street that had been slated for gentrification. The Beechwood contained 100 modest SRO rooms with communal bathrooms and a kitchen on the ground floor. The Franciscan Order provided \$500,000 toward the \$550,000 purchase price; it cost another \$100,000 to give it what Father McVean termed a "cosmetic rehab." In 1981, the newly christened St. Francis Residence became the first nonprofit-owned and -operated permanent supportive residence for individuals with psychiatric disabilities in New York City.

While the two priests were able to raise enough funds to purchase and make the building habitable, they had limited resources for services: the psychiatry students from Bellevue, an HRA caseworker, a psychiatric nurse and, most importantly, an HRA caseworker from the Aberdeen named Al Pettis, who became the residence's first program director. In November 1980, this skeleton staff moved about half of the Aberdeen's mentally ill tenants to St. Francis over a three-week period with only one van. They began to accept new referrals as well, but soon realized that they hardly had the funds to provide adequate support for 100 mentally ill tenants.

"Once we took control, we realized we needed more funds to provide services," recalls Father McVean. A year after the St. Francis Residence opened, the New York City Department of Mental Health's Bureau of Rehabilitation and Special Services let a \$200,000 annual contract to St. Francis Friends of the Poor, using CSS funds for a full-time psychiatric nurse and two activities specialists. HRA provided in-kind support by continuing to station a caseworker, John Gaines, at the St. Francis. After a few years of operation, the Bureau was able to identify more funds to add staff and ten hours of on-site psychiatric consulting. The city Human Resources Administration (HRA) also continued to provide one meal, and later two, a day.

The St. Francis staff adapted the model they had developed at the Aberdeen to the new residence. They continued to offer a team approach to providing services to the tenants, but now had to act as landlord as well. In the words of Father McVean, the program "strongly urged tenants to be medication compliant," but if a tenant refused services or medication, he or she was allowed to remain housed. With the help of formal linkages to specialists in outside medical and psychiatric programs, the residence staff would re-engage the person on their own terms until he or she could once again be stabilized. Often, noncompliant tenants would need to be hospitalized until stable, but almost always returned to the residence once they were capable of maintaining themselves in the housing. One activities specialist at the St. Francis Residence summarized the program's service philosophy best when she said simply, "We are a family here."³²

Homelessness

While many people were aware of the innovative program being implemented at the St. Francis Residence, the city was necessarily devoting most of its resources and attention to generating desperately needed emergency shelter beds for the growing numbers of homeless single adults. The city's efforts grew even more urgent in 1981, when the Callahan v. Carey lawsuit was resolved. Argued by Bob Hayes, a young lawyer at the Sullivan & Cromwell law firm who would go on to found the Coalition for the Homeless soon after, Callahan v. Carey produced a landmark consent decree that clearly delineated the city's responsibility to provide shelter to all homeless single adults. Over the next few years, the municipal shelter system would expand from providing beds for an average of about 3,500 single adults per night to more than 9,600 per night.³³

Establishing a right to emergency shelter may have addressed the most immediate need of homeless people, but the Callahan case had other, more far-reaching consequences. "The most significant thing about Callahan was that it convinced the Koch administration to start renovating *In Rem* housing in earnest," says Hayes. "It was a radical shift—here were all these buildings in tax arrears that the city had been trying to get rid of, and now there was a use for them. Callahan gave the city an economic argument: we can spend the money on shelters or we can spend it on housing."

Consumed by crises in both the single adult and family shelter systems, the city dedicated most of the newly renovated housing to homeless families. For single adults, the city provided shelters and some transitional programs, and quietly advocated for the State Office of Mental Health (SOMH) to take on a greater role in caring for those shelter residents suffering from mental illness. Pointing to the deinstitutionalization that had begun 25 years before, the city argued that the state was responsible for housing people with mental illness. The state countered that it wasn't psychiatric discharges who flooded the shelters, but the victims of a city housing policy that continued to allow valuable SRO units to be lost and low-income tenants to be evicted.

These accusations flew back and forth, until the City Department of Mental Health (DMH) Bureau of Rehabilitation and Special Services and the Office of Management and Budget (OMB) funded demographic surveys and analyses of the single adult shelter population in 1983 and 1985. Conducted by Elmer L. ("Moose") Struening, Ph.D., with the assistance of Susan Barrow, Ph.D., both researchers with the New York State Psychiatric Institute, these studies were some of the first comprehensive investigations of the characteristics of the rapidly expanding shelter population. Among many interesting findings, their studies confirmed that approximately one-third of the City's shelter residents had a serious and persistent mental illness.

Internally, the State Office of Mental Health (SOMH) viewed these and other studies of the homeless population at the time as "political documents," part of a re-election ploy by Mayor Koch to shift blame for homelessness to the state. But the research was conducted by a state agency and the data was convincing. A new lawsuit, *Klostermann v. Cuomo*, argued that the

state's responsibility for mental health treatment included providing a safe place to live. Initially dismissed by a lower court, in 1984 Klostermann was reinstated by the New York State Court of Appeals, and the real threat of a trial loomed.

In response to these political and legal pressures, and the already deafening public outcry over mentally ill people living in public spaces, the state ratcheted up its development of Community Residences in 1984. Additional services and staffing were added to the existing Community Residence model, making it more closely resemble the Community Residences that were eventually created by the NY/NY Agreement. Over the next five years, almost 500 Community Residence units a year were created in New York City alone.³⁴ As in its earlier incarnation, the CR model was still considered a transitional placement, although in practice many residents remained for years. In addition, the DMH Bureau of Rehabilitation and Special Services used increased levels of CSS funding allocated by the State to provide mental health programs in the shelters and housing, and to expand outreach efforts to homeless mentally ill people on the streets.

The Heights

Although the State Office of Mental Health (SOMH) continued to resist building permanent housing for mentally ill persons, State Division of Housing and Community Renewal (DHCR) did earmark some capital money to rehabilitate supportive SRO housing for single adults through its Special Needs Housing Act program. Funding for four projects was approved in 1983, including a second residence by the Franciscans and a 55-unit vacant SRO in Upper Manhattan overlooking the highway approach to the George Washington Bridge that would be called "The Heights."

In building The Heights, the nonprofit Committee for the Heights Inwood Homeless paved the way for all the supportive housing developers that followed, by showing how unrelated government and private funding streams could be cobbled together to build and operate housing with services. In a scenario that nonprofit developers would replicate over the years in a dozen variations, the Committee used the state DHCR grant to secure a low-interest participation loan from the City Department of Housing Preservation and Development (HPD), private bank loans, foundation grants, even funds from a pool of private investors made up of partners at Goldman, Sachs and Company. The city also allocated federal Section 8 certificates to help pay for operating costs. The vanilla and gilt French provincial furniture in the lobby, a donation by the Pierre Hotel, attested to the ingenuity of the group's fund-raising.

If the financing for The Heights was innovative, the design of the service program was no less so. Unlike the St. Francis, The Heights sought to house mentally ill people as part of a mixed tenancy that also included tenants with substance abuse histories, people with AIDS and homeless people moving in directly from the streets. Equally important, residents at The Heights signed leases, unheard of in Community Residences, and something even the St. Francis didn't offer. Ellen Baxter, the Committee's founder, had worked closely with homeless people living in public spaces and this work informed her approach to providing housing.

“It was so obvious to me that what they wanted was a place to live,” she says. “They wanted a key and a room where they could lock the door.”³⁵

Rather than attempt to provide on-site services on its own, the housing developer was the first group to collaborate with a separate, more experienced service provider, Columbia University Community Services (CUCS), at the time a division of the Columbia School of Social Work that provided services to homeless individuals living in public spaces. New York City DMH contracted with CUCS (now called the Center for Urban Community Services) to provide case management and support to all tenants residing in the building.

Although CUCS staff offered many of the same kinds of supportive services as were provided at the St. Francis, they made a subtle but significant shift from clinical and treatment-oriented services to a focus on providing the supports necessary to maintain the tenants’ long-term stability in housing. Believing that the on-site delivery of services should support, but not overshadow, the maintenance of people in housing, the two groups emphasized that The Heights’ residents were tenants first and clients second. And in what would become a truly radical change in the way we provide housing to mentally ill people, tenants were not required to participate in the service program, forcing the providers “to adapt to whom they are serving, not to whom they choose to serve.”³⁶

Finding Funding

Sometime after midnight on a summer night in 1985, real estate developer Harry Macklowe demolished a vacant SRO to make way for a luxury hotel he named after himself, ignoring a court order prohibiting him from destroying what had finally been recognized as a valuable housing resource. Responding to the outrage this aroused, the administration of Mayor Edward I. Koch imposed a moratorium on the conversion or demolition of all commercial SROs. The moratorium severely limited developers’ ability to profit from their properties and made some eager to sell, even as they fought the moratorium in court. Sensing an opportunity, a small group of dedicated managers in the Mayor’s Office of SRO Housing tried to figure out ways that the city could take advantage of the situation and encourage the creation of more housing that looked like the St. Francis Residence and The Heights.

