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Under the Bloomberg administration, New York City has become a national model for how to reduce unsheltered and chronic homelessness. This policy brief—based on interviews with city officials, service providers, and national experts, as well as a review of public documents—describes the administration's policies for reducing street homelessness and developing supportive housing; the results of those policies; and the major policy issues that the next administration will have to address. Under the Bloomberg administration, the city has built a system for moving chronically homeless individuals off the streets and into permanent housing. The major policy innovations in this area were restructuring the contracts for homeless street outreach, developing alternatives to shelter for the chronically homeless, and, in partnership with New York State, creating thousands of supportive housing units for people experiencing or at risk of homelessness. As a result, the number of people living on the street has been reduced by 28 percent and the number of individuals experiencing chronic homelessness has been reduced by 59 percent.[1] These gains are not irreversible, however, and additional progress relies on continued focus on permanent housing placements among street outreach providers and increased investment in supportive housing.

Context

For most people who experience it, homelessness is a one-time, relatively short phenomenon. However, roughly 18 percent of all people experiencing homelessness on a given night are chronically homeless and will likely remain so without access to supportive housing, which combines a permanent housing subsidy with on-site social services and case management (Kuhn and Culhane 1998). People living on the streets are more than twice as likely to be chronically homeless as those living in shelters: 33 percent versus 16 percent, respectively (HUD 2013). Chronic homelessness significantly reduces an individual's life expectancy (O'Connell 2005). It also has large public costs. Analysis of shelter data in New York and Philadelphia has shown that, while only 10 percent of shelter users are chronically homeless, this population accounts for 50 percent of shelter resources (Kuhn and Culhane 1998). In addition, people experiencing chronic homelessness are frequent users of other emergency services such as jails, emergency rooms, detox facilities, and psychiatric institutions.

Programs that condition permanent housing on successful completion of transitional or treatment programs are often unable to help individuals experiencing chronic homelessness (Greenwood et al. 2005). Housing First programs, which place clients experiencing chronic homelessness into permanent housing as quickly as possible and then provide wraparound supports to promote long-term stability and independent living, have been much more effective (Greenwood et al. 2005). Despite the success of Housing First programs, many communities have struggled to develop policies that systematically engage chronically homeless individuals living on the streets and place them into permanent housing. Street outreach programs are often underfunded and not focused on permanent housing placements, and supportive housing units are not always prioritized for the chronically homeless with the greatest needs.[2]

Policy Response

The Bloomberg administration built a system for moving chronically homeless individuals off the streets and into supportive housing. It restructured funding for street outreach to prioritize permanent housing placements for chronically homeless individuals and held providers accountable for results. It developed new Safe Haven programs to provide immediate housing for the chronically homeless as they worked toward permanent housing; and, in a joint commitment with New York State, it made the biggest investment in supportive housing ever made by local government.

History

The problem of large-scale street homelessness first emerged in New York City in the late 1970s, following the failure to successfully reintegrate mentally ill individuals exiting state psychiatric institutions back into the community and the decline in the city's single-room-occupancy housing (Houghton 2001). In 1983, the New York State Supreme Court's ruling in *Callahan v. Carey* established a right-to-shelter for eligible homeless single men in New York.[3] By 1989, more than 11,000 single adults, many with serious mental illnesses, were in the city's shelter system; despite the right-to-shelter, thousands more were estimated to be living on the streets. In 1990, in what was called the New York/New York Agreement, New York City and New York State committed to create 3,314 units of supportive housing for homeless mentally ill individuals. The agreement's initial target date for constructing all units was 1992, but it took until 1998 to meet the goal (Houghton 2001). Despite the development challenges, the agreement was hugely successful. Sixty percent of residents remained in their housing two years after placement (Houghton 2001), and nearly all the costs of the supportive housing were offset by savings from shelters, public health, and corrections (Culhane, Metraux, and Hadley 2002). The increase in supportive housing also may have helped temporarily reduce demand for single-adult shelter (Culhane, Metraux, and Wachter 1999), but as development slowed down the single-adult shelter population swelled. In 1999, Mayor Giuliani and Governor Pataki signed the second New York/New York supportive housing agreement (NY/NY II), which committed the city and state to 1,500 new units of supportive housing over five years for mentally ill people experiencing homelessness. Despite being a significant investment, the agreement fell short of advocates' goal to create 10,000 new units over five years.[4]

