An Assessment of the Housing Needs of Persons with HIV/AIDS

New York City
Eligible Metropolitan Statistical Area

Final Report

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The HIV/AIDS Housing Needs Assessment Team

- Hudson Planning Group
- University of Pennsylvania Center for Mental Health Policy & Services Research
- Center for Urban Community Services
- Public Sector Research

Acknowledgements

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- The Hudson Planning Group has conducted a parallel study of HIV/AIDS housing needs in the balance of New York State, which was supported by funding from the New York State Department of Health AIDS Institute.

- Support and guidance for the study is provided by an Advisory Group composed of consumers and providers of HIV/AIDS housing and services, representatives of New York City and State government agencies, and members of the private business sector.

- Special thanks are due to ten peer survey workers who assisted the assessment team with administration of an extensive consumer survey; to the over 2,000 New Yorkers with HIV/AIDS who responded to the consumer survey; and to the many individuals and organizations who have participated in key informant interviews and focus groups.

Advisory Group

The study's Advisory Group has not had an opportunity to review or comment on the final report and its issuance should not be understood as an endorsement by the Advisory Group.

The HIV/AIDS Housing Needs Assessment Team extends its thanks to its Advisory Group:

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Joe Tribbie, Greyston Foundation
Rev. Terry Troia, Project Hospitality
Barbara Van Buren, Westside Federation for Senior Housing
Arlene Wysong, Newmark & Company

Assessment Team

The Hudson Planning Group **(HPG)** assembled a team of consultants with expertise and experience in qualitative and quantitative research and analysis, and has coordinated the team's work to conduct an assessment of the housing and support service needs of persons with HIV/AIDS in the New York City Eligible Metropolitan Statistical Area (EMSA), consisting of the five boroughs of New York City and the Tri-County Lower Hudson Region of New York State.

HPG is a New York State not-for-profit corporation that provides technical assistance and engages in research and planning activities in support of not-for-profit community-based providers of health and human services. HPG works with a broad array of service providers in New York City and State as well as other parts of the country, providing expertise in special needs housing, health care planning, behavioral health services (mental health and chemical dependency treatment) and related fields. HPG has extensive experience working with AIDS services organizations ("ASOs") active in housing, health care, and related social/supportive services.

HPG, as project manager, coordinated the work of the Assessment Team, facilitated the ongoing activities of the project Advisory Group, and had primary responsibility for communications with the New York City Department of Health and Mental Hygiene's Office of AIDS Policy (OAP) and the Postgraduate Center for Mental Health (PCMH), and for the preparation and presentation of interim and final data, reports, and recommendations. HPG also had primary responsibility for conducting in-depth interviews and focus groups with key informants, and for related research to gather information regarding the supply and demand for HIV/AIDS housing and services in the NYC EMSA, funding sources for HIV/AIDS housing, opportunities for and barriers to the development of such housing in the New York City EMSA, and the HIV/AIDS housing assessment, referral and placement process.

University of Pennsylvania's Center for Mental Health Policy and Services Research **(U Penn Center or the Center)** has worked since 1986 in collaboration with public agencies to address the problems of vulnerable adult populations, particularly persons with behavioral health problems, persons who are homeless, and people with HIV/AIDS. A core faculty of social psychologists, sociologists, epidemiologists, and health services researchers conducts investigator-initiated research projects, and responds to requests for proposals from federal, state and local agencies. The Center regularly conducts surveys and other primary data collection efforts for vulnerable adults, including functional assessments, housing preferences, and consumer satisfaction surveys. The Center also surveys provider organizations about their organizational structure, service mix, revenues and expenditures, and staffing patterns. The U Penn Center has developed a national reputation for its methodological expertise in the integration and analysis of large administrative databases in order to track service users longitudinally, and to evaluate major system changes and policy interventions.

The U Penn Center had primary responsibility for assessing the housing and support service needs and preferences of consumers of HIV/AIDS housing services. A consumer survey designed and administered by the U Penn Center was used to collect and analyze information from a statistically significant sample of persons living with HIV/AIDS in the NYC EMSA regarding: housing needs and preferences, support service access and needs, and housing placement experiences.

Center for Urban Community Services **(CUCS)** is a nonprofit organization founded at Columbia University in 1979 that currently provides a continuum of housing and services for homeless and low-income people, particularly those with special needs such as HIV/AIDS, mental illness, and substance use issues. CUCS service programs are based in New York City and include a drop-in center, two transitional housing programs, seven permanent supportive housing projects serving 1,400 individuals, and extensive vocational and employment services.

CUCS had primary responsibility for developing an inventory of currently available HIV/AIDS housing and related support services in the NYC EMSA, which was collected and maintained using CUCS' existing Supportive Housing Database.

Public Sector Research, LLC **(PSR)**'s principals are doctors from the Department of Epidemiology and Social Medicine of Montefiore Medical Center/Albert Einstein College of Medicine. Each of these members of PSR has extensive experience in the assembly, analysis and interpretation of demographic and epidemiological data, and has conducted national, state, and New York City-based needs assessments of persons with HIV/AIDS and related studies.

PSR provided epidemiological support to HPG, the U Penn Center and CUCS in the performance of the needs assessment.

Participating Providers
Consumer Survey Distribution

820 River St., Inc.
AIDS Center of Queens County
African Services Committee
American Indian Community House
AIDS Related Community Services
Asian Pacific Islander AIDS Coalition
Bailey House
Bowery Residents Committee
Brooklyn AIDS Task Force
Brooklyn Legal Services
Brooklyn Pediatric AIDS Network
Church Avenue Merchants Block Association
Casa Betsaida
CitiWide Harm Reduction
Coalition For The Homeless
Community Health Care Network
Center for Urban Community Services
Fortune Society
Foundation for Research for Sexually Transmitted Diseases
Gay Men's Health Crisis
Green Chimneys Youth Services
Greyston Foundation
Haitian Centers Council
Haitian Women's Program
Harlem United Community AIDS Center
Heartshare
Helping Hands Unlimited
Hetrick Martin Institute
Hispanic Aids Forum
HIV Law Project
Housing Works
J-Cap Residential Drug Rehab and HIV Services
Legal Action Center
Lesbian and Gay Community Center
Lincoln Place
Living Together
Momentum
Montefiore Medical Center Adolescent AIDS Program
Musica Against Drugs
NYC AIDS Housing Network
NYC Ryan White Planning Council PWA Advisory Group
Osborne Association
Positive Health Project
Project Hospitality
Project Samaritan AIDS Services
Queens Pride House
Safe Horizons
Services for the Underserved
Staten Island AIDS Task Force
The New Hope Dinners
The Sharing Community
Touch Of Rockland County
Westside Federation for Senior Housing
Women's Prison Association

Key Informants

820 River Street, Inc.
AIDS Center of Queens County
African Services Committee
AIDS Housing Corporation, Boston
AIDS Related Community Services
AIDS Service Center of Lower Manhattan
Ali Forney Center
Asian Pacific Islander AIDS Coalition
Bailey House
Bowery Residents Committee
Bridge Fund of Westchester
Bronx HIV Care Network
Brooklyn AIDS Task Force
Brooklyn Legal Services
Casa Betsaida
Catholic Charities
Church Avenue Merchants Block Association
CitiWide Harm Reduction
Coalition For The Homeless
Columbia University, Mailman School of Public Health
Common Ground
Community Health Care Network
Community Service Society
Consumers in Independent and Supportive Housing
Consumers Seeking Housing
Corporation for Supportive Housing
Eden Information & Referral, Inc.
Floating Hospital
Fortune Society
Foundation for Research for Sexually Transmitted Diseases
Gay Men's Health Crisis
Grace Church Community Center
Green Chimneys Youth Services
Greyston Foundation
Haitian Centers Council
Haitian Women's Program
Harlem United Community AIDS Center
Health Force
Heartshare
Helping Hands
Hetrick Martin Institute
Helping Individuals with Criminal Records Reenter through Employment
Hispanic Aids Forum
HIV Law Project
Hogan's Residence
Housing Connections
Housing Needs Assessment Peer Survey Workers
Housing Works
J-Cap Residential Drug Rehab and HIV Services
Legal Action Center
Legal Aid of Rockland
Legal Services of New York City
Lesbian and Gay Community Center
Lincoln Place
Living Together
Momentum
Montefiore Medical Center Adolescent AIDS Program
Musica Against Drugs
National Equity Fund
New York AIDS Coalition
NYC AIDS Housing Network
NYC Ryan White Planning Council, Housing Work Group
NYC Ryan White Planning Council, PWA Advisory Group
New York Community Trust
Newmark & Company
Osborne Association
Positive Health Project
Postgraduate Center for Mental Health
Pratt Area Community Council
Praxis Housing
Prime Realty
Project Hospitality
Project Samaritan AIDS Services
PROMESA
Queens Pride House
Robin Hood Foundation
Staten Island AIDS Task Force
Services for the Underserved
Sharing Community
St. Johns Park Care Pavilion
St. Nicholas Neighborhood Preservation Corporation
Staten Island AIDS Task Force
Steinway Child and Family Program
The New Hope Dinners
The Sharing Community
Touch Of Rockland County
Tri-County Lower Hudson Region Ryan White Planning Council Housing Work Group
Unique People Services
Urban Strategies
Westchester HARP Program
Westside Federation for Senior Housing
William F. Ryan Center
Women's Prison Association

Government Agencies

County of Rockland Office of Community Development
Mt. Vernon HOPWA
NYC Department of Health and Mental Hygiene, Office of AIDS Policy
NYC Department of Homeless Services
NYC Department of Housing Preservation and Development
NYC Department of Mental Health, Retardation and Alcoholism Services
NYC Housing Resources Administration HIV/AIDS Services Administration
NYC Housing Authority
NYC Office of the Mayor
NY State Department of Health, AIDS Institute
NY State Department of Housing and Community Renewal
NY State Office of Alcohol and Substance Abuse Services
NY State Office of Mental Health
NY State Office of Temporary and Disability Assistance/Homeless Housing Assistance Program
Rockland County Department of Health
Rockland County Department of Social Services
U.S. Department of Housing and Urban Development
Westchester Planning Department
Westchester County Department of Health
Westchester County Department of Social Services

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I. Executive Summary

PREFACE: NOVEMBER 2004

This report is the final deliverable of a study of the housing needs of persons with HIV/AIDS in the New York City Eligible Metropolitan Statistical Area that was commissioned in 2001 by the New York City Mayor's Office of AIDS Policy Coordination under the U.S. Department of Housing and Urban Development's Housing Opportunities for Persons with AIDS (HOPWA) program. The Hudson Planning Group (HPG) and a team of professionals including the University of Pennsylvania Center for Mental Health Policy and Services Research, the Center for Urban Community Services, and Public Sector Research was selected to perform the assessment under the direction of the Postgraduate Center for Mental Health (PCMH), as the City's Master Contractor, and with the help of an Advisory Group composed of consumers, service providers, government representatives and experts in health and housing policy.

The release of the report has been delayed close to a year beyond its due date. The assessment was scheduled to take two years and to be completed in the fall of 2003, in accordance with the terms of an agreement between HPG and the PCMH. HPG submitted a complete draft of the report to the York City Department of Health and Mental Hygiene's Bureau of HIV/AIDS in February 2004. Review and comment by City agencies and HPG's revisions to the draft took an extended time and the final report is being released in November 2004. Accordingly, data in the report are current as of December 2003, with the exception of a few cases where it is noted that more recent data were provided at the request of a City agency reviewing the report.

As the original solicitation for a consultant set forth, the goal of this needs assessment was to collect comprehensive quantitative and qualitative data to be used to inform ongoing planning by government and community advisory groups to meet the housing needs of persons with HIV/AIDS in the NYC EMSA. This final report, while not a planning document, includes recommendations for improving the mix and volume of housing available to persons with HIV/AIDS that emerged from the Assessment Team's data collection.

Since the completion of the final draft in February 2004, several promising developments have occurred in New York City that suggest that some City agencies may be moving in the directions suggested by the report. First, the City's HIV/AIDS Services Administration (HASA) reports that it

has begun to implement changes to its policies and procedures, including entering into new memoranda of understanding with commercial SROs, discontinuing its 28-day relocation policy, improving timeliness of rental assistance application processing, and exploring strategies to improve client assessment, placement, and tracking. Second, in June 2004 Mayor Bloomberg announced his plan to end chronic homelessness in New York City in five years, which increased the City's commitment to creating new supportive housing units to 12,000 units. Third, in September 2004 the Mayor announced the implementation of voluntary rapid result HIV testing for single men entering Department of Homeless Services shelters. Because these developments took place after major sections of the report were completed, they are not mentioned in its body and were not discussed with the Advisory Group or with key informants whose analysis, impressions and suggestions drove the report's findings and recommendations; nonetheless, they seem to represent positive steps.

The scope of services for the assessment included a total of fifteen deliverables that were produced over the past three years. They provide key information and analysis that serve as critical building blocks for the final report. The contract for the study was based on a detailed scope of services and methodology, which was prescribed by the Mayor's Office of AIDS Policy Coordination and the PCMH in its original solicitation for a consultant. During the course of the study, a Project Management Team comprised of HPG staff, PCMH, and the Office of AIDS Policy met monthly to review and approve deliverables and other progress. In April 2003, the City announced that the Mayor's Office of AIDS Policy Coordination, which had originally commissioned the needs assessment, would become part of the NYC DOHMH. Accordingly, HPG worked with DOHMH staff during the completion of the project. It is worth noting that none of the City or PCMH staff involved in developing the scope of services or monitoring the project during its two-year contract period from 2001 to 2003 have been involved in finalizing the study over the past year.