“We didn’t have a lot of money, and we knew that if we asked for too much, the city would never do it,” says Liz Glass, who oversaw a small loan program in the Mayor’s Office that provided up to \$5,000 per unit to private SRO landlords for minor systems replacement and renovations under Article 8A of the New York State Private Housing Finance Law.³⁷ Yet increasingly nonprofit organizations and private landlords were identifying SRO buildings that needed much larger investments to purchase and rehabilitate than the Mayor’s Office could provide. Without some kind of significant capital funding, the buildings would be lost to gentrification or be warehoused while thousands slept on the streets.

One ingenious plan developed by the Mayor’s Office netted the city almost \$5 million by allowing private landlords to circumvent the SRO conversion moratorium by paying \$45,000

per unit they wished to convert. With money in the bank, the Mayor's Office set about establishing a broader lending authority through Articles 8 and 11 of the Private Housing Finance Law, which allowed much larger loans, including loans made primarily to purchase the buildings. This unit became the SRO Loan Program, which was moved to the City Department of Housing Preservation and Development (HPD) in 1987.

The Mayor's Office also worked with HPD to apply some of its allocation of federal Section 8 Moderate Rehabilitation funds to The Heights and to the Brooklyn-Queens Catholic Charities' Caring Communities Initiative, which had begun to transform three recently closed parochial schools into supportive SROs in Brooklyn. The Mayor's Office also found the legal authority and some funds to allow the City to assist the West Side Federation for Senior & Supportive Housing to purchase an almost fully occupied SRO, the Westbourne, in order to preserve what was now almost universally recognized as an essential part of the City's housing stock.

Another funding stream for SROs was created in 1985 in response to the Koch administration's plan to build three massive municipal shelters to ease overcrowding in the existing emergency shelter system and to comply with the *Callahan* consent decree. City Council President Carol Bellamy led the fight against the shelters, advocating for the construction of transitional and permanent housing programs with on-site services instead. The Mayor was opposed to the city assuming such a large role in developing special needs housing, as these were traditionally the state and federal governments' responsibility but, in the end, agreed to provide \$25 million over three years to fund such housing in exchange for the rehabilitation of an abandoned Manhattan Psychiatric Center building on Ward's Island into an emergency men's shelter. This money would fund some of the first transitional programs in the shelter system, such as the aforementioned Valley Lodge, as well as three supportive SROs in Manhattan and Brooklyn developed by Lutheran, Jewish and Catholic charity organizations.

More funding became available in the late 1980s when the federal Low Income Housing Tax Credit was established to allow private investors to receive tax breaks in exchange for direct investment in low-income housing. Most providers used these funds to create operating reserves that provided some security in case rental income didn't cover all of the building's ongoing expenses. The state also transformed and expanded the Special Needs Housing program into the Homeless Housing Assistance Program (HHAP). For its part, the city made "Bellamy money" into a permanent funding source, the Capital Budget Homeless Housing Program.

The city and state also agreed to jointly fund the SRO Operating Subsidy, which gave nonprofit supportive SRO providers \$150 per unit per month, primarily to help defray one of their biggest expenses, front desk coverage. The Operating Subsidy came out of the same pool of money that paid for the single adult shelters, a tacit acknowledgement by the city and the state that SROs were a viable alternative for housing homeless people. In addition, the City Department of Mental Health allocated even more CSS funding to pay for mental health services such as psychiatrists, psychiatric nurses, social workers and activities staff at some of the SRO sites.

Approaching Agreement

By 1989, nonprofit housing and social service organizations were operating over a thousand supportive SRO units across the city. With successful precedents up and running, advocates, providers and some dedicated administrators in the Mayor's Office, HRA, DMH and HPD had been able to secure enough funds to nurture an ongoing development pipeline. The level of support offered varied from site to site, depending on the provider's service philosophy and resourcefulness, but there was no doubt that a growing consensus embraced the effectiveness of the supportive SRO housing model.

The State Office of Mental Health had also continued to expand its Community Residence program, funding the operation of over 3,500 CR beds in New York City by 1989. While it still resisted assuming responsibility for providing permanent housing to mentally ill individuals, SOMH had recognized by now that the lack of affordable housing was beginning to compromise the transitional nature of the Community Residence model. In an attempt to graduate residents from the CRs, SOMH experimented with a one-time \$2,000 payment to CR providers who were able to move their highest functioning residents into private apartments.³⁸

The new housing built by both the city and the state drew frequent praise from advocates, public officials and the press. But the political and fiscal obstacles to a housing program large enough to have an impact on the problem of homelessness among mentally ill persons remained, until political circumstances created a window of opportunity for a broader development initiative.

The winter of 1989 saw New York City's single adult shelter system swell to as many as 11,000 people per night, its highest level ever.³⁹ Thousands more on the streets, many of them mentally ill, confirmed to the public that homelessness was a full-fledged public health emergency. Running for reelection, Mayor Koch faced an especially tough primary challenge (that he eventually lost to Mayor David N. Dinkins), with the city's response to homelessness one of the most contentious issues of the campaign.

Mayor Koch had been commended for the city's ambitious \$5.1 billion ten-year housing development plan, but only a small portion of this money would be spent on housing for homeless single adults, mostly to empty the general population shelters and also to comply with a court order to provide housing to homeless shelter residents with AIDS. The Mayor continued to resist funding the construction or operation of housing for people with mental illness, citing the state's traditional responsibility for this population. The Mayor was willing to renovate SRO housing through payments by private owners seeking to circumvent the 1985 SRO conversion moratorium. But when the state Court of Appeals struck down the SRO conversion moratorium in 1989, this funding scheme was no longer possible and pressure grew on the Koch administration to address the problem head-on.

Public concern about homelessness was also putting pressure on the state. Facing a \$1.5 billion budget gap in 1989, the State Office of Mental Health (SOMH) had announced massive cuts and staff layoffs in the psychiatric center system and outpatient mental health clinics.

Many advocates predicted that these cuts would increase homelessness among mentally ill people, which would in turn necessitate more shelters (for which the state paid half the operating expenses). And pending litigation against both the city and the state hospitals over inadequate discharge planning of psychiatrically disabled inpatients caused some officials to fear that they might be forced to meet court-imposed housing development targets at a time of especially scarce resources.

As so often happens, both the city and the state supported the concept of housing with services for homeless mentally ill individuals, but neither wanted to commit what would necessarily be an enormous and ongoing responsibility. The state was especially apprehensive about the city's demographic studies and a facility plan that pushed for a wholesale transfer of mentally ill shelter residents to the care of SOMH. Frequent criticism from advocates and city officials that the CR system was discriminating against homeless people exacerbated the situation. And despite the clear success of the supportive SROs constructed to date, and an internal study by the city's Office of Management and Budget that argued for the cost-effectiveness of permanent housing with services over shelters, the Mayor and HPD were hesitant to fund additional housing construction for yet another special needs population, given the city's already generous commitment to emergency shelter and permanent housing for homeless families and people with AIDS.

The new Commissioner of the State Office of Mental Health, Dr. Richard C. Surles, attempted to reach out to the city, signing on to a city plan to create "Reception Centers," transitional housing programs that would bring mentally ill homeless people living in public spaces to a safe haven away from the shelters, where they would be stabilized for placement into transitional or permanent housing. He also toured the St. Francis Residence with city officials, promising that SOMH would for the first time attempt to create an unlicensed scatter site permanent housing program that would offer supported services similar to those found in an SRO, after a model developed in his previous position in Philadelphia.

With Governor Cuomo favoring the general idea of a state initiative to build housing for mentally ill individuals, Surles was given instructions to do something substantial enough to still the criticisms of homeless advocates and protect both the city and the state from further litigation. Knowing that to be effective he would need someone familiar with efforts to house homeless mentally ill people in New York City, Surles hired Cindy Freidmutter, a former aide to Carol Bellamy who had been instrumental in securing funding for some of the early supportive SROs. And by the time the city and state reached accord on the contentious issue of the difficulties congested city hospital emergency rooms were having referring inpatients to the state psychiatric centers, the level of trust between the two administrations had grown enough that they could sit down and discuss the much larger issue of supportive housing.

Over two months in the fall of 1989, Freidmutter hammered out the broad outlines of an agreement with William Grinker, the HRA Commissioner, and his chief negotiator, Diane Baillargeon. Both sides had to contend with colleagues reluctant to take such a big step: while the city negotiators contended with reservations from within other city agencies, the state's negotiators had to overcome an institutional bias within SOMH that favored maintaining psychiatric centers over community-based housing. "Even after it was finally approved," remem-

bers Freidmutter, "I think the entire \$30 million in capital allocated for the first year of NY/NY was less than what was spent renovating just one of the psychiatric centers that year." That the city and state could both point to track records of development went a long way to quell concerns about the ambitiousness of the program, while a fortuitous real estate slump made the purchase and renovation of additional housing units more possible.