Meanwhile, street homelessness persisted. A hodgepodge of social service agencies provided meals, clothing, blankets, and other assistance to individuals living on the streets. Although these services provided immediate aid, they did little to address the underlying housing issue. Outreach workers were generally unable to convince unsheltered homeless individuals to accept referrals to shelters or treatment programs. In the 1990s, the Times Square Business Improvement District (BID) provided $600,000 to social service agencies to refer clients living on the streets or subways in Times Square to a respite center, with the promise of subsidized housing after they reached sobriety and received counseling. While the agencies made 1,511 contacts with 206 individuals, only 15 ever stayed in the respite center and just two were permanently housed (MacDonald 1997). New York City did not collect regular statistics on street homelessness in the 1990s, but it is widely believed that the problem became less visible under the Giuliani administration. However, Giuliani was criticized for using the police to forcibly remove individuals sleeping on the streets or in homeless encampments.[5]

Setting a Goal and Measuring Progress
In 2004, the Bloomberg administration released *Uniting for Solutions Beyond Shelter*, which called for a two-thirds reduction in street homelessness within five years. Measuring progress against this goal required a consistent, citywide measure of street homelessness, which the city lacked. In 2005, New York City's Department of Homeless Services (DHS) completed the first citywide street survey, called the Homeless Outreach Population Estimate, or HOPE. HOPE was conducted by volunteers and led by street

outreach agencies. The process includes a "shadow" count, conducted by independent researchers, in which homeless "decoys" are deployed across the city. At the end of the survey, the researcher assesses what percentage of decoys was missed by volunteers. DHS uses this percentage to adjust the final estimate, thereby accounting for clients who may have been missed by the endeavor. For the most part, the city has retained the same core methodology since 2005, allowing for reliable reporting of year-to-year trends. The US Department of Housing and Urban Development (HUD) now requires all communities to complete an annual homeless point-in-time survey, and New York City is considered a standard-setter for how to conduct a thorough count.

Restructuring Homeless Outreach Contracts

In 2006, New York City consolidated funding from DHS and the Department of Health and Mental Hygiene (DOHMH) to issue a joint Request for Proposal (RFP) for homeless street outreach services. The new RFP made several changes to how the city funded street outreach. First, rather than funding multiple grantees to serve the same neighborhood, the new RFP funded one grantee for each catchment area. This was intended to establish a single point of accountability for each zone. Second, the RFP required outreach teams to focus intensively on the chronically street homeless population (DHS and DOHMH 2006). Third, it instituted performance-based outcome payments. In the first year of the contract, 10 percent of providers' contracts were performance based, with providers receiving $850 each time they placed a chronically homeless individual into transitional housing (with an additional $1,900 if that individual then moved to permanent housing), or $2,750 each time they placed an individual directly into permanent housing. In subsequent years, the performance-based component increased to 25 percent and providers were paid $2,000 for each transitional housing placement (and $5,000 for each subsequent placement in permanent housing) or $7,000 for a direct placement into permanent housing. Finally, funding was allocated proportionally based on need, as determined by the street homelessness counts in each borough.

Safe Havens

The failure of the Times Square BID demonstrated that for outreach workers to successfully transition individuals off the streets, the city must have an attractive portfolio of housing options. DHS interviewed street homeless individuals to understand why they were not utilizing the shelters the city is legally obligated to provide them. The interviews revealed that unsheltered individuals deliberately avoided the shelters for various reasons, including safety concerns and an unwillingness to comply with shelter rules. In response to this feedback, DHS converted a number of single-adult shelters into Safe Havens and opened new Safe Havens. Safe Havens differ from emergency shelters in several ways. First, there is no sobriety requirement, although residents are not allowed to use drugs or alcohol on the premises. Second, there is no curfew, and many of the other shelter rules are waived or relaxed. Third, residents have private rooms. Fourth, individuals do not have to go through the single-adult central intake centers but can be referred directly by outreach providers. Fifth, Safe Havens are generally smaller than shelters. Finally, Safe Havens have a lower ratio of residents to case managers and provide intensive supports to help individuals acclimate to living off the streets, build independent living skills, and navigate the process for applying for, and getting placed into, supportive housing.