The study's Advisory Group has not had an opportunity to review or comment on the final report and its issuance should not be understood as an endorsement by the Advisory Group. The Advisory Group reviewed a draft of the study's recommendations and provided extensive feedback and consultation.

I. EXECUTIVE SUMMARY

This study of the housing and support service needs of persons with HIV/AIDS in the New York City Eligible Metropolitan Statistical Area (EMSA) is among the first attempts to assess current and future housing needs of New Yorkers living with HIV/AIDS.[1] The AIDS epidemic has had a dramatic impact on New York City: the Department of Health and Mental Hygiene (DOHMH) estimates that there are more than 87,000 persons who have been diagnosed and reported as living with HIV/AIDS in New York City, and further that one-quarter of persons living with HIV have never been tested and do not know that they are infected. Since the emergence of the epidemic in the mid-1980s, New York City has recognized the importance of housing to the treatment and prevention of HIV/AIDS. The City has provided non-shelter housing for homeless persons with AIDS and other HIV-related illness, and has supported development of an extensive and unprecedented housing system. Housing resources have expanded rapidly in response to the epidemic: in 1990, fewer than 4,000 HIV/AIDS-specific housing units were available; by the end of 2003, the system included nearly 29,000 units. At least 23% of New Yorkers with HIV/AIDS now receive some kind of public support to meet their housing needs. New York City's system for housing persons with HIV/AIDS has served as an extremely effective public health intervention, improving the health status of New Yorkers with HIV/AIDS, while simultaneously reducing homelessness overall, caring for the homeless mentally ill, and providing housing to persons with substance use and other issues.

This unprecedented investment has demonstrated remarkable success in promoting stability and connection to health care for a group of people who might not otherwise find housing at all. Of more than 2,000 New Yorkers with HIV/AIDS surveyed as part of this study, almost two-thirds (64%) are stably housed, having moved one or fewer times in the last three years; and more than 70% are satisfied with their housing. These findings are particularly impressive in the light of the multiple and complex issues faced by these consumers, who report extremely high levels of past homelessness, co-occurring mental health and substance use issues, and histories of incarceration. Stability leads residents to improved health: of those surveyed, 95% reported a relationship with a

[1] This study examines housing needs in the five boroughs of New York City and the Tri-County Lower Hudson Region. The Hudson Planning Group has conducted a parallel study of the housing needs of persons with HIV/AIDS in each region of Upstate New York and Long Island, funded by the New York State Department of Health AIDS Institute.

primary care provider, and 75% reported participation in life-sustaining Highly Active Anti-Retroviral Treatment (HAART).

This housing system faces significant challenges in both the near and long terms. Many of these challenges are driven by population growth. Because of improved treatments, the number of persons living with HIV/AIDS in the NYC EMSA has more than doubled since 1996. By 2010, the number is projected to increase to more than 160,000. Using conservative estimates, the current unmet need for housing among persons currently living with HIV/AIDS is 2,400 additional units. By 2010, conservative estimates suggest that the system will require a total of more than 10,000 to 14,000 additional housing units. The potential costs of such housing are significant, but the NYC EMSA must begin to explore and develop financing models that will address this need.

Recent increases in the numbers of homeless persons in New York City pose a clear threat to the success of the HIV/AIDS housing system. The homeless shelter population has increased by 82% since 1998, from 21,100 persons in shelters on a given night, to 38,400 currently. The number of emergency housing placements made by the HIV/AIDS Services Administration (HASA) also has increased dramatically. In December 2003 alone, HASA made almost 3,000 emergency housing placements in transitional programs and commercial single room occupancy (SRO) hotels.[2] If this trend continues, it would represent a nearly 300% increase in emergency placements since 2001.

New York City's HIV/AIDS housing system is particularly fragile as a result of its reliance on the private housing market: eighty-six percent of persons supported by the system receive rental assistance or reside in subsidized scatter site units in the private market. The private housing market is becoming increasingly unaffordable in New York, making it nearly impossible to locate apartments renting for the $480/month "standard enhanced" rent provided to persons with HIV/AIDS. The private market also is inhospitable to many groups of persons living with HIV/AIDS who have significant unmet housing needs, including people leaving jail and prison and those with past felony convictions, undocumented immigrants, persons of transgendered experience, families with children, adolescents and youth aging out of foster care, persons in need of harm reduction services, and persons over 50 years old. Many persons with HIV/AIDS, moreover, have

[2] The number of placements, 2,889, represents 2,050 clients, some of whom presented as homeless more than once during the month of December.

experienced discrimination in securing and maintaining housing: of those surveyed, many reported perceived discrimination based on race/ethnicity, HIV/AIDS, and income source, among other factors.

In the face of reduced availability of vacant land and funding, development of new supportive housing units targeted to persons with HIV/AIDS has slowed. If the City does not plan appropriately to meet the housing needs of the population living with HIV/AIDS by 2010, it will face a major public health crisis.

There are immediate opportunities to improve the existing housing system. Persons living with HIV/AIDS face significant barriers to their independence. As their health status improves, they increasingly demand a housing "bridge" to work: more than three-quarters of persons in the HIV/AIDS housing system cannot work full- or part-time without jeopardizing their eligibility for housing supports. The existing system for assigning housing to those entering the system, moreover, squanders limited resources: people are assigned to housing on a first-come, first-served basis, with no ability to target the most intensive levels of supportive housing to those with the greatest needs. As a result, more than 1,500 persons with significant needs live in commercial SRO units that are substandard and dangerous, and on which the City spends more than $27 million each year. Many of these units can be rehabilitated and preserved as permanent housing for persons with HIV/AIDS and other low-income persons.

Strategy for Change

Meeting present and future challenges will require simultaneous action on a number of fronts. Appropriate housing must be preserved and strategies employed to prevent housing loss and homelessness. The enhanced rental assistance program for persons with HIV/AIDS must be adjusted to ensure its continued viability in the New York City EMSA private housing market. The existing supportive housing system must become more effective by assessing each incoming applicant's housing and service needs and linking him or her to housing with an appropriate level of supports. New units of affordable and supportive housing must be created and designated for persons with HIV/AIDS. The connection between housing and health care must be mandated through program funders' requirements, and documented with data on outcomes including connection to primary care, treatment adherence and reduction in risk behaviors. All of these steps

will require renewed commitment by government, providers, advocates and persons with HIV/AIDS to the preservation and creation of HIV/AIDS housing resources.

This report details a number of concrete recommendations necessary to improve New York City's existing HIV/AIDS housing system, and to meet the growing need for more housing. Some of the most pressing recommendations include:

- Acquire and preserve the remaining stock of commercial SROs, to provide more units of permanent affordable housing;

- Peg the level of enhanced rental assistance provided to persons with HIV/AIDS under New York State regulations to 110% of HUD's Fair Market Rent, which is the standard used by NYC's public housing authorities for their Section 8 Housing Choice Voucher programs (currently $933 for a studio apartment);

- Assess the housing and service needs of each person entering the housing system, to ensure that supportive units are provided to persons with greatest needs;

- Create a "land trust" supported by public and private funds to secure appropriate sites on the private market for future development of HIV/AIDS housing; and

- Establish a "bridge to work" allowing persons in the HIV/AIDS housing system to work part- or full-time without losing their housing benefits.

These recommendations, like the others presented in this assessment, are ambitious. If they are not implemented, however, the New York City EMSA risks not only continued erosion of its existing system, but creation of a new crisis of homelessness and AIDS.

This Assessment

Initiated by the Housing Work Group of the New York City HIV Planning Council and New York City's Office of AIDS Policy Coordination, this Housing Needs Assessment gives policy makers and providers in New York City and the Tri-County Lower Hudson Region the tools they need to plan for the effective use of resources to meet the housing needs of people with HIV/AIDS. It draws upon quantitative data secured through more than 2,000 anonymous consumer survey responses from a representative sample of New Yorkers living with HIV/AIDS, as well as qualitative information collected through interviews and focus groups with more than 200 key informants. The assessment makes specific recommendations for ensuring that the mix and volume of housing

resources available to New Yorkers living with HIV/AIDS supports the public health goals that current policy has established as precedent.

The Housing Needs Assessment is timely for several reasons. First, in the face of limited public resources, New York City and State agencies must have the information they need to ensure that adequate funding continues to be directed to housing for people with HIV/AIDS and that available resources are used efficiently to meet the growing demand. Second, Mayor Bloomberg's housing plan, *New Housing Marketplace,* introduced in December 2002, is the first large-scale City housing initiative since the highly successful 10-year plan launched by the Koch Administration in the late 1980s. This commitment to meet the housing needs of New Yorkers calls for bold housing initiatives that capitalize on the plan's promise to eliminate barriers to development and use public and private resources effectively. Finally, the concrete and data-driven methodology and analyses employed by the Housing Needs Assessment are critical in the current outcome-oriented policy climate.

HIV/AIDS Housing as a Public Health Intervention

The existing HIV/AIDS housing system has promoted stability and connection to health care for people with multiple and complex needs. The consumer survey conducted for this assessment shows that:

- Almost half (45%) of respondents report a history of "literal" homelessness, sleeping in a shelter or on the streets. More than half of African American respondents (53%) have been homeless.

- Four out of five survey respondents (80%) report a substance use problem or mental health issue in the past or present. 61% report substance use issues and 56% report mental health issues, while 37% report co-occurring mental health and substance use issues. Almost a quarter of all respondents (23%) have been hospitalized for mental health issues, indicating more serious and persistent mental health needs.

- More than forty percent of all respondents (43%) have a history of incarceration. Of those, two-thirds have been convicted of a felony (31% of all respondents). Twelve percent of all respondents report being released from jail or prison within the last year.

Despite these histories, and the potential barriers to securing and maintaining housing that they present, the overwhelming majority of people surveyed are stably housed, having moved 0 to 1 times

in the last 3 years, outnumbering unstably housed individuals (3+ moves in the last 3 years) by a ratio of 4.6 to 1.

Much of this unexpected stability can likely be attributed to "wrap around" support. Medicaid and grant-funded support services such as case management, medical and social day programs, harm reduction programs for active substance users, and mental health care provide the supports that keep many people in independent housing stable and connected to health care. These services are increasingly important as consumers' health status changes because of aging, prolonged HIV treatments, and co-occurring substance use and mental health issues.

The combination of housing and services appears to not only lead residents to housing stability but also to improved health. Consumer survey respondents report a significant level of connection to primary health care (95% report a relationship with a primary care provider) and participation in HAART (77% overall). Conversely, housing instability is associated with disruption of HIV care. A quarter of all respondents (25%) report that a lack of appropriate housing has at some point interfered with their ability to adhere to HAART or other HIV medications.

History

Since the mid-1980s, New York City has employed a "housing first" approach to address the public health threats posed by co-occurring and inter-related epidemics of homelessness, HIV, chronic drug use, mental illness, tuberculosis and, more recently, Hepatitis C. The City was at the forefront in recognizing the connection between homelessness and HIV/AIDS. Homeless people are at greater risk of HIV infection than the general population, and people with HIV/AIDS are significantly more likely to become homeless. When homelessness first peaked in the late 1980s, it was estimated that as many as 15% to 30% of all homeless New Yorkers were HIV seropositive; one study showed HIV infection levels higher than 60%.

As early as 1988, New York State Health Department policy prohibited hospital discharges of persons disabled by AIDS who lacked adequate housing placements, and the City Office of Special Services for Adults required that any homeless person with AIDS be offered private housing outside the City congregate shelter system. The impact of these and subsequent initiatives was rapid and significant. During the early 1990s the number of homeless single adults in City shelters declined by

37%, from 11,000 per night in 1989 to an average of 6,100 per night in 1994. While the creation of 3,615 units of New York/New York housing for persons with mental illness in the first half of the 1990s has been cited as an important factor in the dramatic decline in single adult homelessness, by December 1994 almost 15,000 homeless and unstably housed New Yorkers with AIDS were receiving non-shelter housing – 11,000 through the use of the City and State funded enhanced rental assistance program, 1,900 in supportive scatter site and congregate programs, and 1,800 in emergency SROs.

The Present HIV/AIDS Housing System

Housing resources for persons with HIV/AIDS in NYC have expanded rapidly in response to the growing epidemic. In 1990 fewer than 4,000 housing units were available (3,600 enhanced rental subsidies and 186 supportive units); by the end of 2003, the system served almost 29,000 persons; 20,500 using enhanced rental subsidies, 5,200 in permanent supportive housing, and 2,900 in emergency and transitional placements. In City fiscal year 2003, New York City's expense budget spending on housing and related services for persons with HIV/AIDS totaled more than $189.6 million.

The enhanced rental assistance program for New Yorkers with HIV illness and AIDS, which subsidizes clients' rents in private market apartments, is by far the most extensive housing subsidy for New Yorkers with HIV/AIDS. Administered by the New York City Human Resources Administration HIV/AIDS Services Administration (HASA), the program currently enables more than 20,000 persons with HIV/AIDS, close to 72% of those receiving HIV/AIDS housing resources, to remain housed in the private rental market. This program was established early in the epidemic by New York State regulations that provide for $480 in rental assistance for a single person, and an additional $330 for each family member. In order to make the program viable in New York City, HASA routinely conducts case-by-case financial assessments and approves rents at or close to fair market rates, known colloquially as "exceptions to policy." HASA reviews each case individually to determine if higher rents can be approved. Consumer survey respondents using rent subsidies report an average ratio of *total* rent to income of 124%, meaning that on average unsubsidized rents are greater than income. The average ratio of *out-of-pocket* rent to income, however, is 48%. While a 48% rent burden still constitutes a severe housing hardship, the difference illustrates that people with HIV/AIDS who receive rental assistance would not have access to the

private market without this subsidy; and many would become homeless. The rental assistance program is unique in its scope, extremely effective for the majority of New Yorkers with HIV/AIDS who receive housing assistance, and should serve as a model for meeting the housing needs of other extremely poor and disabled persons.