Even so, the Agreement was held up for almost a year, first by the State Senate, which threatened to withhold the first year of capital dollars for the Agreement. Once the state budget was resolved with only a symbolic paring of the Agreement's funding, the change in mayoral administrations caused further delays. But the negotiations finally concluded successfully, and on August 22, 1990, Governor Mario M. Cuomo and Mayor David N. Dinkins signed the NY/NY Agreement to House Homeless Mentally Ill Individuals in a public ceremony in front of the St. Francis Residence attended by providers, elected officials, bureaucrats, the press, and even some homeless mentally ill individuals.

IV. The NY/NY Agreement

Unambiguously described by the press as “the state’s most ambitious effort to date to solve the problem of New York City’s homeless mentally ill,” the NY/NY Agreement called for the city and state to work together to place 5,225 homeless mentally ill individuals into “appropriate residential and service settings” by June 30, 1992.⁴⁰ While the legalistic contract language obscures much of what the two signers had agreed upon, a careful reading unearths the heart of the Agreement: the accord between the city and state to create 3,314 units of licensed and supportive housing for homeless mentally ill individuals.

In many ways, the document’s language almost soft-pedals the extraordinary commitment the NY/NY Agreement represented. The ambitious development targets of the Agreement, laid out in a confusing “Vacancy Availability Schedule,” committed the state and city to constructing far more housing in much less time than they had in any of the previous years. The Agreement also describes in detail the extensive mechanisms that would be required to assess, approve and place so many mentally ill individuals into housing, none of which were in place. Lastly, the Agreement emphasizes the importance of outreach and transitional mental health programs, and obligates both sides to maintain the current levels of funding for existing mental health programs serving homeless people.

An Ambitious Schedule

Both parties realized even before the signing that the Agreement’s development schedule could be difficult to accomplish in the two years allotted. Acknowledging that pioneering providers like the Committee for the Heights Inwood Homeless and others were already housing the homeless mentally ill population without SOMH support, the Agreement’s start date was revised back more than a year to include 162 units in four residences that had opened during the protracted negotiations. Similarly, some Community Residence beds and supportive housing units already in state and city development pipelines were designated for the NY/NY population.

Despite these head starts, the Agreement allowed for a one-year extension to June 30, 1993. When this second deadline passed with only 478 of the state’s 1,888 planned units in operation, an October 1993 amendment extended the NY/NY Agreement even further to June 30, 1995. In return, the state agreed to fund services for an additional 500 units of supportive housing to be rented from existing housing stock. After completing 60% of its projects by the June 1993 deadline, the city met its NY/NY development target in May 1997 with the opening of the 20-unit Corner House supportive SRO, built and operated by Project Reachout of the Goddard-Riverside Community Center. The State’s development concluded the following year when PIBLY Residential Programs, Inc. opened the Rosebud House MICA Community Residence in October 1998.

Though the language of the Agreement was modest, there was no holding back the rhetoric in front of the St. Francis the day of the Agreement signing. All agreed that the Agreement was unprecedented, and the politicians attempted to outdo each other in their assessment of the Agreement's historic importance. "Is it going to be expensive?" Governor Cuomo asked with one of his trademark rhetorical flourishes. "It's going to cost a fortune. [But] if government can't take care of the homeless, the mentally ill and the people who are addicted, what is government for?"⁴¹ The editorial the next day in *The New York Times* tried to do him one better, proclaiming that the Agreement "marks a monumental advance for the unkempt mentally ill who wander the streets and parks talking to the voices in their heads."⁴²

At the time, there were many who doubted that the Agreement would deliver on its promises. The State's well-documented fiscal troubles and the difficulty of siting the housing in neighborhoods already saturated with social service programs threatened to inhibit the Agreement's implementation from its inception. But the cautious optimism marking that day was borne out in the Agreement's subsequent, if delayed, success.

Emphasizing Placements

Both parties emphasized the 5,225 placements that would be made under the Agreement, rather than the 3,314 housing units that would be newly constructed (the far more significant figure). After so many years of delays, it was hardly necessary to inflate the Agreement's importance, but the press dutifully repeated the higher number when describing the Agreement. However, the Agreement stated plainly that 1,045 of the 5,225 placements were to be made into already existing "private sources"—adult homes, adult foster care and family reunifications. These placements most likely would have been made at the same rate with or without the Agreement. More legitimately, the Agreement amplified the placement totals by counting the vacancies predicted to occur as a result of move-outs, evictions and deaths in the new housing. This swelled the number of placements by another 866 above the 3,314 initial placements that would occur when the residences first opened.⁴³

But by stressing placements over development, the two parties acknowledged from the beginning that placing homeless mentally ill individuals into housing is much more complicated than just handing out leases and keys. It was understood that many of the individuals in the targeted population would need to spend time in transitional programs before they were ready to live in the housing created by the Agreement. To ensure that these gateways to housing were preserved, the Agreement contains a clause stating, "both the City and the State agree to maintain current levels of support for these programs during the term of this Agreement."⁴⁴ Another section in the document mentions the importance of reception centers and outreach teams in moving people off the streets and into housing.⁴⁵

Finally, the public is generally very supportive about placing homeless people into housing, but can be resistant to siting and building the housing necessary for these placements. By speaking of placements, the red-hot siting issue stayed on the back burner. While an emphasis on bricks and mortar, even on specific sites, may have been appropriate, and may have helped

advance mentally ill people's right to housing and protection from discrimination, political pragmatism won the day. Sound bites stayed on message, and no one objected to the prospect of homeless mentally ill people moving into their neighborhoods. At least, not on that day....

Who Would Be Housed?

Unlike any previous housing program in New York, the NY/NY Agreement confined its tenancy only to individuals who were both homeless and mentally ill. According to some involved, defining who would be housed by the Agreement became one of the most contentious issues in the negotiations. The decisions made by the signatories regarding who would benefit from NY/NY open a window on some of the questions government faces when apportioning public resources.

As the source of most of the service dollars for the housing, SOMH officials were adamant that an individual had to have a serious and persistent mental illness to qualify for NY/NY housing. Their definition explicitly excluded individuals with personality disorders, or Axis II mental illnesses—people who may have difficulty functioning in the world and maintaining interpersonal relations, but can still perceive the difference between fantasy and reality. The apparently relentless rise in the shelter census raised concerns that providers might mischaracterize shelter residents suffering primarily from substance abuse as mentally ill in order to qualify them for NY/NY housing. Both sides acknowledged the pervasiveness of shelter residents with addictions and personality disorders. But SOMH funding was restricted to treating mental illness, specifically Axis I mental illness, and there was little political or legal pressure on the state to provide housing and services to people suffering from addiction.

The city did little to argue the decision: in our society's constantly shifting definitions of deserving and undeserving poor, substance abusers rarely escape the latter category. The two sides eventually agreed that to qualify for the housing, the homeless individual would have to meet the existing mental health criteria for participation in CSS programs; i.e., have an Axis I mental illness—schizophrenia, bipolar disorder or major depression. Although it was expected that many of the tenants would have histories of substance abuse, a primary diagnosis of addiction would not be enough to meet the criteria for NY/NY housing.

The city had its own concerns about defining who would be served. Though SOMH had greatly expanded Community Residence development in the years leading up to the Agreement, most of these beds were filled by inpatients leaving the rapidly downsizing State Psychiatric Centers. To be sure, many of these individuals would have become homeless were it not for these placements. But homeless advocates and some city officials had long complained that homeless mentally ill people residing in shelters and public spaces had been effectively shut out of the Community Residence program. On the verge of finally securing housing for this population, city officials were determined to ensure that it be reserved exclusively for those who were not just housing-needy, but “truly” homeless.

Homelessness is notoriously difficult to define. Just as an overly generous definition could open the NY/NY housing to persons with access to other equally appropriate housing options, a narrow definition would almost certainly exclude some homeless people with no other housing alternatives. The city proposed four qualifying categories: the first three included those who had lived in the shelter system contiguously for four months or more, those who used the shelter system sporadically but regularly (at least 14 of the past 60 days), and those who were known to drop-in centers and used private shelter beds operated by the Partnership for the Homeless.

A fourth category sought to answer advocates' concerns by making provisions for homeless individuals who lived in public spaces and were not known to the shelter or drop-in systems. These applicants would have to supply a letter from "an outreach team or other reliable source" to qualify for the housing. The two parties agreed that it was important to serve this most visible portion of the homeless population, but, concerned about creating an unregulated back door, they limited the number of applicants from this fourth pool to no more than 10% in any one year. Even at the signing, city and state officials expressed a willingness to be flexible regarding the street population. As it turned out, placements from this category only slightly exceeded 10% in the first years of the Agreement, and this limitation was eliminated in a 1993 addendum to the Agreement. After ten years, homeless mentally ill individuals living in public spaces accounted for 19% of all NY/NY placements.⁴⁶

At the city's behest, individuals who become homeless during a hospital stay are specifically excluded by the Agreement (although hospitalized individuals who met the homeless criteria before they entered the hospital are eligible). This prohibition regularly frustrates acute and residential hospitals alike, including the city's own Health and Hospitals Corporation (HHC) hospitals. But city negotiators insisted on this restriction, fearing that municipal shelter residents would not be able to compete for the limited amount of housing against mentally ill individuals being discharged from state psychiatric centers, individuals living doubled up with their families, or people in other undesirable, but not necessarily inappropriate, living situations.