Expanding Access to Supportive Housing

On November 5, 2005, Mayor Bloomberg and Governor Pataki announced the New York/New York III Supportive Housing Agreement. The agreement committed the city and state to jointly invest $1 billion in capital costs and $156 million in annual operating costs to develop 9,000 supportive housing units over 10 years. It is still the largest investment in supportive housing ever made by local government. While NY/NY I and II focused exclusively on individuals with serious and persistent mental illnesses, NY/NY III included youth aging out of foster care or other institutional settings, chronically homeless families, single adults with substance use disorders, and single adults with HIV/AIDS (table 1).

Table 1. Target Populations for NY/NY III Supportive Housing

Population	Planned units
A. Chronically homeless single adults with a serious mental illness (SMI) or are mentally ill and chemically addicted	3,950
B. Single adults in New York State (NYS) operated psychiatric centers who would be at risk of homelessness if discharged without supportive housing	1,000
C. Young adults (18–25) with serious mental illnesses being discharged from NYS residential treatment facilities or psychiatric centers	200
D. Chronically homeless families in which the head of household has a SMI	400
E. Chronically homeless single adults with a substance abuse disorder	750
F. Homeless single adults who have completed a course of treatment for a substance abuse disorder	750
G. Chronically homeless families in which the head of household has a substance abuse disorder, disabling medical condition, or HIV/AIDS	750
H. Chronically homeless single adults with HIV/AIDS and a serious mental illness and/or a substance abuse disorder	1,000
I. Young adults (18–25) exiting foster care who are at risk of homelessness	200
Total	**9,000**

NY/NY III also narrowed the homeless eligibility criteria for supportive housing. Except for populations exiting institutional settings, NY/NY III supportive housing is reserved for people experiencing chronic homelessness.[6] Housing placement was also restructured to improve targeting. As in past agreements, the Human Resource Administration (HRA) screens all applicants for eligibility using the HRA 2010E universal online application form. Referrals to HRA can come from any agency that has been trained on the system and given a username and password, including street outreach providers, shelters, correctional facilities, mental health clinics, Safe Havens, and hospitals. In the old system, once HRA determined an applicant's eligibility, the referral agency would work directly with supportive housing providers to move the client into an available unit. NY/NY III created "placement entities" for each target population that are responsible for making referrals to supportive housing providers. DHS is the placement entity for populations A, D, E, F, and G (table 1). The other placement entities are the New York State Office of Mental Health (B and C), the HIV/AIDS Services Administration (H) and the Administration for Children's Services (I). As the placement entity, DHS prioritizes eligible applicants based on duration of homelessness and vulnerability. In addition, to minimize "creaming" (i.e., avoiding the more challenging applicants), DHS instituted a one-in-three rule. Under this rule, placement entities must provide three referrals for each available supportive housing unit. The supportive housing provider is then obligated to accept one of those three.[7]

Supportive Housing Development Results

Sixty-nine percent of new units to be created under NY/NY III are project based, meaning they are units dedicated to a particular mixed-income residential building. Most of these units are studio apartments where tenants have their own kitchen and bathroom facilities, while some are single-room-occupancies with shared facilities. The remaining units are scattered site, meaning housing providers lease apartments in the private rental market. In all supportive housing units, tenants have their own keys to the apartment, can come and go as they please, and have their names on the lease.

By 2009, the city and state had met the unit goal of creating 2,750 units of scattered-site supportive housing (Branca 2013).[8] As planned, project-based units—which require capital investments for the acquisition, development, or rehabilitation of the building, as well as community approval for siting—have taken longer to become available. This delay was partly because the city and state were still working through the pipeline of units committed in NY/NY I and NY/NY II; also, the 2008 recession's impact on

credit markets and state and city budgets may have made it more difficult to finance new projects (IBO 2010). However, since 2010 the city and state have developed more than 2,200 new units with roughly 2,500 additional units in the pipeline. In 2012, the city and state jointly announced plans to double the annual production of supportive housing. They have achieved this by finding new sources of investment, including state Medicaid dollars, rent subsidies from the New York City Housing Authority and New York State Homes and Community Renewal, and bond financing and direct subsidies from the New York City Housing Development Corporation. As of October 31, 2013, the city and state had created 2,421 congregate units (HRA 2013b). They are on pace to have broken ground on all project-based units by City Fiscal Year (CFY) 2016 and have all units available by CFY 2018. Although the development goal has been delayed slightly from year to year, progress has been made from achieving NY/NY I and II goals. Additionally, despite some resistance from community boards, particularly to housing active substance users, the city has successfully sited new projects in various desirable locations.[9]