More than 5,000 units of supportive housing complement rental assistance subsidies. These programs are designed to facilitate stable housing among persons with significant multiple diagnoses and complex life issues. Despite the overall stability of persons housed through the HIV/AIDS housing system, a significant group of persons (18%) experiences high levels of housing instability. This group is likely to be younger, male, African American or Latino, and to have histories of homelessness, incarceration and substance use and/or mental health problems. These people are good candidates for supportive housing, with its availability of intensive services.

While respondents in independent housing reported the highest level of stability, the consumer survey showed that tenants of supportive housing are no more likely to be unstably housed (3+ moves in the last 3 years) than residents of independent housing, all other factors held equal. Fifty-six percent of residents of supportive scatter site housing and 40% of supportive congregate residents report stable housing (0-1 move in the last 3 years), compared to 54% of persons in independent housing. Availability of supportive housing, however, is limited, with need far outpacing the development of new units. Mental health housing, public housing, and other special needs housing systems do not serve as significant sources of housing assistance for New Yorkers living with HIV/AIDS.

There are differences in health care use by housing model and race/ethnicity. Residents of subsidized independent housing, for example, report the highest level of HAART participation (82%), and SRO residents the lowest (71%). African American respondents report the lowest rate of HAART participation among ethnic groups (73% compared to 86% among whites), and all non-white respondents are almost twice as likely as white respondents not to be on HAART. And while overall connection to health care is more than 95%, ten percent of SRO residents report that they need but do not have a primary care provider.

Challenges for the Future

New York City's extremely successful housing intervention faces critical challenges that, if not met, could jeopardize the current stability and health of thousands of New Yorkers with HIV/AIDS, and will seriously erode the ability of public health institutions to treat and prevent HIV infection in the years to come. Due to improved treatments and declining death rates, the number of persons living with AIDS in the NYC EMSA has more than doubled since 1996. Simultaneously, the population of homeless single adults in shelters and on the streets has been increasing since the mid-1990s. During 2003, the number of homeless New Yorkers residing in shelters each night reached the highest point in New York City history. In December 2003, more than 38,400 homeless men, women and children were sleeping each night in the New York City shelter system, including 16,600 children, 13,300 adult family members, and 8,500 single adults. The homeless shelter population has increased by 82% since 1998.

This growth has translated into a growing demand for housing and related supports, the most visible evidence of which is the 2,000 persons with HIV/AIDS in emergency and transitional housing placements. During the entire fiscal year 2001, HASA made a total of 13,000 placements in emergency transitional programs and commercial SROs and welfare hotels. In contrast, HASA made close to 3,000 transitional and commercial SRO placements in December 2003 alone.[3] If this trend continues, it represents almost a 300% increase in emergency placements in just two years. The total number of clients using housing supports provided through HASA rose to 27,000 in December 2003, up 65% from five years ago.

Best estimates based on consumers' service needs indicate an immediate unmet need for approximately 900 additional rental assistance subsidies, and close to 1,500 additional permanent supportive units. These resources are needed just to more appropriately house persons currently placed in HIV emergency and transitional housing, or whose independent housing is unstable due to unmet service needs. Even conservative projections of the number of persons living with HIV/AIDS and related housing needs indicate that 10,000 to 14,000 additional units of housing will be needed to meet the housing needs of New Yorkers with HIV/AIDS in 2010 (6,000 to 9,000

[3] The number of placements does not necessarily correspond with the number of clients occupying emergency housing, because some clients present as homeless more than once.

additional rental assistance subsidies; 3,000 to 4,000 permanent supportive housing units; and 300 to 500 new transitional units).

Access to the private rental market is the key to the existing housing system: eighty-six percent of all HIV/AIDS housing assistance taking the form of direct tenant rental assistance or scatter site supportive housing. Despite Citywide improvements in housing conditions and value, however, the rental market remains extremely tight, with an overall vacancy rate of only 3%, and vacancy rates at the low-cost end of the market of only 1% to 2%. More than 84% of all survey respondents report a total monthly rent of $999 or less; in this segment of the housing market, vacancy rates range from 1.04% to 3.77%.

- 24% of survey respondents report that they pay $399 or less in rent – the vacancy rate for apartments in this range is only 1.26%.
- 16% pay $400-$599 in rent – the vacancy rate for apartments in this range is less than 2%.
- 26% pay $600-$799 in rent – the vacancy rate for apartments in this range is slightly more than 2%.
- 18% pay $800-$999 in rent – the vacancy rate for apartments in this range is 3.66%.

In order to meet anticipated need, it is critical that new housing units be developed, yet the rate of growth in the supportive housing system has slowed in recent years while the number of persons living with HIV/AIDS continues to rise rapidly.

Recommendations

As this needs assessment documents and describes, New York City's system for housing persons with HIV/AIDS has served as an effective public health intervention and has demonstrated the critical importance of housing as the foundation for effective healthcare provision. To date, New York City's HIV/AIDS housing system has developed on an ad-hoc basis, by responding to needs as they have arisen. With the data and analysis provided in this needs assessment, the City and its provider network have the opportunity to make proactive decisions that will result in more efficient delivery of existing housing resources, and strategic expansion of resources in response to anticipated needs.

The following recommendations suggest that, as part of an HIV/AIDS Housing Plan, the City focus immediately on four areas of critical concern: eliminating use of commercial SROs as emergency housing, and converting them to permanent housing where possible; restructuring HASA so that consumers' housing needs are assessed and centralized housing placements are based on these assessments; ensuring that the enhanced rental assistance program continues to work in the private housing market; and planning for development of new supportive housing units.

These recommendations are presented in three formats:

A. Key Plan Priorities: The Assessment Team recommends that the City immediately begin to develop a five-year HIV/AIDS Housing Plan to meet HIV/AIDS housing needs in New York City, now that the findings of this needs assessment can guide that planning process. Four key priorities are set forth that should serve as the first elements of the Plan.

B. Chart of Short-term Strategies: The attached chart lists 25 concrete strategies to be deployed over the next 12 to 24 months, in accordance with their projected difficulty and expense.

C. List of Recommendations, Needs, and Strategies: A comprehensive list is attached in Section V.B. of detailed recommendations, needs, and strategies that have been identified through the process of conducting the needs assessment as essential to improve the mix and volume of HIV/AIDS housing and support services available to consumers in the NYC EMSA.

A. A Plan to Address HIV/AIDS Housing Needs in New York City

The Assessment Team recommends that a comprehensive, concrete five-year HIV/AIDS Housing Plan incorporating unified planning and priority-setting be developed to improve and expand the existing system for meeting the housing needs of persons with HIV and AIDS. The Plan should be spearheaded by the Office of AIDS Policy, and should involve the HIV Health and Human Services Planning Council of New York City, consumers, providers, and key government agencies, particularly HASA and HPD.

The HIV/AIDS Housing Plan will need to address the inherent tension between the need to provide low-threshold and long-term housing services as a critical public health intervention, and the resource constraints of the system. The Housing Plan should focus initially on four key priorities: eliminating the use of the commercial SROs as emergency housing; restructuring HASA's assessment and placement process; ensuring the future success of the rental assistance program; and developing supportive housing for consumers with intensive service needs. These steps will lead to important and high-profile improvements to the system.

PRIORITY ONE: Eliminate the use of commercial SROs as emergency housing placements, and preserve those units that can be made available as permanent low-income housing.

The use of commercial SROs as emergency housing placements is extraordinarily expensive, concentrates the most troubled consumers in inadequate, often sub-standard and unsafe housing without supportive services, and has the potential to lead to a major and prominent health and safety crisis. The City must conduct an assessment of existing SRO units immediately, and determine which can be salvaged as permanent housing. In many cases conversion to permanent housing will require providing separate bathrooms and cooking facilities. It then must take the following steps:

- For those persons who need emergency housing, locate them in transitional housing where supportive services and housing placement assistance are available on-site.
- Compel existing owners of existing units to bring all units into compliance with building and safety codes.
- Require all commercial SROs that receive HASA placements to enter into contracts with HASA that impose uniform housing and safety standards and provide for regular oversight and enforcement.
- Explore City or not-for-profit ownership of SROs, through the exercise of eminent domain or 7A proceedings, and create a governmental SRO Housing Authority to acquire and improve SRO housing stock. Although this recommendation would involve significant initial investment, that investment should be balanced against the current cost of the SROs. If HASA pays a minimum of $50/night for more than 1,500 clients, it is

spending more than $27 million on emergency SRO placements each year. Converting half of the commercial SRO stock (750 units) to permanent housing, at $100,000 per unit, would cost $75 million.

PRIORITY TWO: Restructure HASA's assessment and placement process, so that available housing resources are matched most efficiently to consumers' needs.

Despite the size of the existing HIV/AIDS housing system, consumers receive no assessment of their housing needs upon entry. Housing resources are made available to consumers on a first-come, first-served basis, regardless of health and other support service needs. The lack of a uniform assessment and placement process results in inefficient use of existing resources. As need grows, it will become even more critical to ensure that consumers' housing needs are assessed upon their entry to the system, and that they are matched with the appropriate level of housing supports. HASA should introduce new procedures and restructure its services immediately as follows:

- Develop and implement a standardized assessment tool, administered by HASA and community-based service providers, to determine housing and related service needs, based on objective eligibility criteria. This tool should be administered by persons with appropriate qualifications and training.
- Develop and implement a centralized referral and placement system administered by HASA or by a contracted provider, to allocate housing resources according to a triage methodology based on the standardized assessment. (Detailed recommendations for improving the housing assessment, referral, and placement process were submitted as Deliverable 10 of the needs assessment.)
- For supportive housing in particular, match applicants to vacancies through a standardized database manager.
- Institute written communication of permanent housing options by HASA to consumers in emergency and transitional housing, providing information about programs, applications, and requirements.

- Track outcomes of housing referrals and placements, to assess consumers' stability and identify those in need of greater housing supports.

PRIORITY THREE: Ensure the continued success of the enhanced rental assistance program that supports persons with HIV/AIDS living in independent housing.

New York City's enhanced rental assistance program supports more than 20,000 persons with HIV/AIDS, close to 72% of those receiving HIV/AIDS housing resources, in housing in the private rental market. This program is a cost-effective strategy for meeting the housing needs of those persons who can live independently, but its continued success is precarious because of its reliance on the private market and the potential for housing loss among a vulnerable population. If drug therapies continue to be effective, it is likely that more consumers will be able to live independently and will want to return to work. The City should make the following changes to ensure that the enhanced rental assistance program succeeds in the future:

- Peg the level of enhanced rental assistance available under New York State regulations to 110% of HUD established fair market rents (FMRs), the standard used by NYCHA and HPD for their Housing Choice Voucher Section 8 programs, so that consumers are able to secure decent private market housing and can compete effectively with persons with Section 8 subsidies.
- Create a bridge-to-work program that disregards earned income during a trial return-to-work period, and limit the housing cost burden to a uniform 30%, so that the loss of housing supports is not a barrier to consumers who are able and ready to return to work.
- To address isolation and lack of independent living skills, ensure availability of COBRA and Ryan White case management, living skills training, harm reduction supports, financial planning and financial management services, legal services, and other wrap-around services.
- Ensure the availability of adequate code enforcement services, emergency utility assistance, and other emergency housing supports.

- Create incentives to encourage consumers to move out of supportive housing and into independent housing when ready.

PRIORITY FOUR: Expand supportive housing and services for consumers who have the most need.

As the results of the consumer survey have demonstrated, a significant portion of consumers in HIV-specific housing struggle with complex life issues. Some of these consumers are best served in supportive housing. Although the percentage of consumers receiving HIV/AIDS housing resources who are in supportive housing programs is relatively small (23%), given the projected increase in persons living with HIV and AIDS, the Action Plan will need to include strategies to expand the supply of supportive housing. The City should take the following steps to meet that need:

- Enter into contracts for new supportive scatter site housing units in which the primary lease is held by a social service provider. By 2010, the City will need an estimated 1,000 to 1,400 additional HIV-specific supportive scatter site units.
- Plan for the development of new supportive congregate housing units to meet the projected need. By 2010, best estimates suggest that the City will need an additional 700 to 1,000 HIV-specific congregate units; at $120,000 per unit, this development will require an investment of $84 to $120 million.
- Address housing needs of special and underserved populations, including those being released from prison and jail, undocumented persons, persons of transgendered experience, and adolescents.
- Create a land trust to secure appropriate sites on the private market for future development of HIV/AIDS housing. This trust could be seeded initially with $5 to $10 million of public and private funds, including contributions from foundations and financial institutions.