Hospitalizations for these individuals sometimes occur when tensions at home boil over. It's not surprising that a family overwhelmed by the pressures of caring for a mentally ill daughter or son would explore alternative housing options when faced with their discharge. But the city negotiators insisted on the prohibition, saying, quite correctly, that these "housing-needy" individuals could still qualify for one of the thousands of SOMH Community Residence beds not limited to the homeless population. The exclusion remains a cause for the occasional complaint from hospital social workers, but does not appear to be as contentious an issue as it once was, largely because hospitals continue to make the highest percentage of successful referrals, about 36% of all placements into NY/NY housing.

Placement Procedures

Sharply defining eligibility standards reassured city and state negotiators that the housing would reach its intended target population. It also allowed them to open up the application process to a theoretically infinite number of referral sources. Referrals to NY/NY housing can (and do) come from municipal, state and voluntary hospitals, shelter-based mental health programs, transitional programs, drop-in centers, general shelters, street outreach teams and other community-based programs. No matter the source, the applications will be evaluated and accepted, as long as the individual meets the criteria laid out above.

The potential for confusion inherent in such a wide-open referral process is greatly reduced by the NY/NY Housing Referral Application, or the "HRA 1990," as it was universally known among providers until a redesign five years later updated it as the "HRA 1995." The HRA 1995 requests all the information regarding the applicant's homelessness, mental health, medical condition, ability to live independently and substance abuse history. Along with a narrative psychosocial assessment of the applicant that provides additional detail about education levels, employment history, military service, family ties and other subjects, the HRA 1995 supplies all the information a housing provider would need to assess the applicant's suitability for housing. That very few providers ask for more than what is contained in the form attests to its utility.⁴⁷

Referral sources submit the HRA 1995 and a psychosocial narrative describing the individual to the HRA Office of Health and Mental Health Services (OHMHS) for approval, along with a separate psychiatric evaluation. Hospitals, CSS-funded transitional programs and some other referral sources have ready access to psychiatrists to make these assessments. For shelters, transitional housing and some other programs, the HRA OHMHS provides free psychiatric consultations in order to make the evaluations (HRA OHMHS psychiatrists are also available for consultations to tenants of the city's supportive SRO residences).

A separate arm of HRA OHMHS then reviews the entire package and makes an eligibility determination. A second psychiatrist reviews the psychiatric evaluation to confirm that the applicant meets the NY/NY mental health criteria. The applicant's homeless status is confirmed by checking the city's computerized Shelter Care Information Management System (SCIMS), which keeps a record of every individual who has used the shelter system. For unsheltered homeless applicants unknown to the system, HRA OHMHS investigates homeless status through phone calls to providers.

When the applicant meets both the homeless and psychiatric requirements, HRA OHMHS then considers the individual's functioning level and housing history and recommends the most suitable type of housing for the applicant. While this recommendation is binding, it can be appealed if the referral source believes that the type of housing suggested is inappropriate for the applicant. Staff at HRA OHMHS attempts to qualify applicants for every housing model suitable to their level of need in order to provide applicants and referral sources as many

choices as possible. Once approved, the referral source and applicant discuss the NY/NY housing options available to the applicant, then submit applications to the residences in which he or she is interested.

The Residential Placement Management System

A particularly creative aspect of the Agreement designated the nonprofit service provider Center for Urban Community Services (CUCS) to oversee the NY/NY Residential Placement Management System (RPMs). When an applicant is approved by OHMHS, RPMs is notified and contacts the referral source. With extensive knowledge of NY/NY providers and residences, their unique characteristics, program requirements and expectations, RPMs staff advises the referral source and guides them through the interview and placement process.

Without any regulatory authority over referral sources or housing providers, RPMs can act as a supportive, but impartial, facilitator to the placement. RPMs staff's assistance helps give inexperienced referral sources an equal chance to secure an appropriate housing placement for their clients. And its ongoing involvement in the placement process provides government agencies insights into the workings of NY/NY they might not otherwise be privy to. Finally, RPMs has used NY/NY funding as well as grants from federal and private sources to create a training curriculum and provide technical assistance in supportive housing service delivery for providers and referral sources.

Clubhouses and Other Auxiliary Supports

Three relatively unheralded but essential components of the NY/NY service continuum help NY/NY residents remain stable and fulfilled after they've been placed into housing. The NY/NY Agreement provides additional resources to MFY Legal Services, Inc. to provide often-critical benefits advocacy and other legal assistance to NY/NY residents. Another program, operated by the nonprofit Hospital Audiences, Inc. (HAI), arranges and pays for excursions to cultural events and activities for residents of NY/NY housing, including concerts, plays, sporting events and other entertainments. These socialization activities improve the quality of NY/NY residents' lives and have immense, if often overlooked, therapeutic value.

The final component contributing to the residential stability of NY/NY housing is the Clubhouse. Officially known as Clubhouses for Psychiatric Rehabilitation, these consumer-oriented rehabilitative programs offer a noninstitutional setting where mentally individuals collaborate with staff in mutually planned vocational, educational and social activities. There are no "clients" and no "clinicians" at Clubhouses, and no rules enforcing participation. Clubhouse members share responsibilities with staff and are consulted in all activities and decisions. Much of the activities required to keep the Clubhouse in operation—preparing and serving meals, administrative duties, horticulture, cleaning and maintenance, and small enterprises

like a publishing a newsletter or running a thrift shop—are vocational or educational in nature. Clubhouses regularly link members to outside paid employment opportunities. An intrinsic characteristic of the clubhouse model is that members determine how it will operate.

The groundbreaking nonprofit mental health provider Fountain House developed the clubhouse as an alternative to clinical day treatment programs. Community Access, a NY/NY housing provider on the Lower East Side, has refined another successful variation on the model. Like anyone else, mentally ill individuals need meaningful activities to give definition and significance to their lives. Unlike clinical day treatment, which focuses on treating and stabilizing the individual's mental illness, the Clubhouse program attempts to turn members' focus outward, to socialization, work, education and collaborative activities. By retaining control over the way the clubhouse is run, members are assisted to regain their self-respect, purpose and confidence.

Prior to NY/NY, three clubhouses operated in New York City, including the flagship program at Fountain House. Joined by advocates, family members and mental health consumers, James R. Schmidt, the Executive Director of Fountain House at the time and the DMH Bureau of Rehabilitation and Special Services lobbied SOMH to use NY/NY funds to establish ten additional clubhouses throughout the city, at an annual cost of approximately \$4.3 million. Operated by mental health and housing providers, these clubhouses are required to enroll at least half of their members from the NY/NY residential population.⁴⁸

V. Getting Results and Moving Forward

Despite some not so inconsequential delays, the NY/NY Agreement to House Homeless Mentally Ill Individuals of 1990 has been remarkably successful at achieving its promise. Beginning with a goal of constructing 3,314 units of supportive and licensed housing, it concluded with the creation of 3,112 new housing units and the ongoing subsidy of 503 existing units, for a grand total of 3,615 places that an equivalent number of homeless mentally ill individuals now call “home.”

Over the years, the housing funded under the Agreement has provided remarkable stability for a group of people not known for staying still: after one year, 73% of the formerly homeless NY/NY residents remain in their placements; after two years, 60% are still there.⁴⁹ NY/NY residents leave the housing for many reasons, some negative and some positive. A portion of those who leave are reunited with their families in a stable living situation, some move on to other types of NY/NY housing, still others decompensate and return to homelessness. Whatever the final outcome, during the time that they live in NY/NY residences, these individuals will most likely drastically reduce their use of expensive emergency services like hospitalizations, incarcerations or shelter stays.

But the money they save is only half the story, for them and for us. For the homeless mentally ill individual, NY/NY housing means an end to an aimless, confusing life full of danger, despair and punishing isolation, and the beginning of a return to purpose, hope and a place in society. For the rest of us, NY/NY housing helps to reclaim public spaces, revitalize neighborhoods, and perhaps ease our collective conscience.

Since the inception of the Agreement slightly more than ten years ago, 7,925 homeless mentally ill individuals have moved into NY/NY housing. Almost half have schizophrenia; another 40% have mood disorders like major depression. Half have a substance abuse problem in addition to a psychiatric disability, although with the help of on-site social and clinical services, most are able to maintain their sobriety while living in the housing.

By definition, all NY/NY residents were homeless before they moved into their apartments and rooms. But they took many different routes. More than a third were discharged from state, city, voluntary and Veterans Administration hospitals directly into the housing. Just less than a third came from the array of transitional programs that now operate within the Department of Homeless Services (DHS) municipal shelter system. Another third were living in drop-in centers, private shelters and in public spaces. All of them need some help to make it in housing. Most would still be homeless if it wasn't for the housing created by the NY/NY Agreement.