Placements into Housing
In addition to the thousands of new supportive housing units, the city has created 545 Safe Haven beds by repurposing single-adult shelters and opening new sites. This investment has created a pipeline to move chronically homeless individuals off the streets and into permanent housing. Since the city restructured its street outreach contracts in 2007, outreach providers have successfully placed more than 4,100 chronically homeless individuals into transitional and permanent housing (DHS 2013). Annually, the number of homeless single adults referred by DHS to supportive housing has increased 61 percent: from 1,141 to 1,841 (DHS 2013). In total, NY/NY III has generated more than 7,500 placements into permanent supportive housing, including 3,549 chronically homeless single adults and families (HRA 2013b).

Supportive Housing Retention and Cost Savings
One year after placement into NY/NY III supportive housing, 85 percent of all clients remained housed in the program. Two years after placement, 74 percent remain housed (HRA 2013b). These retention rates are comparable to national averages for supportive housing for formerly homeless individuals (Wong et al. 2006). Housing retention differs significantly by target population. The family populations (D and G) have the highest retention rates. Chronically homeless single adults with an SMI (A) and active substance users (E) both have above-average retention rates. Although some agency officials and supportive housing providers were concerned about permanent housing for active substance users, their housing retention rates are actually significantly higher than single adults who received substance abuse treatment (F). Single adults discharged from state psychiatric centers (B), chronically homeless single adults with HIV/AIDS (H), and youth aging out of foster care (I) all have below-average retention rates (figure 1).[10]
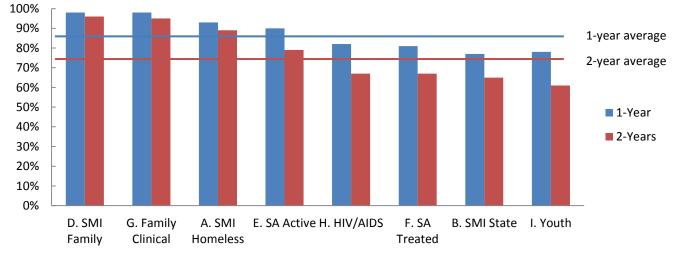
Figure 1. One- and Two-Year Housing Retention Rates for NY/NY III Tenants

Source: HRA NY/NY III Agreement Quarterly Progress Report through September 30, 2013.
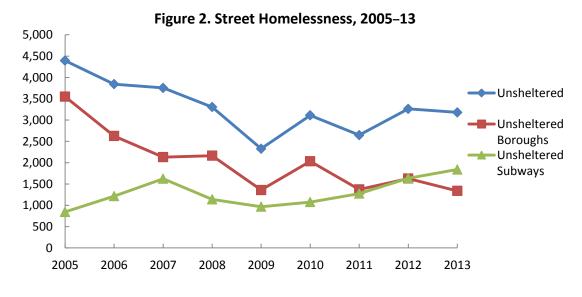
Overall, 38 percent of all clients ever placed into NY/NY III supportive housing units have moved out. In 25 percent of these cases, it was unknown where the client had moved to. Eighteen percent of moves were positive exits to other supportive housing or independent living arrangements. Thirteen percent were to live with friends or family. The other common move-out destinations were prison (9 percent), death (9 percent), hospitals (7 percent), and shelter (5 percent; see HRA 2013b).

DOHMH's interim evaluation report of NY/NY III compared costs and use of supportive housing, shelter, correctional facilities, health care, and cash assistance for NY/NY III tenants of one year or longer to unplaced eligible applicants.[11] The report found that, on average, the net costs of the comparison group were $10,100 more than the costs of NY/NY III tenants (Levanon et al. 2013). The greatest savings came from reduced use of state-operated psychiatric facilities, primarily for population B.

Reductions in Street and Chronic Homelessness

As placements into permanent housing have increased, the number of unsheltered and chronically homeless individuals has decreased. From 2005 to 2013, unsheltered homelessness fell 28 percent (figure 2).

In 2005, a total of 3,550 street homeless individuals were identified on the city's surface areas by the HOPE survey; in 2013, that number was 1,339—a 62 percent decrease. However, during these eight years, the number of homeless individuals in the city's subway system more than doubled, from 845 to 1,841. Fifty-eight percent of unsheltered homeless individuals are now sleeping underground in the subway system.

Figure 2. Street Homelessness, 2005–13

Sources: HOPE counts, 2005–13.