B. Strategies for Improving New York's HIV/AIDS Housing System within 12 to 24 Months

	Easier to Implement	Difficult to Implement
Inexpensive	∉ Develop and implement standardized assessment tool for HASA ∉ Give consumers clear and uniform information about their permanent housing options, and their obligations for rent and utilities ∉ Develop and implement integrated funding application for capital, operating, and supportive services ∉ Provide financial planning and financial management services ∉ Expand in-reach for discharge planning for persons leaving prison and jail ∉ Expand code enforcement services for persons in independent housing and commercial SROs ∉ Create a web-based brokers' listing for potential development sites ∉ Encourage persons in homeless shelters and outreach/drop-in programs to seek HIV testing and counseling	∉ Create centralized referral and placement system for HASA ∉ Create a bridge-to-work program ∉ Track outcomes of housing referrals and placements ∉ Limit housing cost burdens to a uniform 30% ∉ Develop a pilot project providing housing supports to persons who are HIV-asymptomatic ∉ Change zoning to increase allowable densities of small housing units ∉ Require community board notification only as a condition of HPD capital funding ∉ Create incentives to encourage consumers to move from supportive to independent housing when ready
Expensive	∉ Peg enhanced rental assistance to 110% of HUD fair market rents (FMRs) ∉ Expand supportive scatter site programs ∉ Create a land trust to secure development sites on the private market ∉ Expand emergency utility assistance ∉ Initiate research on the overlapping issues of homelessness and HIV/AIDS through merger of databases maintained by DOHMH, DHS, and HASA	∉ Develop 1,500 additional congregate supportive housing units ∉ Eliminate use of commercial SROs for emergency housing placements, and return them to the permanent housing stock ∉ Redirect HOPWA funding from supportive services to direct housing and housing-related assistance

C. Recommendations, Needs, and Strategies

The Assessment Team's research, analyses, and findings resulted in a series of concrete recommendations that, while acknowledging the unique effectiveness of New York's response to the housing needs of persons living with HIV/AIDS, identify particular actions to be taken to improve and build on that effectiveness, eliminate inefficiencies in the system, and anticipate and meet the need of increasing numbers of persons living with HIV/AIDS in the New York City EMSA. Seven broad goals emerged from the study:

1. Promote Housing Retention and Stability as a Baseline for HIV Treatment;

2. Realize Efficiencies in the Current HIV/AIDS Housing System through Improved Housing Referral and Placement;

3. Support the Greatest Possible Level of Consumer Independence;

4. Create New Units of Affordable and Supportive Permanent Housing to Meet Current and Future Housing Needs;

5. Coordinate Public and Private Advocacy in Support of Increased Funding for Low-Income Housing Available to New Yorkers with HIV/AIDS;

6. Engage in Ongoing Research on the Need for and Effectiveness of HIV/AIDS Housing Assistance; and

7. Develop an Action Plan to Ensure Results by Empowering an Interagency Commission to Implement Recommendations.

A full list of the recommendations within each of these goals is provided in Section V.B.

The Assessment Team

This HIV/AIDS housing needs assessment has been funded by the New York City Department of Health and Mental Hygiene Office of AIDS Policy (OAP) under the United States Department of Housing and Urban Development's Housing Opportunities for Persons with AIDS (HOPWA) program. The Hudson Planning Group (HPG) was selected to perform the assessment under the direction of the Postgraduate Center for Mental Health (PCMH), and with the help of an Advisory Group composed of consumers, service providers, government representatives and experts in health and housing policy. HPG conducted the assessment in collaboration with key partners that contributed a unique breadth and depth of expertise and experience to the project:

- HPG conducted in-depth interviews and focus groups with key informants as well as related research on: supply and demand for HIV/AIDS housing and services in the NYC EMSA, funding sources for HIV/AIDS housing, opportunities for and barriers to the development of such housing in the New York City EMSA, and the HIV/AIDS housing assessment, referral and placement process;
- The University of Pennsylvania Center for Mental Health Policy and Services Research (U Penn Center) assessed housing and support service needs and preferences of consumers of HIV/AIDS housing services, through development and analysis of a consumer survey;
- The Center for Urban Community Services (CUCS) developed an inventory of currently available HIV/AIDS housing and related support services in the New York City EMSA, building on CUCS' existing Supportive Housing Database; and
- Public Sector Research, LLC (PSR) provided epidemiological research and support.

Methodology[4]

The team collected data through consumer and provider survey instruments, and maintained the data in two databases: one designed for the analysis of consumer needs and preferences, representing the "demand" side of the gaps analysis; and the other designed to collect and maintain information regarding existing housing and service resources, representing the "supply" side of the gaps analysis. Fifty-five providers of housing and support services for persons with HIV/AIDS assisted the Assessment Team to collect over 2,000 anonymous consumer survey responses from a representative sample of New Yorkers living with HIV/AIDS; and the demographic profile of survey respondents closely reflects all persons living with AIDS in the NYC EMSA. Program information was collected from 147 providers of supportive housing units targeted for persons with HIV/AIDS including all existing programs that receive operating funding through the New York City Human Resources Administration's HIV/AIDS Services Administration, HUD's HOPWA and McKinney-Vento programs, and the Ryan White CARE Act. These data were augmented by qualitative information gathered through research and via interviews and focus groups conducted with more than 200 key informants.

[4] A full description of the methodology is provided in Appendix A.

Organization of this report

Section II of the body of this final report describes the historical context and development of the NYC EMSA HIV/AIDS housing system, research demonstrating the connection between stable housing and HIV health care and prevention, funding sources and uses in NYC, the HIV/AIDS housing inventory, housing-related services, other special needs housing systems available to persons with HIV/AIDS, and the use of commercial SROs as emergency housing. Section III describes persons served by the HIV/AIDS housing system by presenting detailed findings from the survey of more than 2,000 consumers of HIV/AIDS housing in NYC, examining results by consumers' demographics, complex life issues faced by consumers, housing stability and connection to care, housing models, satisfaction, preferences, and support service needs, and obstacles to getting and keeping housing. Section IV describes a number of critical challenges to the current HIV/AIDS housing system revealed by the needs assessment, including projected housing need, emerging needs and special populations, the affordable housing crisis, barriers to housing development, inefficient use of existing HIV/AIDS housing resources, and barriers to consumer independence. Section V sets out complete lists of key findings and recommendations for improving the mix and volume of housing resources available to persons with HIV/AIDS in the NYC EMSA.

Appendices include: a detailed description of the study's methodology; detailed recommendations for improving the referral and placement system; data provided by borough and county; an analysis of the relationship between housing costs and public income supports; detailed descriptions of funding sources for development and operation of housing for persons with HIV/AIDS; results of key informant interviews and focus groups; and the study's bibliography.

II. The Response of the New York City EMSA to the Housing Needs of Persons with HIV/AIDS

II. A. HIV/AIDS HOUSING AS A PUBLIC HEALTH INTERVENTION

New York City's policy since the mid-1980s of providing non-shelter housing for persons with HIV/AIDS is unprecedented in its scope and effectiveness.

New York City and State, working in collaboration with non-profit providers of housing and services, have made an unprecedented investment in housing for persons with HIV/AIDS that has had a significant impact, not only improving the health status of New Yorkers with HIV/AIDS, but simultaneously reducing homelessness overall, caring for the homeless mentally ill, and providing housing to persons with substance use issues who would otherwise be on the streets or in City shelters.

While not consciously structured or studied as a public health intervention, New York City has been in the forefront since the mid-1980s in the use of a "housing first"[1] approach to the public health threats posed by co-occurring and inter-related epidemics of homelessness, HIV, chronic drug use, mental illness, tuberculosis and now Hepatitis C. Since the beginning of the HIV/AIDS epidemic, New York City and State public health officials have understood the critical connection between housing and health, and housing opportunities have been a key component of the New York City and State response to HIV/AIDS.

When the first cases of what became known as AIDS were reported in 1981, New York City's HIV/AIDS housing system began as a crisis response by a handful of concerned government officials and infected and affected advocates and community based providers. By 1985, New York City and State had established a system of enhanced housing assistance and "one-stop shop" social services to meet the unique needs of persons disabled by AIDS.[2]

New York City determined at the beginning of the HIV/AIDS epidemic that congregate homeless shelters posed unacceptable health threats to persons with Centers for Disease Control (CDC) defined AIDS. Beginning in the mid-1980s, accordingly, it became New York City policy that

[1] See Section IIC below for a description of a "housing first" approach.
[2] A 1985 New York State regulation established an enhanced rental assistance program for persons with AIDS and HIV-related illness who are eligible for public assistance. The New York City Human Resources Administration established the Division of AIDS Services in 1985 to facilitate public entitlements for persons with AIDS.

persons with CDC-defined AIDS were provided enhanced rental assistance to maintain or secure housing, and, if homeless, were provided non-shelter emergency housing placements through the New York City Human Resources Administration HIV/AIDS Services Administration (HASA).[3] A 1988 New York State Health Department policy prohibited hospital discharges of persons disabled by AIDS who lacked adequate housing placements, and the City Office of Special Services for Adults required that any homeless person with AIDS be offered private housing outside the City shelter system.[4,5] Still, housing resources for persons with AIDS were considered a short-term intervention, primarily for the middle class, largely white, gay men first identified as living with AIDS, to provide palliative care for persons with short life expectancies.[6]

The growing problem of tuberculosis among homeless persons and persons with HIV brought the dramatic intersection of homelessness and HIV to the attention of providers, advocates and government in the late 1980s. An emerging epidemic of multi-drug resistant tuberculosis posed a serious threat to persons with HIV, in whom TB was more likely to occur and was harder to cure.[7,8] Litigation initiated in 1988 sought to enforce New York precedents establishing a right to safe and habitable shelter for homeless persons, by asserting the right of all homeless persons with HIV-related immune suppression to non-shelter housing.[9] Although that lawsuit was ultimately unsuccessful, in 1997 eligibility for HASA-administered HIV/AIDS housing resources was codified and expanded to all persons with symptomatic HIV illness.

Local Law 49 of 1997, found at Sections 21-126 to 128 of the Administrative Code of the City of New York, requires HASA staff to provide persons with HIV/AIDS with certain benefits and services, including medically appropriate emergency and permanent housing, and housing subsidies

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[3] The HIV/AIDS Service Administration (HASA) was previously called the Division of AIDS Services and Income Support, or DASIS. It should be noted that in contrast to the "right" to non-shelter housing in NYC, emergency housing for homeless persons with HIV/AIDS is extremely limited in the Tri-County/Lower Hudson Valley region of the EMSA.

[4] City of New York, Office of the Mayor, Human Resources Administration, and Department of Health and Hospitals Corporation. 1990. *Continuum of Housing and Services for the Medically Frail and HIV*-Ill. New York, New York.

[5] New York City Special Services for Adults. 1998. Document B.A.I.S.-88-10. New York, New York.

[6] AIDS Housing of Washington. 2000. *AHW Fact Sheet: AIDS Housing: A History*. Seattle, Washington. http://www.aidshousing.org.

[7] Frieden, T. R., et al. 1996. "A Multi-Institutional Outbreak of Highly Drug-Resistant Tuberculosis: Epidemiology and Clinical Outcomes." *Journal of the American Medical Association* 1229: p. 279.

[8] Barnes, P. F., et al. 1991. "Tuberculosis in Patients with Human Immunodeficiency Virus Infection." *New England Journal of Medicine* 1644: p. 234.

[9] *Mixon v. Grinker*. 1996. 88 N.Y.2d 907, 669 N.E.2d 819, 646 N.Y.S.2d 661.

such as the enhanced rental assistance for persons with HIV/AIDS. "Medically appropriate" housing is defined in the law as housing that is "suitable for persons with severely compromised immune systems" including "individual refrigerated food and medicine storage and adequate bathroom facilities."[10]

HASA's policies and procedures provide for same-day emergency housing placements for medically eligible homeless persons who seek housing assistance. New York City's Department of Homeless Services (DHS) refers individuals who self-identify as HIV-positive or living with HIV/AIDS to HASA for placement in medically appropriate (non-shelter) emergency housing.[11] As expressed by one consumer focus group participant, a resident in a temporary emergency placement: "The best thing about the HIV/AIDS housing system in New York is that I have a place to sleep every night."[12]

Now, in 2004, almost 20 years after the establishment of the New York City HIV/AIDS housing system, it is largely administered by HASA, and provides housing resources and related supports to more than 28,000 men, women and children living with HIV illness and AIDS – the majority of whom are black or Latino, many of whom have histories of homelessness, extreme poverty and/or incarceration, and the majority of whom struggle with complicating substance use and mental health issues. HIV-specific housing resources have grown from 3,626 rent subsidies and 186 units of supportive housing in 1990, to over 20,000 rent subsidies and almost 6,500 units of supportive housing targeted to persons with HIV/AIDS.[13,14] As described below, the HIV/AIDS housing system has served as a unique intervention to address the related health threats that place homeless and unstably housed New Yorkers at greatest risk of HIV infection and poor health outcomes.

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[10] City of New York. Administrative Code, Sections 21-126 and 128.

[11] Recent litigation has reinforced the right to a same-day emergency housing placement for persons with AIDS and HIV-related illness (***Hanna v. Turner***, 2001 N.Y. Misc. LEXIS 842 (Sup. Ct. N.Y. 2001)), as well as the requirement that such placements meet minimum standards of habitability and appropriateness, including accessible rooms where non-elevator buildings are used, clean bathrooms and placements that are free from vermin. (***Winds v. Turner***, 2003 N.Y. Lexis 4899 (App. Div. N.Y. 2003)).

[12] New York City Housing Needs Assessment (HNA), Key Informant Interviews 2003.

[13] *Continuum of Housing and Services for the Medically Frail and HIV-Ill.*

[14] The remaining 2,000 persons receiving HIV/AIDS housing services are in emergency placements, including 1,500 in commercial SROs. New York City Human Resources Administration, HIV/AIDS Service Administration (NYC HRA HASA.) *HASA Facts.* New York, New York: Dec. 2003.

New York City's Homeless Crisis in the 1980s and the Emergence of HIV/AIDS

In the winter of 1989, New York City's single shelter population rose to as many as 11,000 people per night, its highest level ever.[15] The dramatic increase in visible homelessness during the mid to late 1980s has been attributed to a number of intersecting causes, including a decline in the availability of low-cost single room housing stock, a widening housing affordability gap, and the deinstitutionalization of New Yorkers with mental illness.[16,17]

During this time the HIV/AIDS epidemic was also creating housing instability among affected persons and posing a new threat to homeless persons at high risk due to substance use, sex for survival or other behaviors linked to homelessness. The intersection of extreme poverty, homelessness, drug use and mental illness operated to place a group of vulnerable New Yorkers at extreme risk, feeding the growing and connected epidemics of HIV and tuberculosis.