In addition to the 7,925 individuals placed into NY/NY units, another 3,332 individuals applied for and received eligibility for NY/NY housing, but in the end were placed into other types of housing not funded through the Agreement. Some gained entry into SOMH Community Residences that were open to all mentally ill persons, regardless of their homeless status. Others were reunited with family or placed into adult homes. While these individuals were not placed into housing paid for by the Agreement, the psychiatric evaluations, psychosocial assessments and the entire NY/NY application process were instrumental in their successful placements into housing.

The development of the NY/NY II Agreement is now well under way and some of its first residences are already providing housing and hope to individuals who have enjoyed precious little of either. Recent supportive housing projects like the 201-unit Muhlenberg Residence, operated by Lutheran Social Services on Atlantic and Third Avenues in Brooklyn, and Common Ground Community's latest achievement, the 416-unit Prince George Hotel in the Murray Hill section of Manhattan, continue the tradition of care established by their predecessors. But the inadequate size of this second effort has already been supplemented by the state's commitment to develop 320 units of supportive housing for mentally ill individuals with high service needs. The city has responded to this effort by funding 400 units. SOMH also allocated funding in 1999 for an additional 975 supported housing units for New York City, for both homeless and currently under-housed or hospitalized mentally ill individuals.

A recurrence of the hiatus in development that occurred between the first two NY/NY initiatives would have a grievous effect on transitional programs for homeless mentally ill individuals. Such an interruption would also risk dissipating the institutional knowledge accrued by the community of housing developers, architects, contractors and service providers who have built and operated this housing so successfully. With these concerns in mind, advocates, providers and many government officials are joining together now to call for a third NY/NY housing initiative that would fully meet the need.

In January 1990, during the campaign for the first NY/NY Agreement, Anna Quindlen of the New York Times wrote a column in support of building the housing that has since been created. After seeing the transformation of New York City streets and shelters that occurred since NY/NY, her argument has even more power and credibility. She wrote:

"We may have one of two motives in this matter, vastly different but leading us to the same place. We can demand that government finance more small permanent residences like the Heights because that is the right thing to do, because we have looked into the faces of homeless men and women and occasionally recognized ourselves...."

But there is another reason to demand that government support these groups that have found humane and permanent solutions. The Heights costs about \$15 per person per day, including the cost of its staff of social workers and counselors. The armory, that vast expanse of temporary beds, costs at least twice that.

Look at it from a purely selfish point of view as well. You want the sidewalks and the parks to be clear again. You want to be left alone and not importuned for a dollar a dozen times a day. And up in Washington Heights, and in other quietly compassionate places all over this city, there are people who can help make that happen in a way that will not shame us as human beings.” ⁵⁰

The history of mental health care in the 20th century is one of institutions. When mental illness struck, our first response always seemed to be to separate the individual from the rest of society. Once safely tucked away and isolated from the world, we waited until our friend or family member appeared “better,” then released him, to begin the cycle once again. With the effective medications and therapies we have today, we rarely need to resort to such extreme actions, yet our mainstream mental health systems remain wedded to this century-old approach.

Over the last 40 years, growing numbers of people have joined together to create a mirror image of this archaic system, conceiving and refining a way to treat mental illness that is centered on the person’s home, his community and his position in society, not apart from it. The housing built by the NY/NY Agreement represents the beginning of the last step of a reform that began with a few people reaching out to mentally ill people living in shabby hotels with little to offer but their concern and support. It will end only when we close the last emergency shelter and move the final homeless person off of the streets. Much more needs to be done; many more units of housing will have to be built. But now that we can see just how effective, how humane—how beautiful—this approach can be, we have no choice but to finish what we started. We’re closer than we think.

Endnotes

1. Telephone interview with Dr. Carl Cohen, SUNY Downstate Medical Center 3/24/01.
2. Names of NY/NY residents have been changed to protect their privacy.
3. Development numbers are taken from agency documents supplied by the New York State Office of Mental Health, the New York City Department of Housing Preservation and Development, and the Center for Urban Community Services Residential Placement Management System. Placement figures and demographic data were supplied by the New York City Human Resources Administration Office of Health and Mental Health Services.
4. The term "Supportive SRO" was consciously avoided in the early years of the NY/NY Agreement to minimize confusion with the disreputable commercial SRO. As the nonprofit supportive single room residence became more prevalent and the number of commercial SROs dwindled, the term supportive SRO lost any negative connotations it may have had and became an acceptable usage.
5. Two notable examples of these collaborations include the Committee for the Heights Inwood Homeless and Common Ground Community, two nonprofit supportive housing organizations that built and now operate seven supportive single room residences between them, all of which have on-site supportive services provided by the Center for Urban Community Services (CUCS).
6. New York City Department of Homeless Services Shelter Census Survey.
7. Changes in development plans and in the program names and designs of different NY/NY housing models can make it difficult to keep track of what housing was built under the Agreement. A chart delineating development is included in an Appendix to this account.
8. 1998 conversation with Tony Hannigan, Director of the CUCS.
9. Appendix B of the University of Pennsylvania's study, "The Impact of Supportive Housing for Homeless Persons with Severe Mental Illness on the Utilization of the Public Health, Corrections and Emergency Shelter Systems: The New York-New York Initiative" (Culhane, Metraux, Hadley, 2001), contains an analysis of NY/NY housing costs.
10. All government funding sources were included in the cost calculations made by the University of Pennsylvania study.
11. The immense size of The Times Square's rehabilitation masks its economies of scale: construction costs averaged over the residence's 652 units come out to a competitive, cost-effective \$55,000 per unit.
12. The following six paragraphs paraphrase concepts explained on pp.133-134 of *Communities of the Alone*, Joan Hatch Shapiro, Association Press, New York 1969.
13. *Communities of the Alone*, p.23.
14. *Ibid.*, p.134.
15. Street, W. R., A Chronology of Noteworthy Events in American Psychology, American Psychological Association, Washington, DC, 1994.
16. New York State Office of Mental Health, Mental Health Statistics Unit document, 9/96.
17. The New York Times 11/22/72, p. 1.
18. Telephone interview with Father John McVean 12/00.
19. Telephone interview with Dr. Carl Cohen 3/23/01.
20. Telephone interview with Dr. Steve Estrine 12/00.
21. The New York Times 11/16/72, p. 1.
22. The New York Times 11/17/72, p. 44.
23. *Ibid.*

24. The New York Times 11/23/72, p. 1.
25. The New York Times 11/21/72, p. 28.
26. The New York Times 11/22/72, p. 1. The internal document cited by the New York Times is no longer available, sharing the same mysterious fate of almost all estimates of the number of commercial SRO units and the extent of their disappearance. While it is reasonable to assume that there was a basis for this and the estimate included in the same newspaper article cited in footnote 17, and there is ample anecdotal evidence to suggest that this many SRO units did exist at one time and subsequently disappeared, it is difficult, if not impossible, to verify the accuracy of this figure.
27. Ibid.
28. The New York Times 1/19/73, p. 37.
29. The New York Times 5/15/73, p. 37.
30. New York State Office of Mental Health, Division of Housing and Community Capital document 1/3/97.
31. Conversation with Father John McVean 3/23/01.
32. All information from conversations and site visits with St. Francis I staff 11/00.
33. Department of Homeless Services Shelter Census Survey.
34. New York State Office of Mental Health, Division of Housing and Community Capital document 1/3/97.
35. The New York Times, 1/21/90, p. IV-21.
36. Ellen Baxter, quoted on page 29 of The Final Report and Program Recommendations of the Supported Housing Alternatives Project, White Paper, 1/17/91.
37. Telephone interview with Liz Glass 12/00.
38. Telephone interview with Chris Roblin, SOMH Div. of Housing & Community Capital 1/01.
39. New York City Department of Homeless Services Shelter Census Survey.
40. The New York Times 8/23/90, p. 1.
41. Ibid.
42. The New York Times editorial, 8/24/90, p. A28
43. The New York/New York Agreement to House Homeless Mentally Ill Individuals 1990.
44. Ibid.
45. Ibid.
46. NYC HRA OHMHS placement statistics through 12/31/00.
47. A copy of the HRA 1995 form is attached.
48. Description of Clubhouse model and related information from a Request for Proposals issued by NYC DMH 3/17/93.
49. HRA OHMHS NY/NY placement statistics through 12/31/00.
50. The New York Times editorial, 8/24/90, p. A28.

Sites and Providers

129th Street Residence

West Side Federation for Senior & Supp. Housing

2643 Broadway

Volunteers of America

35th Street SRO

Clinton Housing

35th Street Supported Housing

Postgraduate Center for Mental Health

74th Street Home

West Side Federation for Senior & Supp. Housing

98th Street Apartment Treatment Program

Postgraduate Center for Mental Health

Abraham Residence III

Metropolitan Council on Jewish Poverty

Access House I

Access Development

Access House II

Access Development

Access House III

Access Development

Aurora Residence

Heritage Health & Housing

Avenue D SRO

Community Access

Beach 85th Street

Services for the Underserved

Bergen Street Residence

Lutheran Social Services

Bronx & Queens Supported Housing

Health Industries Resources Enterprises, Inc.