In 2005, 7,002 individuals were experiencing chronic homelessness on the night of the HOPE count. In the 2013 HOPE count, 2,839 individuals were experiencing chronic homelessness, a 59 percent decrease (figure 3).
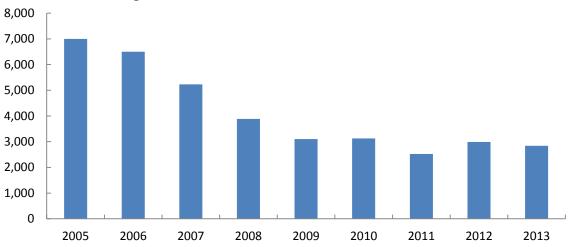
Figure 3. Trends in Chronic Homelessness, 2005–13

Sources: HUD point-in-time counts of chronically homeless individuals, 2005–13.

Related Policies and Programs

For brevity's sake, this brief has not addressed a number of policies and programs related to street homelessness and supportive housing under the Bloomberg administration. Although this brief focuses on permanent housing placements, the city has also made safety improvements for the homeless through extreme weather protocols (Code Blue and Code Red) and quarterly monitoring and reporting of homeless deaths. The city's homeless prevention and shelter policies, both critical components of reducing street and chronic homelessness, are addressed in a companion brief from the Urban Institute. This brief also does not address the Moving On Initiative, a DHS program aimed at helping clients who no longer required the program services and case management of supportive housing move on to subsidized private-sector housing. Although Moving On is no longer operating, a similar program could help thousands of stabilized

supportive housing tenants, freeing up capacity to serve more people currently on the streets, in shelters, or in institutional settings. Whether and how to facilitate successful program exits from supportive housing is an important and difficult policy issue that deserves more in-depth analysis. Finally, this brief does not address the role of Medicaid in financing both housing and services for supportive housing. New York is at the forefront of this issue and is using its state Medicaid funding to invest in a number of pilot housing programs that could have major implications for our understanding of how stable housing can be used as a platform for improving health outcomes, and reducing costs, for homeless and at-risk populations.

Looking Ahead

The next administration could end chronic homelessness in New York City by continued emphasis on implementing current policies and further investment in Safe Havens and supportive housing. Based on interviews with city agency staff and other key stakeholders, the following policy recommendations appear to have widespread support.

Incorporate Subways into DHS Street Outreach System
The city must address the rise in homelessness within the subway system. Unlike homeless outreach throughout the city, which is managed by DHS, outreach on the subways has been managed by the Metropolitan Transportation Authority (MTA). MTA does not use the same performance-based, permanent housing–focused contract system as DHS. Also, though the majority of street homelessness now occurs on the subways, MTA's street outreach budget is a fraction of what DHS provides through its consolidated RFP. To this end, in winter 2013 DHS and the MTA agreed that DHS would take over street outreach on the subways. Incorporating the subways into the DHS street outreach contracting system will help ensure that the same intensive, housing-focused approach that has helped reduce street homelessness across the city extends to the subways. DHS should also continue to develop flexible and dynamic solutions to meet the emerging needs of the street homeless.

Create Additional Safe Havens
Safe Havens have provided a place for chronically homeless individuals to get off the streets as they work toward a permanent housing placement. However, DHS data show that the average lengths of stay in Safe Havens have doubled from six months in 2009 to 12 months in 2012. Although DHS funded 70 additional beds during this period, because of reduced turnover, it served only 10 more clients in 2012 than it did in 2009. As a result, the program is now oversubscribed, and DHS reports getting 25–30 applications for each available bed. For the most part, the increased length of stay seems to be the result of longer wait times for supportive housing vacancies. One street outreach provider estimated that it now takes six to nine months to place a category-A eligible individual into supportive housing. For individuals who do not have a serious mental illness, the wait time is a year or longer. In the past, the city created Safe Havens through repurposing smaller single-adult shelters and opening new ones. The increase in the sheltered single-adult population (Durham and Johnson 2014) now makes these repurposings more difficult. With a $25 million investment, the city could create 500 additional Safe Haven beds (Nashak 2013).

Increase Supportive Housing Capacity
Having a single entity responsible for coordinating and overseeing joint supportive housing commitments across city and state agencies could help sustain focus amid competing priorities. It could also address problems created by different agencies reporting through different chains of command. For example, the New York City Department of Housing Preservation & Development, the agency responsible for the development of supportive housing, reports to the Deputy Mayor for Economic Development; DHS, DOHMH, and HRA all report to the Deputy Mayor for Health and Human Services.