The racial and geographic communities most heavily impacted by the rise in homelessness also faced the greatest risk of HIV. Approximately 90% of homeless New Yorkers are black or Latino, although only 53% of New York City's total population is black or Latino.[18] These New Yorkers are also disparately impacted by HIV/AIDS: 74% of cumulative AIDS cases and 84% of new AIDS cases in New York City have occurred among black or Latino individuals.[19] Of the eight New York City neighborhoods with the highest rates of new AIDS cases, six are located in community districts whose populations are least 75% African American or Latino.[20] A study of the previous addresses of homeless families revealed that over 60% of these families came from four New York City neighborhoods with the highest concentration of poverty and severe housing problems – the South Bronx (25%), Harlem (15%), and the Bedford-Stuyvesant and East New York neighborhoods of

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[15] Houghton, T. 2001. *A Description and History of the New York/New York Agreement to House Homeless Mentally Ill Individuals*, p. 33. Corporation for Supportive Housing. http://www.csh.org/.
[16] Ibid.
[17] Markee, P. 2003. *A History of Modern Homelessness in New York City.* Coalition for the Homeless. New York, New York. http://www.coalitionforthehomeless.org.
[18] Culhane, D. & S. Metraux. 1999. "One-Year Rates of Public Shelter Utilization by Race/Ethnicity, Age, Sex, and Poverty Status for New York City (1990-1995) and Philadelphia (1995)." *Population Research and Policy Review* 18: pp. 219 – 236.
[19] New York City Department of Health and Mental Hygiene, HIV/AIDS Surveillance Program. 2002. *HIV/AIDS Semi-Annual Report.* New York, New York.
[20] New York City Department of City Planning. 2000. Community District Profiles 2000. http://www.nyc.gov/html/dcp/home.html. (Includes data from the U.S. Census for Year 2000).

Brooklyn (21% combined).[21] Not surprisingly, these neighborhoods also bear a disproportionate impact of the HIV/AIDS epidemic: of the ten New York City neighborhoods with the highest rates of new AIDS cases, two are in Harlem (East Harlem and Central Harlem); three are in the South Bronx (Croton-Tremont, Highbridge, and Hunts Point); and three are in Central Brooklyn (Bedford – Stuyvesant, Williamsburg - Bushwick, and East New York).[22]

HIV/AIDS Housing as a Key Component of New York City's Response to the Homeless Crisis

A series of important housing initiatives launched in the late 1980s coincided with dramatic reductions in New York City's homeless population. The Koch Administration's ten-year, $5.2 billion "Housing New York" capital investment plan funded the creation or rehabilitation of 150,000 affordable apartments Citywide, with 10% of units targeted to homeless households. The City's SRO Loan Program (now the Supportive Housing Loan Program) was established by the City's Department of Housing Preservation and Development (HPD) in 1987, and in the late 1980s the State's Special Needs Housing Program was transformed and expanded into the Homeless Housing Assistance Program (HHAP). The historic 1990 New York/New York Agreement to House Homeless Mentally Ill Individuals, a joint effort by New York State and New York City, created 3,615 units of supportive and licensed, permanent and transitional housing for homeless mentally ill people in New York City.[23,24,25] It was also during this period that New York State and City implemented the enhanced rental assistance program for persons with AIDS and HIV-illness, and that the first HIV-specific scatter site and congregate supportive housing programs were introduced.[26] These initiatives were funded through a combination of City and State funding, with substantial reliance on federal funding from HUD, Stewart B. McKinney homeless housing assistance, and commitment of Section 8 housing vouchers for operating support.[27]

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[21] Culhane, D., C. Lee, & S. Wachter. 1997. "Where the Homeless Come From: A Study of the Prior Address Distribution of Families Admitted to Public Shelters in New York City and Philadelphia." *Understanding Homelessness: New Policy and Research Perspectives*. Fannie Mae Foundation.
[22] *HIV/AIDS Semi-Annual Report* (2002).
[23] Houghton, T. 2001. *A Description and History of the New York/New York Agreement to House Homeless Mentally Ill Individuals.* Corporation for Supportive Housing. http://www.csh.org/.
[24] In 1999 the City and State announced a second, significantly more modest NY/NY II initiative, committing funding for only 1,500 additional units of mental health housing.
[25] Markee, P. p.6
[26] *Continuum of Housing and Services for the Medically Frail and HIV-Ill*.
[27] New York City Department of Homeless Services. 1990. *Continuum of Care Plan.* U.S. Department of Housing and Urban Development.

The federal response to the increase in homelessness, including the housing needs of persons with HIV/AIDS, provided New York with the motivation and many of the resources that it utilized in addressing the crisis. This response included affordable housing programs such as HOME, enacted in 1992, and the provision of funding through the McKinney-Vento Homeless Housing Assistance program, which requires the implementation of the integrated Consolidated Planning Process for housing and services, and introduction of the Continuum of Care concept, which seeks to link homeless and housing resources.[28] The National Affordable Housing Act of 1990 established the Department of Housing and Urban Development's Housing Opportunities for Persons with AIDS (HOPWA) program, which provided New York City and State with funding to meet housing needs of persons with HIV/AIDS. In 1991, Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, which provided the first federal formula grant funds for the care and treatment of persons living with HIV/AIDS.

The impact of these initiatives was rapid and significant in New York City. During the early 1990s the number of homeless single adults in City shelters declined by 37%, to an average of 6,100 per night in 1994; street homelessness also became much less visible by the mid-1990s.[29,30] While the creation of the 3,615 units of New York/New York housing in the first half of the 1990s has been cited, with good cause, as an important factor in the dramatic decline in single adult homelessness, by December 1994 almost 15,000 homeless and unstably housed New Yorkers were receiving non-shelter housing – 11,000 through the use of the City and State funded enhanced rental assistance program, 1,900 in supportive scatter site and congregate programs, and 1,800 in emergency SROs.[31]

The Relationship between AIDS and Homelessness

Since the beginning of the AIDS epidemic, HIV/AIDS and homelessness have been inextricably linked. Housing is lost due to discrimination, and HIV-related illness causes the loss of jobs, the depletion of financial resources and, finally, the loss of housing. Meanwhile, persons already

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[28] Persons with HIV/AIDS have been recognized as a significant segment of the homeless population, and for the last two years persons living with or at heightened risk of HIV infection have been selected by the New York Coalition on the Continuum of Care as priority populations for new funding under the McKinney-Vento Act homeless housing assistance program.

[29] Markee, P. pp. 6-7.

[30] Houghton, T. 2001. *A Description and History of the New York/New York Agreement to House Homeless Mentally Ill Individuals*, p. 33. Corporation for Supportive Housing. http://www.csh.org/.

[31] NYC HRA Division of AIDS Services. 1994. *AIDS Fact Sheet*.

homeless are at unusual risk of HIV infection. Drug use is endemic, both as a cause and effect of homelessness; many homeless persons engage in sex for survival, including sex for money, food, shelter and drugs; and homeless persons with limited access to health care and social supports often lack the knowledge and resources necessary to practice HIV risk reduction.

Recent research demonstrates a strong association between housing status and risk for HIV transmission, with the homeless and unstably housed at much greater risk of engaging in high risk behaviors.

Important new research demonstrates a strong association between housing status and risk for HIV transmission, with the homeless at greater risk than the unstably housed and both groups at greater risk than the stably housed.[32] This research found that HIV-positive people who were homeless or unstably housed were 3 to 6 times more likely to share needles than those in stable housing, and that the homeless were 4 times more likely, and the unstably housed 2 times more likely to exchange sex for money or drugs than people living in stable and secure housing. Moreover, longitudinal analysis revealed that homeless or unstably housed persons whose housing had improved were about half as likely to use hard drugs, use needles, or report unprotected sex at last intercourse than persons with no change in their housing situation, and that persons whose housing worsened over time were 4 times as likely to have exchanged sex in the recent past. The research suggests that the condition of homelessness, and not simply the traits of homeless individuals, influences risk behaviors, and that the provision of housing is a promising structural intervention to reduce the spread of HIV.

Both providers and consumers interviewed for this study confirmed that stable housing serves as an important means of secondary HIV prevention. Participation in supportive housing appears to increase involvement in programs designed to reduce the harm associated with risky drug use as well as sexual practices, and to decrease particular high-risk behaviors such as trading sex for shelter.[33]

Although it is clear that HASA and the NYC HIV/AIDS housing system have successfully moved persons with AIDS and other HIV-related illnesses out of the congregate shelter system and into more appropriate housing, no actual data are available on the past and present extent of HIV/AIDS

[32] Aidala, A., et al. 2002. "Housing as a Structural Intervention to Reduce HIV Risk Behaviors among HIV Positive People." Center for Applied Public Health, Mailman School of Public Health. XIV International AIDS Conference. Barcelona, Spain. (Cited with the authors' permission).
[33] HNA, Key Informant Interviews (2003).

among Department of Homeless Services shelter users.[34] Public health experts and homeless and HIV/AIDS service providers have estimated that the homeless population has a median rate of HIV prevalence at least three times higher than the general population (3.4% versus 1%), and even higher rates (8.5% to 62%) have been found in various subpopulations.[35] In the late 1980s, researchers estimated that as many as 15% to 30% of all homeless New Yorkers were HIV seropositive.[36] Other estimates have been much higher. A study published in 1990 documented a seropositivity rate of over 60% and a 30% rate of HIV-related illness among a group of homeless men who sought medical care in a New York City men's shelter clinic.[37]

Perhaps the most systematic examination of the co-occurrence of AIDS and homelessness are the results from the integration of administrative databases for AIDS surveillance and public shelter utilization in Philadelphia.[38] This merger of the Philadelphia AIDS registry with Philadelphia shelter data confirmed that homelessness and AIDS frequently co-occur, such that homeless persons had ten times the risk of having AIDS as the general population, and PWAs were more than three times as likely to have been homeless than the general population. Although the range of estimates among various studies is broad due to different study protocols, locales, subpopulations and definitions of homelessness, all of the figures, not surprisingly, are significantly higher than the estimated prevalence among the general population.[39]

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[34] The methodology for this needs assessment includes a merge of the administrative database of shelter users maintained by the NYC Department of Homeless Services (DHS) with the AIDS Registry maintained by the NYC Department of Health and Mental Hygiene (DOHMH), to examine the historical overlap between homelessness and an AIDS diagnosis. Protocols for the data merge have been approved by the institutional review boards of the NYC DOHMH and the University of Pennsylvania, and Assessment Team members from the University of Pennsylvania Center for Mental Health Policy and Services Research have negotiated an interagency memorandum with DHS and DOHMH to conduct the research.

[35] Song, J., et al. 1999. "HIV/AIDS & Homelessness: Recommendations for Clinical Practice and Public Policy." National Health Care for the Homeless Council, Health Care for the Homeless Clinician's Network. p.1. http://www.nhchc.org.

[36] Arno, P. & D. Rogers. 1989. "AIDS in the United States: Patient Care and Politics." *Journal of the American Academy of Arts and Sciences* 118(2).

[37] Torres, R., Sridhaar, M. & J. Altholz. 1990. "Human Immunodeficiency Virus Infection Among Homeless Men in a New York City Shelter." *Archives of Internal Medicine*, 150: p. 2030-2036.

[38] Culhane, D., et al. 1996. *Prevalence of AIDS Among the Homeless in Philadelphia: AIDS Housing Needs Assessment 1997-2001.* The Philadelphia Office of Housing and Community Development.

[39] Song, J., et al. p. 6

Some groups of homeless persons, such as homeless youth and the mentally ill, appear to be particularly vulnerable to HIV infection.[40] Street youth are involved in multiple high-risk behaviors, including sex for survival and chronic, high-risk drug use.[41] A study of Toronto street youth found that the rate of HIV infection was seven times greater for a group of young men aged 20 to 25 than it was for a younger group, aged 14 to 19.[42] A merger of Philadelphia Medicaid data identifying mental illness with Philadelphia shelter data indicated that 2.8% of shelter users with serious mental illness were also diagnosed with AIDS; and a merger of Philadelphia Medicaid and AIDS Registry data revealed that 4.1% of the persons with serious mental illness had AIDS.[43]

The relationship between HIV/AIDS and homelessness also flows the other way, with persons with HIV/AIDS at significant risk of homelessness. National estimates have suggested that as many as one-third to one-half of persons with AIDS and HIV-related illness are homeless or in imminent danger of becoming homeless.[44] AIDS Housing of Washington reports that 41% of persons with HIV/AIDS surveyed in ten communities across the U.S. have experienced homelessness.[45] In New York State, a 1996 state-wide study of the scope and magnitude of housing needs among clients of HIV/AIDS housing and service providers found that a high percentage (34%) of such clients were homeless or marginally housed at the time that they first contacted a participating agency, and that there were dramatic levels of "housing distress" among housed clients, with nearly one-third living "doubled-up" in temporary or cramped conditions, and at least one-half facing difficulties paying for rent and utilities.[46] As described in Section IIIA below, forty-six percent of the respondents to the consumer survey conducted for this assessment report that they have experienced literal homelessness at some point (in a shelter or on the streets); and 13% of all respondents report currently living doubled up with another household.

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[40] AIDS Housing of Washington. 2003. *AHW Fact Sheet: Homelessness and HIV/AIDS.* Seattle, Washington. http://www.aidshousing.org.