Burnside Residence

Federation Employment & Guidance Services

Casa Mutua

Lenox Hill Neighborhood Center

Cecil Ivory House

Bowery Residents' Committee

Cluster House CR

Urban Pathways

Cluster House SRO

Urban Pathways

Clyde Burton House

Bowery Residents' Committee

Columba Hall

Columba Kavanagh

Corona Supported Housing

Transitional Services of New York, Inc.

Cromer House

Fifth Avenue Committee

East 6th Street Graduate Housing

The Bridge

East Bronx Supported Housing

Beacon of Hope

East Village House

The Bridge

Eastern Parkway

Institute for Community Living

EGA Hall

Columba Kavanagh

Emerson Apartment Treatment Program

Institute for Community Living

Emerson Family Center

Institute for Community Living

Euclid Hall

West Side Federation for Senior & Supp. Housing

First Street MICA Supported Housing

Institute for Community Living

Frederic Fleming Residence

West Side Federation for Senior & Supp. Housing

Fulton House

Bowery Residents' Committee

Garden Residence

ARMI

Gema Hall

Columba Kavanagh

Gouverneur Court

Community Access

Halsey House
Institute for Community Living

Harlem Rehabilitation
Trustees of Columbia University

Haven Apartments
Unique People Services

Henry Street SRO
United Jewish Council of the Lower East Side

Holland House
Project Renewal

Houston House
The Bridge

ICL Supported Apartment Program
Institute for Community Living

ICL Supported Apartments
Institute for Community Living

Ilene R. Smith
HOMEE Clinic

INCA Supported Housing
Metropolitan Council on Jewish Poverty

Independence House
ARMI

Ivan Shapiro House
Urban Pathways

Ivy House
Brooklyn Community Housing & Services

Judson Post Hall
YWCA

Kelly Street
South Bronx Mental Health Council

Kizzy House
PIBLY Residential Programs

Knickerbocker
Services for the Underserved

Lawton Street
Institute for Community Living

Libby House
Community Access

Los Vecinos
Bowery Residents' Committee

Los Vecinos CR
Bowery Residents' Committee

Manhattan Supported Housing
Heritage Health & Housing

Maple Street Residence
Jewish Board for Family & Children's Services

Mercy Gardens
Brooklyn-Queens Catholic Charities

Metro House
Metropolitan Council on Jewish Poverty

Miracle Makers SRO
Miracle Makers

Monica House
Brooklyn-Queens Catholic Charities

Mount Eden SRO
Volunteers of America

Muhlenberg Plaza
Lutheran Social Services

Multi-Borough Supported Housing
Fountain House

New Era Veterans Residence
New Era Veterans

Oak Hall
Brooklyn Community Housing & Services

Odyssey House
Odyssey House

Old Broadway
The Bridge

Pacific House
First Avenue Baptist Church

Paige Apartments
Community Action for Human Services

Patchen Avenue
Services for the Underserved

Pathways Supported Housing
Pathways to Housing

Project Hospitality MICA CR
Project Hospitality

Project Renewal
Project Renewal

Prospect House
Institute for Community Living

Prospect Park YMCA
YMCA of Greater New York

Richard Dicker
Postgraduate Center for Mental Health

Rosebud House
PIBLY Residential Programs

Sara K. Abrams
Educational Alliance

St. Anthony's Residence
St. Anthony's

St. John's Community
Lutheran Social Services

St. Mark's Supported Apartments
Services for the Underserved

Stanton House
Educational Alliance

State Street
Institute for Community Living

Supported Housing
Metropolitan Council on Jewish Poverty

Supported Housing
GEEL

Supported Housing
Federation Employment & Guidance Services

Supported Housing
ARMI

Supported Housing
Sisters of Charity

Supported Housing
Services for the Underserved

Supported Housing Opportunity Program (SHOP)
PIBLY Residential Programs

Supported Housing Program
Fountain House

The Corner House
Goddard-Riverside Community Center

The Delta
The Committee for the Heights Inwood Homeless

The Edgcombe
The Committee for the Heights Inwood Homeless

The Heights
The Committee for the Heights Inwood Homeless

The Majestic
Services for the Underserved

The Prince George
Common Ground Community

The Rio
The Committee for the Heights Inwood Homeless

The Stella
The Committee for the Heights Inwood Homeless

The Times Square
Common Ground Community

Throop Court
Services for the Underserved

Tiebout Supported Housing
University Consultation Center

Union Avenue Residence
GEEL

Veterans Residence
Salvation Army

VOA 97th Street SRO
Volunteers of America

Wanaque Residence
Fountain House

Webster Avenue SRO
Volunteers of America

West 124th Street Residence
Federation Employment & Guidance Services

West 37th Street Residence
Fountain House

White Plains Road
Federation Employment & Guidance Services

Glossary

Housing Types

Supportive Housing: The general term used to describe subsidized housing “supported” with social services. Most supportive housing is built and managed by nonprofit organizations using funding from both government and private sources. Many serve a mixed tenancy of formerly homeless, disabled and low-income people – including people with mental illness, histories of substance abuse, and chronic illnesses, as well as employed low income tenants who lived in substandard housing. In most supportive housing programs, tenants sign leases and their participation in services is voluntary. Services are usually provided on-site and may include health, mental health, substance abuse, employment, basic living skills and education services, as well as entitlements counseling, budgeting assistance and medication management. Rent is usually set at 30% of the tenant’s income.

Supportive SRO: The most common model of supportive housing, the supportive SRO offers “Single Room Occupancy” (SRO) apartments with on-site supportive services. These apartments range from rooms that share bathrooms and kitchens to efficiency apartments fully equipped with private baths and kitchenettes. Residents sign leases and are expected to be able to live independently with some assistance from social services staff. Most supportive SROs require that tenants be substance-free for at least three months prior to tenancy and have some insight into their mental health needs. Supportive SROs vary greatly in size from as small as 20 units to as large as the 652-unit Times Square Hotel.

Supported Housing: A supportive housing model funded by the New York State Office of Mental Health that offers either individual or shared apartments to people with mental illness who are able to live independently with minimal support. While some Supported Housing apartments are clustered together, most are scattered among buildings within a neighborhood. Nonprofit organizations manage the apartments and provide case management and other supportive services to tenants, usually off-site in nearby offices.

Community Residence: Transitional housing for mentally ill individuals licensed and funded by the New York State Office of Mental Health. Community Residences provide intensive clinical and social services focused on preparing the resident to live in more independent housing within two years. Residents usually share bedrooms and are required to participate in the service program. Variations of the Community Residence (CR) model include Supervised CRs, Intensive-Supportive CRs, and MICA (Mental Illness and Chemical Abuse) CRs, which serve mentally ill individuals with a secondary co-occurring diagnosis of substance abuse. While Supervised Community Residences usually contain 24 beds at one location, many Community Residences offer beds in apartments scattered throughout a neighborhood, served by visiting case management and clinical staff, and are now called “Apartment Treatment Programs.” Community Residences provide many of the same services offered in supportive housing programs, with an added emphasis on psychotropic medication monitoring and on improving residents’ Activities of Daily Living (ADL) skills. Residents of CRs are also required to participate in some kind of

structured activity during the day. The CR resident's SSI benefits are supplemented by State SSI Level II funding, all of which goes directly to the CR provider, except for a small monthly personal needs allowance provided to the resident.

CR/SRO: A hybrid model of permanent, congregate housing designed to serve residents with significant mental health needs licensed and funded by the State Office of Mental Health and operated by nonprofit organizations. Services are more intensive than those offered in supportive housing, but unlike Community Residences, participation is not mandated. They include 24-hour staff coverage, meal plans offered in an on-site dining area, assistance with basic living skills, money management, case management, crisis intervention and recreational activities. Existing CR/SROs range from 24 to 78 units, and offer efficiency apartments with private bathrooms. Like Community Residences, providers receive SSI Level II funding, although residents are provided a significantly larger monthly personal needs allowance.

Residential Care Center for Adults (RCCA): A long-term transitional housing model for individuals with severe psychiatric disabilities licensed and funded by the State Office of Mental Health. The RCCA offered congregate care similar to the Community Residence with a longer expected stay. It has since been subsumed into the Community Residence program under the larger designation of "Congregate Treatment Programs."

Commercial SROs: Privately owned, for-profit Single Room Occupancy (SRO) hotels that offer single rooms with shared bathrooms in exchange for modest rents. During the 1960s and '70s, commercial SROs were the primary housing resource for mentally ill individuals in the community who were not living with their families. Over the years, government agencies and nonprofit organizations began to provide social services to tenants on-site at many of the commercial SROs, leading to the development of the not-for-profit supportive SRO housing model. The commercial SRO has largely disappeared in most American cities, redeveloped mostly into market rate housing, although many supportive SROs operated by nonprofits were formerly commercial SROs, such as The Times Square or Euclid Hall.

Residence For Adults (RFA): A nonprofit-operated permanent housing model that provides similar care to that found in Private Proprietary Homes for Adults, or Adult Homes. Residents share bathrooms and sometimes bedrooms, and are provided housekeeping, linen and meal services. Services include medication management, counseling, on-site recreation, case management and 24-hour staff coverage. Licensed by the New York State Department of Social Services, RFAs receive Level II funding directly and provide personal needs allowances to residents.