Additionally, while there is widespread support for continuing the placement entities and one-in-three referral rule, supportive housing providers have raised concern about placement entities' ability to match eligible applicants with the most appropriate housing provider. In some cases, placement entities refer clients who providers claim do not meet their preference criteria; in other cases, the placement does not meet the client's preferences. Such issues can probably be resolved through experience and increased training. Also, some outreach providers believe it would expedite placement if they could communicate directly with supportive housing providers, rather than having to communicate through a placement entity. However, supportive housing providers must continue to house the hardest-to-serve clients.

Finally, supportive housing providers and service agencies have struggled with housing retention for some populations—most notably, individuals discharged from state psychiatric hospitals and youth aging out of foster care. Some of these challenges stem from not having a strong evidence base for successful independent housing models for these populations. Improving housing retention and other client outcomes is the subject of ongoing evaluation and adjustment among NY/NY agencies and providers. One persistent challenge raised by city agencies and providers is the payment rates. Providers are paid for each client they house based on a capitated annual rate, which covers both housing and services. The rates range from approximately $14,000 a year for chronically homeless individuals with an SMI to approximately $25,000 a year for chronically homeless individuals with HIV/AIDS (Levanon et al. 2013). These rates have stayed flat while the costs of rental housing have risen. For scattered-site programs renting apartments on the private market, this leaves less money to spend on services for each client. While there are no data on how much funding is needed for each client, anecdotally the erosion of services funding is making housing retention more difficult for some populations. In addition, the flat funding levels for program administration may make it more difficult for providers to retain staff.

The largest challenge with supportive housing in the city is that there simply is not enough of it. There are currently 5.8 HRA-approved clients for every one vacant supportive housing unit. While the city and state continue to add new congregate units, they have not matched the initial burst of new scattered-site units that became available in the first few years after the agreement. With the city and state closing in on NY/NY III development goals, a new agreement is necessary to create the next pipeline of units. While the scope and time frame of a new agreement still must be negotiated, there is widespread hope that the success of the prior agreements will lead to a NY/NY IV. Such an agreement is essential to continue the city's progress.

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Notes

[1] These figures are based on New York City's annual point-in-time count as reported to HUD (https://www.onecpd.info/resource-library/coc-homeless-populations-and-subpopulations-reports/). The chronic homeless count is based on the definition used by the US Department of Housing and Urban Development (HUD): an individual (or family head of household) with a disability who has either been homeless continuously for one year or has experienced at least four episodes of homelessness in the past three years. In 2013, for the first year HUD asked communities to report on the number of chronically homeless families in the PIT count. New York City reported 4,328 total chronically homeless people in its 2013 count: 2,839 individuals and 1,489 people in families. For the purposes of consistency, our analysis of trends in chronic homelessness looks only at the number of chronically homeless individuals.

[2] "Chronic Homelessness in Focus," US Interagency Council on Homelessness, accessed December 31, 2013, http://usich.gov/population/chronic/in_focus/.

[3] Later rulings expanded this right to women, families, and people with AIDS.

[4] Raymond Hernandez, "Pataki and Giuliani Agree on Housing for the Mentally Ill," *New York Times,* April 22, 1999.

[5] David Herszenhorn, "1,000 in Park Denounce Giuliani on Homeless Arrest Policy," *New York Times,* December 6, 1999; "A Bum Rap in the Big Apple," *The Economist,* January 27, 2000.

[6] The definition of chronic homelessness used to determine eligibility for NY/NY supportive housing differs from the federal definition. The eligibility criteria for chronic homelessness is individuals or families who have spent two of the past four years on the streets or in shelter or a family or individual living with a disability who had spent 365 days homeless during the past two years.

[7] DHS encourages all facilities to follow the one-in-three rule, but it can only mandate it for DHS-contracted facilities.

[8] There are now more than 3,000 scattered-site supportive housing units; some agencies have swapped some of their project-based unit goals for scattered-site units.

[9] Seventy-three percent of all units are located in Manhattan or Brooklyn, and 35 percent are located in Manhattan south of 96th Street.

[10] Population C is not included because the first placement for this group was not made until 2011.

[11] Capital costs are not included in the cost estimate for supportive housing.