[41] Clatts, M.C. & W.R. Davis. 1999. "A Demographic and Behavioral Profile of Homeless Youth in New York City: Implications for AIDS Outreach and Prevention." *Medical Anthropology Quarterly, 13(2):* pp. 365-374.

[42] Dematteo, D., et al. 1999. "Toronto Street Youth and HIV/AIDS: Prevalence, Demographics and Risks." *Journal of Adolescent Health 25(5)*: pp. 359-366.

[43] Culhane, D., et al. 2001. "The Co-occurrence of AIDS and Homelessness: Results from the Integration of Administrative Databases for AIDS Surveillance and Public Shelter Utilization in Philadelphia." *The Journal of Epidemiology and Community Health 55*: pp. 515-520.

[44] National Commission on AIDS. 1993. *Housing and the HIV/AIDS Epidemic.* Washington, D.C.

[45] AIDS Housing of Washington. 2003. *AHW Fact Sheet: AIDS Housing Survey.* Seattle, Washington. http://www.aidshousing.org.

[46] Bonuck, K. 2001. "Housing Needs of Persons with HIV and AIDS in New York State." *Journal of Health and Social Policy 13(2)*: p. 61.

The Community Health Advisory and Information Network (CHAIN) Project of the Mailman School of Public Health at Columbia University, an on-going longitudinal study that since 1994 has tracked HIV-infected individuals' encounters with medical and psychosocial service providers,[47] has consistently found widespread housing instability among persons living with HIV/AIDS in New York City: 60% of the CHAIN cohort experienced homelessness or unstable housing at least once during the five-year period 1995-1999, and two thirds of these persons have had multiple episodes of homelessness. While the study shows that trends of unstable housing have declined since 1994, at any point in time it is estimated that 10 to 15% of all people living with HIV in NYC are unstably housed.[48]

The CHAIN study found that housing difficulties are often complicated by substance use and mental illness, requiring a comprehensive support service approach. Once the other factors in the model were controlled for, case management services did not increase the odds of getting housing, but having a case manager facilitated a person remaining in housing once he/she was placed. Supportive services, namely case management, mental health and/or drug treatment services, were found to be as important as housing services in securing and successfully maintaining stable housing. The strongest predictor of obtaining housing and of staying in housing once placed, however, is receipt of an ongoing rental subsidy.[49]

The Impact of Homelessness on Persons with AIDS

Homeless persons with HIV/AIDS face unusual heath risks. They are thought to experience higher rates of morbidity and mortality than domiciled persons with HIV/AIDS, to face greater barriers to health care, and to be less likely to have access to and/or the supports necessary to comply with complex anti-HIV drug regimens.[50,51] In New York City homelessness or unstable housing has been

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[47] Funded by Title I of the Ryan White CARE Act through the New York City Health and Human Services Planning Council, the CHAIN researchers have interviewed a cohort of almost 900 persons with HIV/AIDS every six to nine months since the study's inception.

[48] Abramson, David, et al. Jan. 2003. "The CHAIN Retrospective: 1994-2002." *CHAIN Update Report #47*. Community Health Advisory & Information Network (C.H.A.I.N), Mailman School of Public Health. New York: Columbia University.

[49] Aidala, A. & G. Lee. 2000. "Housing Assistance and Housing Stability Among Persons Living with HIV/AIDS." *C.H.A.I.N Update Report #32*. Community Health Advisory & Information Network (C.H.A.I.N), Mailman School of Public Health. New York: Columbia University.

[50] AIDS Housing of Washington. 2003. *AHW Fact Sheet: Homelessness and HIV/AIDS*. Seattle, Washington. http://www.aidshousing.org.

found to be persistently associated with barriers to medical care, lower rates of service utilization, and poor adherence to complex treatment regimens.[52]

As HIV operates to destroy essential elements of the immune system, the HIV seropositive homeless person becomes increasingly vulnerable to infectious disease such as tuberculosis, and to other risks posed by life in congregate homeless shelters or on the streets. Lack of access to health care services for homeless persons with HIV/AIDS means that HIV is not identified as quickly as it could be, the onset of AIDS is accelerated, behavioral disorders are not resolved, and infections and other medical conditions become more prevalent.[53] Recent research in New York City underscores the importance of early identification of HIV: the NYC Department of Health and Mental Health (DOHMH) has found that a significant number of New Yorkers continue to come late to care, receiving an AIDS diagnosis within six months of initial HIV diagnosis;[54] and related research by Columbia University's Center for Applied Public Health shows that New Yorkers who are homeless or unstably housed at the time of their HIV diagnosis are more likely than others to delay entry into medical care.[55] Indeed, ongoing Research is needed to better characterize the extent of HIV/AIDS among homeless people, and to develop successful strategies for decreasing HIV infection among homeless persons.[56]

Stable housing is imperative in order for persons with HIV disease to successfully negotiate bureaucracies, file entitlement applications, keep appointments, and access social and medical services. Lack of stable housing poses a formidable barrier to the consistent health care, adequate nutrition, and other supports that are essential for any HIV positive person, and can be an insurmountable obstacle to drug treatment services, mental health care and other services necessary to address the multiple medical and psychosocial problems faced by many homeless persons with HIV/AIDS. Appropriate housing is also cost effective, as emergency care is replaced by consistent care. Unstable housing and homelessness have been associated with higher rates of health care

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[51] Song, J., et al.
[52] *CHAIN Update Report #47.*
[53] Song, J., et al.
[54] Forlenza, S. MD, MPH. 2003. New York City Department of Health and Mental Hygiene. NYC Integrated Epi Profile Power Point Presentation (November 7, 2003).
[55] Sotheran, J. & E. Waddell. 2003. *Delayed Entry to HIV Care*. Center for Applied Public Health, Mailman School of Public Health. New York: Columbia University.
[56] Song, J., et al. p. 5.

utilization among persons with AIDS.[57,58] As stated in the *Journal of the American Medical Association:* "The life expectancy of an HIV-infected homeless person might well be increased more by $15,000 of housing (or treatment for mental illness or chemical dependency) than by $15,000 of antiretroviral therapy. Where possible, stabilization of housing and health problems is a priority."[59]

The Impact of New York's Housing System for Persons with HIV/AIDS

The benefits of the NYC EMSA housing intervention on the health of New Yorkers living with HIV/AIDS are obvious. In addition to the unprecedented size of the intervention, New York City's housing system for persons with HIV/AIDS has demonstrated that appropriate housing can provide vulnerable persons remarkable stability and connection to healthcare, in spite of multiple and serious co-morbidities. As discussed in Section IIIB below, the overwhelming majority of persons with HIV/AIDS surveyed as part of this study are stably housed, with stably housed persons (0-1 moves in the last 3 years) outnumbering unstably housed persons (3+ moves in the last 3 years) by a margin of 4.6 to 1. Ninety-five percent of survey respondents report a relationship with a primary care provider, and 77% of all respondents report participation in the Highly Active Anti-Retroviral Therapy (HAART). These outcomes are particularly remarkable in light of complex life issues that substantially increase the risk of homelessness and housing instability: criminal history (43%), mental health issues (55%), and substance use issues (61%).

> **New York City's unprecedented investment in housing for persons with HIV/AIDS has had a significant impact not only to improve the health status of New Yorkers with HIV/AIDS, but simultaneously to reduce homelessness overall, to care for the homeless mentally ill, and to provide housing to persons with chronic substance use problems that would otherwise be on the streets or in City shelters.**

The HIV/AIDS housing intervention also has operated in a number of other ways to improve the health of the community. As noted above, the availability of HIV-related housing resources was an important factor in the dramatic 37% decline in single homelessness in the first half of the 1990s. NYC's policy of providing housing for homeless persons with HIV/AIDS outside of crowded

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[57] Arno, P., et al. 1996. "The Impact of Housing Status on Health Care Utilization among Persons with HIV Disease." *Journal of Health Care for the Poor and Underserved 7(2)*: pp. 36-49.

[58] Brickner, P., B. Scanlan, & B. Conanan. 1986. "Homeless Persons and Health Care." *Annals of Internal Medicine 104(3)*: pp. 405-9.

[59] Bangsberg, D., et al. 1997. "Protease Inhibitors in the Homeless**."** *Journal of the American Medical Association 278*: pp. 63-65.

congregate shelters undoubtedly played a significant role in the control and prevention of the threatened tuberculosis epidemic of the early 1990s. The number of persons with tuberculosis identified in New York City's congregate shelter system was 748 in 1991 and 293 in 1994.[60] From 1992 through 1994, there was a 21% decrease in reported cases of tuberculosis in New York City, in contrast to a near-tripling of tuberculosis patients in the City between 1978 and 1992.[61] The number of persons served in the HIV/AIDS housing system with histories of mental health hospitalizations (23% of survey respondents) also indicates that HIV housing resources play an important role in meeting the needs of the homeless mentally ill in the City.[62] And, as consumers interviewed for this study confirmed, housing provided on the basis of an HIV diagnosis is in some cases the first appropriate housing made available to persons whose histories of substance use problems have led to recurring episodes of homelessness.[63]

New York City's intervention has demonstrated that a group of persons often deemed "unhouseable" by government and some social service providers can and will take advantage of permanent housing opportunities in their communities. While there continues to be a significant minority of New Yorkers with HIV illness and AIDS who remain homeless or unstably housed, the overall stability and connection to care among users of HIV-specific housing resources has demonstrated that homeless persons with HIV/AIDS, including those who are chronically mentally ill and/or chemically dependent, can live in independent settings if provided with necessary supports, that they will voluntarily access supportive services that they perceive to be relevant and respectful, and that they will, once stably housed, become active participants in their own medical and psychosocial care. The City's approach has promoted public health by ensuring that persons with HIV/AIDS have the means to preserve individual health.

The Current Homelessness Crisis

The recent dramatic increase in the numbers of homeless New Yorkers poses a clear threat to the public health gains achieved through New York City's unique response to the housing needs of persons with HIV/AIDS. Beginning in the mid-1990s, the population of homeless single adults in

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[60] Frieden, T. R., et. al. 1995. "Tuberculosis in New York City – Turning the Tide." *New England Journal of Medicine 333(4)*: pp. 229-233.
[61] Ibid.
[62] See Section III C below.
[63] HNA, Key Informant Interviews (2003).

shelters and on the streets began to rise again in New York City; and during 2003, the number of homeless New Yorkers residing in shelters each night reached the highest point in New York City history. In December 2003 more than 38,400 homeless men, women and children were sleeping each night in the New York City shelter system, including 16,600 children, 13,300 adult family members, and 8,500 single adults. Overall, the homeless shelter population has increased by 82% since 1998 (from 21,100 people in shelters each night to 38,400 currently). While the number of sheltered families has increased most dramatically (up 105% in the last five years), the number of homeless single adults has increased by 34% since 1994, and the number of homeless single adults currently sleeping in shelters, 8,500, is at the highest point since 1990.[64]

The number of emergency housing requests by New Yorkers with HIV/AIDS has also increased dramatically. Approximately 35% of all newly admitted HASA clients are determined to be homeless and eligible for direct emergency housing placement services.[65] In 2003 the number of homeless persons with HIV/AIDS in emergency and transitional housing placements reached an all-time high, with almost 3,000 placements made in December 2003, and 2,050 units occupied on a given night.[66] To put those numbers in context, during the entire fiscal year 2001, HASA made a total of 13,000 placements in emergency transitional programs and commercial single room occupancy and welfare hotels.[67] In contrast, HASA made almost 3,000 emergency transitional and commercial SRO placements in the one month of December 2003 alone – a trend which, if it continues, represents almost a 300% increase in emergency placements in just two years.[68]

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[64] Coalition for the Homeless. 2003. *State of the Homeless 2003*. New York, New York. http://www.coalitionforthehomeless.org.
[65] NYC HRA HASA. Interview with HASA Representative, May 17 2002.
[66] The number of placements, 2,889, represents 2,050 individual clients, some of whom presented as homeless more than once during the month of December.
[67] NYC HRA HASA. 2001. *Quarterly Performance Report July 2001-September 2001*. New York, New York.
[68] NYC HRA HASA. *HASA Facts*. New York, New York: Dec. 2003.

II. B. HOUSING IS HEALTHCARE

Housing status and stability are key determining factors in an individual's ability to access ongoing health care, and to benefit from HAART and other life-sustaining HIV treatments.

Housing has served as a critical element of systems of health care and HIV prevention for persons with HIV/AIDS in the NYC EMSA. As a national, federally-funded examination of HIV/AIDS and homelessness concludes, "housing for homeless people should be funded as a preventive health measure."[1] The clinical and public policy recommendations resulting from that study note that the Agency for Health Care Policy and Research's HIV Costs and Services Utilization Study (HCSUS) has revealed that large proportions of persons living with HIV in need of medical care have not received it because of competing subsistence needs such as food, housing, or transportation.[2] "An essential element of successful HIV/AIDS care is housing, which provides a place to store medication and food, a stable water supply, bathroom facilities, a secure place to rest, a dependable contact location, protection from harm, emotional security and hope."[3]

With the advent of protease inhibitor therapy treatment, and its significant impact upon morbidity and mortality, stable and adequate housing has become especially critical. The HIV/AIDS epidemic has been transformed in recent years by the introduction of Highly Active Anti-Retroviral Therapy (HAART). Antiviral medications, taken in various combinations, can significantly improve the health and dramatically extend the lives of people with HIV.[4] Not every person with HIV/AIDS, however, benefits equally from HAART. Side effects can be unpleasant or even unbearable, and treatment protocols are complicated and demanding, requiring the coordination of multiple medications with different dosing schedules and different meal requirements. All people with HIV/AIDS require stability and support to fully benefit from the new treatments; co-morbidities such as homelessness, drug use and mental illness make treatment adherence extremely difficult.[5,6] Not surprisingly, stable

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[1] Song, J., et al. "HIV/AIDS & Homelessness: Recommendations for Clinical Practice and Public Policy." National Health Care for the Homeless Council, Health Care for the Homeless Clinician's Network. 1999: p.1. www.nhchc.org.