Private Proprietary Home for Adults (PPHA): A for-profit housing model more commonly known as an Adult Home, PPHAs are generally large facilities licensed by the State Department of Social Services, with as many as 400 residents. Two residents normally share a bedroom and bath. They usually house a mixed tenancy of physically and psychiatrically disabled and elderly residents. While services offered by many PPHAs are minimal, some provide additional clinical and supportive services funded through the SOMH CSS program.

Adult Home: See Private Proprietary Home for Adults (PPHA).

Apartment Treatment Program: See Community Residence.

Supervised Community Residence: See Community Residence.

Intensive-Supportive Community Residence: See Community Residence.

MICA CR: See Community Residence.

Other Terms

Community Support Services (CSS) funding: A State Office of Mental Health funding stream that pays for clinical and supportive mental health services provided by nonprofit organizations in community settings.

Serious and Persistent Mental Illness: A general term used to describe a chronic mental illness that significantly impairs functioning. When used in the context of the NY/NY Agreement, Serious and Persistent Mental Illnesses include schizophrenia, major depression and bipolar disorder. Serious and Persistent Mental Illness can co-occur with substance abuse, but substance abuse alone is generally not included in this definition.

Dual Diagnosis: A co-occurring diagnosis of two disabilities, such as mental illness and addiction, or mental illness and chronic health problems, such as HIV/AIDS.

Homelessness (according to the NY/NY Agreement): The definition used in the NY/NY Agreement regards as homeless 1) individuals with histories of 4 or more months of continuous shelter use, 2) individuals who have used the shelter system 14 out of the last 60 days, 3) individuals who have resided at a voluntary shelter or drop-in center for 14 out of the last 60 days, and 4) persons who reside in public spaces who are known to be homeless by a social services agency.

Inpatient: Care provided within a hospital setting, or the recipient of that care. Often refers to a resident of a State Psychiatric Center.

Outpatient: Care provided in a community setting, such as a doctor's office, medical clinic, or mobile health service, or the recipient of that care.

Medicaid: A federal entitlement program paid for in part by the State that funds health and mental health services to people that meet low-income guidelines. Medicaid covers emergency and chronic care in hospital and community clinical settings, but does not pay for long-term psychiatric care.

Supportive Services: Services offered to supportive housing tenants with a focus on maintaining the tenant's place in housing. Supportive service delivery responds to the tenant's needs as articulated by the tenant and include case management, budgeting assistance, assistance with basic life skills, peer counseling, substance abuse counseling, NA/AA meetings, medication manage-

ment, psychiatric counseling, benefits counseling, education, socialization, employment and training services, primary health care and crisis management. State Psychiatric Center: One of a statewide system of psychiatric hospitals that provide extended care to people with severe and persistent mental illnesses.

Acute Psychiatric Care: Short term psychiatric services, usually provided in a City-operated Health and Hospitals Corporation (HHC), private or Veteran's Administration hospital.

Congregate Care: Residential program that houses or shelters a group of individuals in one location. Often used to indicate a residence that offers shared bedrooms or dormitories.

MICA: Mental Illness and Chemical Abuse. Used to describe the disability of an individual with both a psychiatric disability and an addiction. In common usage, a MICA diagnosis implies that the mental illness is the primary diagnosis. Sometimes a dually-diagnosed individual with a primary diagnosis of substance abuse may be said to have a "CAMI" diagnosis.

Reception Center: An innovative, City-funded 90-day transitional program directed at homeless mentally ill individuals living in public spaces. Reception Centers operate street outreach teams to locate and engage these individuals and convince them to accept shelter and services. Once the individual enters the Reception Center, the program staff provide clinical and social services intended to move the individual into permanent or transitional housing.

Outreach: An all-inclusive term to describe efforts to engage homeless and mentally individuals into services and housing. Most commonly used to describe efforts to engage individuals living in public spaces.

Case Management: A comprehensive service approach to provide support to individuals who have had difficulty living independently. Case management is an open-ended term meant to include a wide range of services that address all of the individual's needs in a holistic manner, from medication and healthcare, to budgeting, to assistance in maintaining a home.

Municipal Shelter System: The system of shelters and transitional housing operated by the New York City Department of Homeless Services (DHS). The municipal shelter system originally provided emergency shelter with few services. But over the years, transitional programs were created to help shelter residents address barriers to housing such as substance abuse, mental illness and chronic health problems. Presently, the municipal shelter system is predominantly comprised of transitional program beds operated by nonprofit agencies under contract with DHS or the New York City Department of Mental Health, Mental Retardation and Alcoholism Services (DMH), including many transitional housing programs that more closely resemble housing.

Transitional Housing: Residential programs intended to prepare homeless individuals for placement into permanent housing. Transitional housing can be funded and licensed by the New York State Office of Mental Health under its Community Residence program, or by the New York City Departments of Homeless Services and Mental Health. Valley Lodge is a good example of DHS-funded transitional housing.



CSH Publications

In advancing our mission, the Corporation for Supportive Housing publishes reports, studies and manuals aimed at helping nonprofits and government develop new and better ways to meet the health, housing and employment needs of those at the fringes of society.

Family Matters: A Guide to Developing Family Supportive Housing *Written by Ellen Hart Shegos. 2001; 346 pages.*

Price: \$15 or download PDF files for FREE at www.csh.org.

This manual is designed for service providers and housing developers who want to tackle the challenge of developing permanent supportive housing for chronically homeless families. The manual provides information on the development process from project conception through construction and rent-up. It also discusses alternatives to new construction such as leased housing. It contains practical tools to guide decision making about housing models, picking partners and service strategies.

A Description and History of The New York/New York Agreement to House Homeless Mentally Ill Individuals *Written by Ted Houghton. 2001*

Price: \$5 or download PDF file for FREE at www.csh.org.

This document provides a description and history of the New York/New York Agreement to House Homeless Mentally Ill Individuals, signed in 1990 by the City and State of New York.

The New York/New York Agreement Cost Study: The Impact of Supportive Housing on Services Use for Homeless Mentally Ill Individuals *Written by Kay E. Sherwood. 2001*

Price: \$5 or download PDF file for FREE at www.csh.org.

A Summary of: *The Impact of Supportive Housing for Homeless Persons with Severe Mental Illness on the Utilization of the Public Health, Corrections and Emergency Shelter Systems: The New York/New York Initiative.* Conducted by Dennis P. Culhane, Stephen Metraux and Trevor Hadley Center for Mental Health Policy and Services Research, University of Pennsylvania. This document summarizes the cost analysis of the New York/New York Agreement.

Between the Lines: A Question and Answer Guide on Legal Issues in Supportive Housing – National Edition

Commissioned by CSH. Prepared by the Law Offices of Goldfarb & Lipman. 2001; 226 pages.

Price: \$15 or download PDF files for FREE at www.csh.org.

This manual offers some basic information about the laws that pertain to supportive housing and sets out ways to identify and think through issues so as to make better use of professional counsel. It also offers reasonable approaches to resolving common dilemmas.

Keeping the Door Open to People with Drug Problems —

Volumes I, II and III *Written by Wendy Fleischer, Juliane Dressner, Nina Herzog and Alison Hong. 2001; 180 pages.*

Price: \$5 Each or download PDF files for FREE at www.csh.org.

This three-part guide offers employment program managers and staff encouragement, strategies and tips for serving people with drug problems. The guide is divided into three volumes to make it easy to read for busy practitioners. Volume I is written with managers in mind. It focuses on the systems needed to train, manage and support staff in a program serving people with drug problems. Volume II is targeted to employment program staff. It covers basic information about drug addiction and treatment, and offers tips for working with people, including sample dialogues and forms. Volume III is focused on employment programs operating in public housing. It discusses the related housing policies and regulations, and some of the challenges and opportunities provided by the public housing context.

The Network: Health, Housing and Integrated Services Best Practices and Lessons Learned *Written by Gerald Lenoir. 2000;*

191 pages. Price: \$5 or download PDF file for FREE at www.csh.org

This report summarizes the principles, policies, procedures and practices used by housing and service providers that have proven to be effective in serving health, housing and integrated services tenants where they live.

Closer to Home: Interim Housing for Long-Term Shelter Residents: A Study of the Kelly Hotel *Written by Susan M. Barrow, Ph.D. and Gloria Soto Rodriguez. 2000; 65 pages.*

Price: \$5 or download PDF file for FREE at www.csh.org

Evidence that a subgroup of homeless individuals have become long-term residents of NYC shelters has spurred a search for new approaches to engaging them in services and providing appropriate housing alternatives. The Kelly Hotel Transitional Living Community, developed by the Center for Urban Community Services with first year funding from the Corporation for Supportive Housing, is one pioneering effort to help mentally ill long-term shelter residents obtain housing.

Forming an Effective Supportive Housing Consortia; Providing Services in Supportive Housing; and Developing and Managing Supportive Housing

Written by Tony Proscio. 2000; 136 pages.