[2] Ibid., p. 11, citing Cunningham W., et al. 1998. "The impact of competing subsistence needs and barriers on access to medical care for persons with human immunodeficiency virus receiving care in the United States." *Journal of General Internal Medicine 13 supp*: p. 60.

[3] Ibid., p. 12.

[4] Deeks, S., et al. 1997. "HIV-1 Protease Inhibitors: A Review for Clinicians." *Journal of the American Medical Association 27*: pp. 145-153.

[5] Aidala, A, T. Jackson, & N. Mayorga-Fuentes. 2000. *Housing, Health & Wellness Study: Final Report.* Mailman School of Public Health. New York: Columbia University.

housing is associated with increased likelihood of taking these therapies.[7] Since physicians may withhold protease therapy from patients who they believe cannot or will not adhere to this regimen[8]-- an ethically debatable practice -- housing may quite literally become a key to health.

The close relationship between stable appropriate housing and healthcare for people with HIV/AIDS has been demonstrated through substantial research showing concrete outcomes such as increased connection to primary health care, and increased participation in and compliance with medication regimes. These research findings are further supported by results on housing stability and connection to health care from the consumer survey conducted as part of this study.

Ninety-five percent of consumers surveyed report a relationship with a primary care provider, and 77% report participation in HAART.

Overall housing stability among consumer survey respondents resulted in stable connections to healthcare.[9] Despite the presence of high rates of mental health and substance issues, consumer survey respondents reported a significant level of connection to primary health care, with 95% overall reporting a relationship with a primary care provider, and 77% reporting participation in HAART. One-quarter of all consumer survey respondents reported, however, that a lack of appropriate housing had at some point interfered with their ability to adhere to HAART or other HIV medications. Respondents also reported differences in health care connection by housing model and race/ethnicity. Ten percent of SRO residents, who experience the greatest housing instability, reported that they need but do not have a primary care provider. Residents of independent housing reported the highest level of HAART participation (82%), and SRO residents reported the lowest (71%). African American respondents reported the lowest rate participation among ethnic groups (73% compared to 86% among whites), and all non-white respondents were almost twice as likely as white respondents to not be on HAART (14% non-participation among whites compared to 27% among African Americans, 24% among Asian/Pacific Islanders, and 23% non-participation among Hispanic/Latino/as).

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[6] Song, J., et al. "HIV/AIDS & Homelessness: Recommendations for Clinical Practice and Public Policy." National Health Care for the Homeless Council, Health Care for the Homeless Clinician's Network. 1999: pp. 32-33. www.nhchc.org.

[7] Messeri, P., & G. Weinberg. 1997. "Introduction of Combination Therapies." *C.H.A.I.N Update Report #1.* Community Health Advisory & Information Network (C.H.A.I.N). New York: Columbia University School of Public Health.

[8] Sontag, D. & L. Richardson. "Doctors Withhold HIV Pill Regimen from Some." *New York Times.* March 2, 1997: Section 1, p.1.

[9] See Section IIIB below for an analysis of survey respondents' housing stability and connection to health care.

These responses are consistent with substantial research showing that housing status and stability are key determining factors in an individual's ability to access ongoing health care, and to benefit from HAART and other HIV treatments. An ongoing study by Columbia University's Center for Applied Public Health shows that lack of housing is associated with remaining outside of medical care and lack of access to treatment options for persons with HIV, while improved housing is associated with improved medical outcomes for formerly homeless or unstably housed persons.[10] Likewise, the New York City CHAIN studies have shown that homeless people with HIV who get any kind of practical housing assistance are almost four times more likely to enter into medical care than those who get case management but not housing assistance, and are twice as likely to enter into appropriate continuing care. The most consistent predictor of remaining unconnected to medical care identified through the CHAIN studies is homelessness. Because the CHAIN studies are longitudinal, they have the advantage of examining behavior over time, and have found consistently that one of the most important factors influencing an individual's use of combination therapy is housing status.[11]

The effect of housing on tuberculosis control is another illuminating example of the impact of housing on health. As the current Commissioner of New York City's Department of Health and Mental Hygiene has stated succinctly, "the relationship between homelessness, substandard housing, and tuberculosis is well recognized."[12] From 1992 through 1994, there was a 21% decrease in reported cases of tuberculosis in New York City, in contrast to a near-tripling of tuberculosis patients in the City between 1978 and 1992. The decrease resulted from a confluence of efforts, among which the City's policy of providing private housing for homeless persons with HIV/AIDS played a significant role; the number of persons with tuberculosis in the congregate shelter system was 748 in 1991, and 293 in 1994.[13] In 2001, the number of confirmed tuberculosis cases in New York City declined for the ninth consecutive year, to 1,261 cases for the year, the lowest ever reported. This is a 66.9% decrease from the 3,811 cases at the peak of the recent epidemic in 1992.[14]

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[10] Aidala, A., et al. Housing is Healthcare for Persons Living with HIV. Power Point Presentation. Center for Applied Public Health, Mailman School of Public Health. New York: Columbia University. (Cited with permission of the author).
[11] C.H.A.I.N. "Housing and Services among Persons Living with HIV/AIDS" *CHAIN Update Report #32* (2000); "Housing and Health Care among Persons Living with HIV/AIDS" *CHAIN Update Report #39* (2001); "Housing Status and Health Outcomes among Persons Living with HIV/AIDS" *CHAIN Update Report #41* (2001).
[12] Frieden, T.R. 1996. "Clarifying the Issues in Tuberculosis Control." *American Journal of Public Health 267*: p. 86.
[13] Frieden, T. R., et al. 1995. "Tuberculosis in New York City – Turning the Tide." *New England Journal of Medicine 333(4)*: pp. 229-233.

In particular, supportive housing has been shown to improve treatment adherence. The Housing, Health and Wellness Study, a collaborative project between the Mailman School of Public Health of Columbia University and Bailey House, Inc., compared the experiences of long-term residents (at least 4 years) of Bailey House's supportive housing programs, to those of CHAIN study participants with similar histories of homelessness, in establishing and maintaining relationships with primary care providers and taking advantage of new treatments. The results demonstrated that supportive housing has a striking impact on adherence to HAART regimens: significantly fewer supportive housing residents reported missing pills (11% compared to 25%); supportive housing residents had a significantly higher rate of exact adherence to treatment regimens (67% compared to 54%); and none of the residents of supportive housing skipped doses frequently, while 9% of CHAIN study subjects described missing pills often. The study also found that case management, self-help drug treatment, mental health services and direct housing services had the greatest effects on treatment adherence. As the Housing, Health and Wellness Study concluded, "[h]omeless persons often deemed unlikely to comply with difficult therapies can thrive on them when they have secure housing with supportive services responsive to their complex needs."[15]

The results of key informant interviews and focus groups conducted as part of this study also confirm the critical role of housing status and stability in ensuring access to health care and adherence to complicated medical regimens. Consumers note that emergency hotel placements are often time-limited, resulting in disruption, uncertainty and stress; that a particular hotel placement might be located far from a person's medical and social service providers; and that the hotels often lack cooking facilities, making it difficult and expensive to meet nutritional requirements related to treatments. Consumers "doubled up" with family members report that the uncertainty and stress involved in their living situations make it difficult to keep appointments, take medicines regularly, and eat properly. Some unstably housed consumers found it a "full time job" to find housing and feed themselves, making it difficult to comply with health care appointments and treatments.[16]

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[14] New York City Department of City Planning. 2002. *Annual Report on Social Indicators.* http://www.ci.nyc.ny.us/html/dcp/html/pub/socind02.html/.

[15] Aidala, A, T. Jackson & N. Mayorga-Fuentes. 2000. *Housing, Health & Wellness Study: Final Report.* Mailman School of Public Health. New York, Columbia University.

[16] HNA, Key Informant Interviews (2003).

Providers of health and social services note that housing loss often results in the interruption of ongoing health care and treatments. Clients in the emergency housing system are repeatedly lost to follow up when they move between hotels, either because a health or social service provider can no longer locate a client, or because the person has been moved to another part of the City and does not have the means to travel to health care or social service appointments. Health care can also be interrupted as part of the "fallout" when a client is discharged from a supportive housing program or evicted from permanent housing.

Key informants noted that, combined with stable housing, services that can support treatment adherence are essential to maintaining and improving health outcomes for persons with complex life issues. Supportive housing providers described residents with serious mental health and substance use issues who have been able to maintain consistent health care and adherence to treatments when provided with necessary supports. Treatment education, intensive case management and access to on-site primary care services were cited as effective means of supporting treatment adherence. Assistance with basic living skills was also noted as an important intervention for clients with long-term histories of homelessness and co-occurring mental health and/or substance use histories. It was observed that for some consumers, the support of a residential community or participation in a medical or social day program is an essential component of health care.[17]

Key informants also stressed the need for continued research to measure the impact of housing resources and related supports on medical treatment access and adherence, and to support the connection between stable housing and improved health access and outcomes. A key informant researcher suggested that these relationships could be examined by matching shelter use data with Medicaid data and death certificates; another suggested an examination of client level Medicaid utilization and mortality rates for persons with HIV/AIDS with different housing histories and/or in different models.[18]

[17] Ibid.
[18] Ibid.

II. C. THE DEVELOPMENT OF HIV/AIDS HOUSING RESOURCES

For more than a decade New York government agencies and housing providers have been at the forefront of a "housing first" approach to the needs of homeless and unstably housed persons with HIV/AIDS, including: prevention of homelessness through support of at risk persons in current housing; placement in permanent housing as soon as possible as the first step towards stabilization, rather than requiring homeless persons to demonstrate housing readiness; low-threshold admissions that do not screen out persons with the greatest current support service need who cannot demonstrate "clean time," stable housing histories or other prerequisites; provision of long-term support services for persons with chronic problems that threaten housing stability; de-linking the availability of housing from compliance with a service plan; and using Medicaid and grant funded services as "wrap-around" supports to sustain housing stability.[1,2,3]

As described in Section IIA above, since the late 1980s people with HIV/AIDS, advocates and service providers have engaged in multifaceted advocacy for the expansion of HIV/AIDS housing resources, and have worked closely with government at the federal, state and local levels to develop, fund and implement a wide array of housing strategies and models to meet the needs of New Yorkers with HIV/AIDS. Existing supportive housing models are described in detail in Section II E below. This section discusses the overall development of HIV/AIDS housing resources in the NYC EMSA, including the operation of the rental assistance program administered by the HIV/AIDS Services Administration (HASA) in New York City and local departments of social services in the Tri-County Region, the development of the permanent supportive housing system, and the funding sources used for the development and operation of this HIV-specific housing.

HIV/AIDS housing resources in NYC have expanded rapidly in response to the growing epidemic, from 3,600 enhanced rental subsidies and 186 supportive units in 1990, to 20,000 rent subsidies and almost 6,500 units of supportive units at the end of 2003; the rate of growth in the supportive housing system, however, has slowed in recent years while the number of persons living with HIV/AIDS continues to rise.

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[1] Corporation for Supportive Housing. 2002. *The Compact to End Homelessness.*
[2] National Alliance to End Homelessness. 2001. "A Plan, Not a Dream: How to End Homelessness in 10 Years." http://www.endhomelessness.org/.
[3] Beyond Shelter. 1999. *The "Housing First" Program for Homeless Families: Methodology Manual.* http://www.beyondshelter.org.

Eligibility for publicly subsidized HIV-specific housing resources in the NYC EMSA is based on HIV diagnosis and financial resources. Most persons with HIV/AIDS in need of housing supports and other public assistance in New York City currently receive services through their connection to HASA, a division of New York City's Human Resources Administration (HRA). Any person who currently has or has ever had a diagnosis of AIDS or symptomatic HIV illness as defined by the New York State Department of Health AIDS Institute is eligible for services through HASA, which may include benefits such as enhanced nutritional, transportation and rent allowances. HASA also provides same day emergency housing assistance to eligible persons who are homeless or potentially homeless. HASA works with people who do not have sufficient monthly income to pay rent, purchase food, or pay for utilities, and whose resources are less than $2,000,[4] are facing a one-time emergency situation, are homeless or pending eviction, or need assistance with activities of daily living. HASA case managers are supposed to give their clients more personal service than regular public assistance workers: they should act as advocates and counselors, assist with benefits, visit clients at home, and, if necessary, process requests for homecare and nursing services.[5]

As of December 2003, 28,600 New Yorkers with HIV/AIDS were receiving rental assistance or other housing aid (23% of the 129,100 total persons estimated to be living with HIV/AIDS as of 2003, and 34% of the 87,000 persons estimated to be diagnosed). Approximately 8,000 persons were receiving direct HIV-specific housing services, including 5,200 persons in permanent supportive housing placements, 1,300 in transitional supportive housing and 1,500 in commercial single room occupancy hotels; the remaining 20,500 persons were receiving rental assistance.[6]

By comparison, HIV-specific housing resources are extremely limited in the Lower Hudson Tri-County Region. The inventory of HIV-specific supportive housing developed as part of this study includes 140 units of permanent supportive housing, primarily in Westchester County. Rental assistance is provided through the use of HOPWA and Ryan White funding, and, to a limited extent, through the New York State program of enhanced rental assistance for persons with AIDS and HIV-related illness.