Price: \$5 Each or download PDF files for FREE at www.csh.org.

These three manuals are designed to assist local communities and service and housing organizations to better understand the local planning consortium, service delivery and funding, and supportive housing development and financing.

Landlord, Service Provider...and Employer: Hiring and Promoting Tenants at Lakefront SRO

Written by Tony Proscio and Ted Houghton. 2000; 59 pages.

Price: \$5 or download PDF file for FREE at www.csh.org

This essay provides a close look at Lakefront SRO's program of in-house tenant employment, as a guide for other supportive housing programs that either hire their own tenants or might want to do so. The lessons of **Landlord, Service Provider...and Employer** are also of potential interest to affordable housing programs whose tenants could become valuable employees given sufficient encouragement, training and clear policies.

The Next Wave: Employing People with Multiple Barriers to Work: Policy Lessons from the Next Step: Jobs Initiative

Written by Wendy Fleischer and Kay E. Sherwood. 2000; 73 pages.

Price: \$5 or download PDF file for FREE at www.csh.org

The **Next Step: Jobs** initiative tested the premise that a range of employment services targeted to supportive housing tenants can help them access employment. It used supportive housing as the focal point for deploying a range of services to address the multiple barriers to employment that tenants face. It also capitalizes on the residential stability and sense of community that supportive housing offers.

Between the Lines: A Question and Answer Guide on Legal Issues in Supportive Housing – California Edition

Commissioned by CSH. Prepared by the Law Offices of Goldfarb & Lipman. 2000; 217 pages.

Price: \$15 or download PDF files for FREE at www.csh.org

This manual offers some basic information about the laws that pertain to supportive housing and sets out ways to identify and think through issues so as to make better use of professional counsel. It also offers reasonable approaches to resolving common dilemmas.

Supportive Housing and Its Impact on the Public Health Crisis of Homelessness *Written by Tony Proscio. 2000; 40 pages.*

Price: \$5 or download PDF file for FREE at www.csh.org

This publication announces the results of research done between 1996 and 2000 on more than 200 people who have lived at the Canon Kip Community House and the Lyric Hotel in California. It also looks at pre-occupancy and post-occupancy use of emergency rooms and inpatient care.

Vocationalizing the Home Front: Promising Practices in Place-Based Employment

Written by Paul Parkhill. 2000; 79 pages.

Price: \$5 or download PDF file for FREE at www.csh.org

Accessibility; inclusiveness; flexibility; coordinated, integrated approach to services; high-quality, long-term employment; and linkages to private and public sectors are hallmarks of a new place-based strategy to help people with multiple barriers to work find and keep employment. The 21 place-based employment programs featured in this report represent some of the most comprehensive and innovative approaches to employing persons who are homeless, former and current substance abusers, individuals with HIV-AIDS, those with physical and psychiatric disabilities and other challenges.

Connecticut Supportive Housing Demonstration Program — Program Evaluation Report

Commissioned by CSH. Prepared by Arthur Andersen LLP, University of Pennsylvania Health System, Department of Psychiatry, Center for Mental Health Policy and Services Research, Kay E. Sherwood, TWR Consulting.

1999; Executive Summary, 32 pages. Complete Report, 208 pages.

Executive Summary Price: \$5 Complete Report Price: \$15

This report evaluates the Statewide Connecticut Demonstration Program which created nearly 300 units of supportive housing in nine developments across the state in terms of tenant satisfaction and community impact—both economic and aesthetic—property values and use of services once tenants were stably housed.

The Next Step: Jobs Initiative Cost-Effectiveness Analysis

Written by David A. Long with Heather Doyle and Jean M. Amendolia.

1999; 62 pages. Price: \$5

The report constitutes early findings from a cost-effectiveness evaluation by Abt Associates of the *Next Step: Jobs* initiative, which provided targeted services aimed at increasing supportive housing tenants' employment opportunities.

Under One Roof: Lessons Learned from Co-locating Overnight, Transitional and Permanent Housing at Deborah's Place II

Commissioned by CSH, written by Tony Proscio.

1998; 19 pages. Price: \$5

This case study examines Deborah's Place II in Chicago, which combines three levels of care and service at one site with the aim of allowing homeless single women with mental illness and other disabilities to move towards the greatest independence possible, without losing the support they need to remain stable.

Work in Progress 2: An Interim Report on Next Step: Jobs

Commissioned by CSH, written by Tony Proscio. 1998; 22 pages. Price: \$5

Work in Progress 2 describes the early progress of the *Next Step: Jobs* initiative in helping supportive housing providers "vocalize" their residences—that is, to make working and the opportunity to work part of the daily routine and normal expectation of many, even most, residents.

A Time to Build Up

Commissioned by CSH, written by Kitty Barnes. 1998; 44 pages. Price: \$5

A Time to Build Up is a narrative account of the lessons learned from the first two years of the three-year CSH New York Capacity Building Program. Developed as a demonstration project, the Program's immediate aim is to help participating agencies build their organizational infrastructure so that they are better able to plan, develop and maintain housing, with services for people with special needs.

Next Door: A Concept Paper for Place-Based Employment Initiatives

Written by Juliane Dressner, Wendy Fleischer and Kay E. Sherwood. 1998; 61 pages. Price: \$5

This report explores the applicability of place-based employment strategies tested in supportive housing to other buildings and neighborhoods in need of enhanced employment opportunities for local residents. Funded by the Rockefeller Foundation, the report explores transferring the lessons learned from a three-year supportive housing employment program to the neighborhoods "next door."

Not a Solo Act: Creating Successful Partnerships to Develop and Operate Supportive Housing

Written by Sue Reynolds in collaboration with Lisa Hamburger of CSH. 1997; 146 pages. Price: \$15

Since the development and operation of supportive housing requires expertise in housing development, support service delivery and tenant-sensitive property management, nonprofit sponsors are rarely able to "go it alone." This how-to manual is a guide to creating successful collaborations between two or more organizations in order to effectively and efficiently fill these disparate roles.

Work in Progress...An Interim Report from the Next Step: Jobs Initiative

1997; 54 pages. Price: \$5
This report provides interim findings from CSH's *Next Step: Jobs* initiative, a three-city Rockefeller Foundation-funded demonstration program aimed at increasing tenant employment in supportive housing. It reflects insights offered by tenants and staff from 20 organizations based in Chicago, New York City and the San Francisco Bay Area who participated in a mid-program conference in October, 1996.

Closer to Home: An Evaluation of Interim Housing for Homeless Adults

Commissioned by CSH, written by Susan M. Barrow, Ph.D. and Gloria Soto Rodriguez of the New York State Psychiatric Institute. 1996; 103 pages. Price: \$15

This evaluation examines low-demand interim housing programs, which were developed by nonprofits concerned about how to help homeless people living on the streets who are not yet ready to live in permanent housing. Funded by the Conrad N. Hilton Foundation, this report is a 15-month study of six New York interim housing programs.

In Our Back Yard

Commissioned by CSH, directed and produced by Lucas Platt. 1996; 18 minutes. Price: \$10 nonprofits/\$15 all others.
This educational video is aimed at helping nonprofit sponsors explain supportive housing to members of the community, government representatives, funders and the media. It features projects and tenants in New York, Chicago and San Francisco and interviews a broad spectrum of supporters, including police, neighbors, merchants, politicians, tenants and nonprofit providers.

Design Manual for Service Enriched Single Room

Occupancy Residences *Produced by Gran Sultan Associates in collaboration with CSH. 1994; 66 pages. Price: \$20*

This manual was developed by the architectural firm Gran Sultan Associates in collaboration with CSH and the New York State office of Mental Health to illustrate an adaptable prototype for single room occupancy residences for people with chronic mental illnesses. Included are eight prototype building designs, a layout for a central kitchen, recommendations on materials, finishes and building systems, and other information of interest to supportive housing providers, architects and funding agencies.

Employing the Formerly Homeless: Adding Employment to the Mix of Housing and Services

Commissioned by CSH, written by Basil Whiting. 1994; 73 pages. Price: \$5

Funded by the Rockefeller Foundation, this report explores the advisability of implementing a national employment demonstration program for the tenants of supportive housing. The paper is based on a series of interviews with organizations engaged in housing, social service and employment projects in New York City, the San Francisco Bay Area, Washington, DC, Chicago and Minneapolis/St. Paul, as well as a body of literature on programs aimed at alleviating the plight of homelessness.

Miracle on 43rd Street

August 3, 1997 and December 26, 1999. 60 Minutes feature on supportive housing as embodied in the Times Square and the Prince George in New York City. **To purchase VHS copies, call 1-800-848-3256; for transcripts, call 1-800-777-8398.**

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Mission Statement

CSH supports the expansion of permanent housing opportunities linked to comprehensive services for persons who face persistent mental health, substance use, and other chronic health challenges, and are at risk of homelessness, so that they are able to live with stability, autonomy and dignity, and reach for their full potential.

We work through collaborations with private, nonprofit and government partners, and strive to address the needs of, and hold ourselves accountable to, the tenants of supportive housing.