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[4] Resources of up to $3,000 are allowed if there is a household member who is 60 years of age or older. Income-eligible persons can also have a car with a fair market value of $4,650 and a burial account, at a bank, of up to $1,500.
[5] Gay Men's Health Crisis (GMHC). 2003. http://www.gmhc.org/.
[6] NYC HRA HASA. *HASA Facts.* New York, New York: Dec. 2003.

Access to HIV-specific housing resources in the Tri-County Region is also complicated by eligibility requirements that turn on periodic reassessment of medical status. Ironically, HIV-related housing resources can be lost if health status improves.[7]

1. New York's Rental Assistance Program for Persons with HIV/AIDS

The enhanced tenant-based rent subsidy for New Yorkers with HIV illness and AIDS enables more than 20,000 persons with HIV/AIDS in the EMSA to remain housed in the private housing market.

Rental assistance to enable persons to remain in their own homes, or to secure housing in the private market, has historically served as the most significant type of housing assistance provided for New Yorkers with HIV/AIDS. Financial assistance, short-term emergency assistance, and long-term, on-going rent supports are all crucial tools to enable persons with HIV/AIDS to continue living independently. These programs rely on housing units available in the private market.

The basic forms of entitlement assistance for low income New Yorkers with HIV/AIDS are income benefits such as Supplemental Security Income (SSI), Social Security Disability Income (SSDI), and public assistance (Safety Net Assistance for singles and Temporary Assistance for Needy Families for families). These cash benefits alone, however, are rarely sufficient to pay housing costs. Many persons with HIV/AIDS who are willing and able to live in private market housing need additional short or long-term rental assistance to subsidize their rents.

Short-term rental assistance may be available for persons with HIV/AIDS who are able to live on entitlements or other income most of the time, but are faced temporarily with extraordinary medical or living expenses. With short-term assistance (usually less than six months) for rental/mortgage payments and/or utility bills, many persons with HIV/AIDS regain enough financial stability to retain their current living situations. Funding for short-term rental assistance is available from local departments of social services ("one-shot" assistance), Housing Opportunities for Persons With AIDS (HOPWA) programs (such as the Sustainable Living Fund in NYC), and through other government programs (such as the Shallow Assistance Program in the Lower

[7] HNA, Key Informant Interviews (2003).

Hudson Tri-County Region, funded in part through federal McKinney Act homeless housing assistance).

New York City's Sustainable Living Fund, overseen by the HOPWA Master Contractor, has proven to be an essential source of rental assistance for individuals and families living with HIV/AIDS who have difficulties in accessing other permanent housing resources, particularly undocumented persons who are not able to establish eligibility for City/State public assistance programs. The Fund provides emergency and short-term rental assistance to a limited number of qualifying individuals and families, and assists such clients in securing and maintaining housing while efforts to secure a stable source of rental assistance can proceed. Currently approximately 130 households receive ongoing rental subsidies through the program at any given time. Key informants noted, however, that available funding is so limited that it is difficult or impossible for the program to commit to providing additional ongoing rent subsidies.

Long-term rental assistance that can be used to maintain or secure a home makes the most significant impact on the housing circumstances of many New Yorkers with HIV/AIDS. The program of enhanced rental assistance for New Yorkers with HIV/AIDS has been particularly significant. Established by New York State regulation in the mid-1980s, the program provides for enhanced "shelter allowance" payments for individuals and families with AIDS or clinical, symptomatic HIV illness as defined by the New York State Health Department AIDS Institute.[8] The program authorizes rental subsidies for households with a member living with HIV/AIDS of up to $480 in rent for the first member of the household, in contrast to the regular public assistance "shelter allowance" of $215, and additionally authorizes increments of $330 for each additional member of the household.

These amounts have remained unchanged since the program was established more than fifteen years ago. Like all public assistance programs in New York State, the actual amount of the rental assistance benefit to the household is calculated by subtracting any income received (such as SSI or SSDI for disabled persons) from the total rent and other needs of the household (equal to a cash allowance of $330 per month in New York City and $137 per month in the Tri-County Region). Because the program adds funding increments for additional family members, it is a better housing

[8] New York State Codes, Rules and Regulations. Title 18. Section 352.3(k).

option for families with a member with HIV/AIDS. The enhanced rental assistance is an entitlement for persons meeting the eligibility requirements, though not all local social service districts in the State participate in the program. The program is funded with a combination of State and local tax-levy dollars, with some additional support from federal sources.

Participation in and administration of the enhanced rental assistance program differs by local social services district. Since the mid-1980s, it has been New York City policy to provide persons with AIDS and HIV-related illness access to enhanced rental assistance to maintain or secure housing. This policy was codified in 1997 in New York City Administrative Code Section 21-128, which requires that HASA provide eligible persons with housing subsidies, including enhanced rental assistance for persons with HIV/AIDS, within twenty business days, and establishes a time line of thirty calendar days for processing completed applications. [9]

As of December 2003, more than 20,000 households were receiving rental assistance through HASA to live independently.[10] While the Assessment Team did not have access to HASA data on all recipients of rental assistance, data were collected through the consumer survey conducted as part of this study on a representative sample of 950 persons receiving the benefit. Not surprisingly, almost 94% of consumers surveyed who report receiving rental assistance identify themselves as HASA clients; compared to only 48% of respondents not receiving rental assistance.[11] Key informants interviewed by the Assessment Team stressed that this market-rate, tenant-based rent program is unique in its scope, extremely effective for the majority of New Yorkers with HIV/AIDS who require housing assistance, and should serve as a model for meeting housing needs of other extremely poor and permanently disabled persons.[12]

Chart IIC-1, included at the end of this section, illustrates the steady increase in HASA rental assistance between 1992 and 2003, particularly after 1997, when eligibility for HASA services was expanded through Local Law 49 to all persons with HIV-related illness. The chart also shows the dominant role played by rental assistance in relation to the other housing supports available for

[9] Local Law 49 of 1997, found at Sections 21-126 to 128 of the Administrative Code of the City of New York, requires HASA staff to provide persons with HIV/AIDS with certain benefits and services, including medically appropriate transitional and permanent housing, and housing subsidies such as the enhanced rental assistance for persons with HIV/AIDS.
[10] NYC HRA HASA. *HASA Facts*. New York, New York: Dec. 2003.
[11] HNA, Consumer Survey (2003).

persons with HIV/AIDS in New York City. Between 1998 and 2003 alone the program grew from 11,500 households to over 20,000, a 74% increase. The chart also depicts, however, that the program is losing ground and is not growing at the same as pace as AIDS prevalence in New York City.[13]

In order for the rental assistance program to continue to serve as a viable housing resource, HASA clients and housing providers must be able to obtain and maintain private market apartments at rents that fall within HASA's rent guidelines. Even the enhanced rental assistance leaves clients with a narrow and ever-shrinking range of apartments that they can afford, and competition for those units is fierce.

As is described in more detail in Section IVC below, the private housing market in New York City is increasingly inhospitable to the needs and resources of low-income people with HIV/AIDS. The affordable housing stock is limited, diminishing, and aging, and rental prices have increased. Results of the consumer survey show that 84% of all survey respondents report a total rent of $999 or less; 24% pay $399 or less; 16% pay $400 to $599 in rent; 26% pay $600 to $799 in rent; and 18% pay $800 to $999.[14] Vacancy rates are extremely low at rent levels at which rental assistance participants seek apartments: in 2002, the vacancy rate for units with rents of less than $500 was 1.54%, and 1.42% for units with rents between $500 and $699, in contrast to a vacancy rate of 4.36% for units with rents between $1,000 and $1,749, and 9.25% for units with rents of $1,750 or more.[15] The map of independent HIV/AIDS housing units provided in Exhibit IIC-2 illustrates that most recipients of rental assistance are clustered in lower-income neighborhoods.

In response to the high cost of housing in New York City, HASA administration of the enhanced rental assistance program includes a process for consideration of requests for "exceptions to policy" authorizing rents in excess of the amounts set by State regulation. Decisions by HASA regarding the amount of enhanced shelter allowance allowed are made on a case-by-case basis through the Case By Case Financial Assessment (CBCFA) procedure. Historically, HASA had never identified a policy or standard to guide payment amounts. In a letter dated September 2001,

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[12] HNA, Key Informant Interviews (2003).
[13] NYC HRA HASA. *HASA Facts*. New York, New York: Dec. 2001-Dec. 2003.
[14] HNA, Consumer Survey (2003).
[15] New York City Department of Housing Preservation and Development. Housing and Vacancy Survey Report. New York, New York: 1999 & 2000.

however, HASA announced that it had instituted the use of United States Department of Housing and Urban Development (HUD) Section 8 Payment Standards in the processing of CBCFAs to guide the determination of rental assistance subsidies provided to eligible HASA clients and their families.[16] Section 8 payment standards currently in effect in New York City are at 110% of HUD's Fair Market Rents (FMRs) for the area, and set the maximum rent amount for a studio apartment with utilities at $933, and the rent for a two-bedroom apartment at $1,180.[17] Even at these levels, however, key informants report that it is extremely difficult to locate private market apartments within the eligible rent levels, and even more difficult to find landlords willing to rent directly to consumers.[18] Moreover, as discussed in Section IIIE below, a significant number of consumer survey respondents report that they have encountered housing discrimination based on, among other things, HIV/AIDS status (23%), income source (25%) and, for formerly incarcerated persons, criminal history (13%).

As of December 2003, 65% of HASA's caseload was receiving some form of rental subsidy – 19% were receiving standard rental assistance (TANF, Safety Net, or Temporary Disability Assistance), 13% were receiving enhanced rental assistance, and 34% were receiving "above enhanced rental assistance."[19] This means that almost two and a half as many HASA clients received the higher level of assistance because HASA itself recognized that these standards, set by New York State regulations, were unrealistic within the New York City housing market. Despite this circumstance, 34% of HASA's caseload is required by New York State regulations to justify, on a case-by-case basis, a more realistic rent subsidy, placing a burden both on an overworked agency and an often fragile client. In addition, it seems unlikely that the other 31% of HASA clients receiving lesser subsidies were able to find stable, safe housing without a great degree of difficulty.

The high rent burden borne by persons with HIV/AIDS who rely on the enhanced rental assistance program was also identified by consumers and providers as a threat to the housing stability of persons who use this rent subsidy to live independently. Because the actual amount of the rental assistance benefit to the household is calculated by subtracting income received (such as SSI or SSDI for disabled persons) from the total rent and other needs of the household (limited to

[16] A copy of the letter is on file with the Hudson Planning Group.
[17] New York City Housing Authority, Leased Housing Department (2003). (FMRs in effect as of October 2003).
[18] HNA, Key Informant Interviews (2003).
[19] NYC HRA HASA. *HASA Facts.* New York, New York: Dec. 2003.

$330 per month in NYC to cover utilities, food and other needs), a single person receiving a standard SSI benefit of $639 and with a monthly rent of $993 (110% of FMR) would be responsible for paying $309 per month towards rent, which represents a 48% rent burden.[20] This calculation is consistent with the results of the consumer survey; consumers in independent housing report an average rent burden of 49%.[21] HUD defines a 50% rent burden as a severe housing hardship.

Despite these obstacles, the enhanced rental assistance program makes a tremendous impact. As set out in Section IIIC below, the average ratio of total rent to income reported by consumer survey respondents in independent housing is 124%, meaning that on average unsubsidized rents are greater than income. However, the ratio of out-of-pocket rent to income for this group is 49% on average. While a 49% rent burden still constitutes a severe housing hardship, the difference illustrates that persons with HIV/AIDS who receive rental assistance would not have access to the private market without this subsidy; many would undoubtedly experience homelessness. Instead, survey respondents in independent housing demonstrate the greatest housing stability (52% of all persons who moved 0-1 time in the last 3 years); and this housing stability, in turn, leads to positive health outcomes: 82% of consumer survey respondents in independent housing report participation in HAART, in contrast to 71% among SRO residents and 77% overall.[22]

Department of Social Services and HOPWA-supported rental assistance programs are the primary source of HIV/AIDS housing assistance in the Tri-County Lower Hudson Region. The local departments of social services in Putnam, Rockland and Westchester Counties report that they participate in the State-wide enhanced rental assistance program for persons with HIV/AIDS, but do not track the number of public assistance recipients that use the program. One significant barrier to the use of the program is the fact that these departments of social services do not provide "exceptions to policy" to approve rents in excess of the rents set by State regulation ($480 for a single).[23] Since, as noted above, the actual amount of the benefit to the household is calculated by subtracting any income received (such as SSI or SSDI for disabled persons) from the total rent and other needs of the household ($137 in the Tri-County Region), a single person receiving a standard

[20] See Section IVF below and Appendix D for examples of consumer budgets.
[21] See Section IIIC below for discussion of rent burden by housing model.
[22] See Section IIIB below.
[23] HNA, Key Informant Interviews (2003).

SSI benefit of $639 is not entitled to any rental assistance under the program ($480 + $137 = $617)[24]. All three counties in the Tri-County Lower Hudson Region use HOPWA funding to provide long-term rental assistance to certain households; these programs currently support approximately 125 households at a given time.[25] Rent burden in these programs is only 30% of income received, and key informants identified these rent subsidies as a more significant resource for persons with HIV/AIDS in the Tri-County Region than the enhanced rental assistance program.[26]

While rental assistance programs are successful in enabling many persons with HIV/AIDS in the NYC EMSA to secure and maintain housing, both key informants and the results of the consumer survey indicate the necessity of a range of "wrap around" support services for the substantial number of persons in independent housing whose housing stability is threatened by co-occurring mental health and/or substance use issues. Forty-eight percent of consumer survey respondents living in independent housing report substance use issues, 29% report co-occurring mental health and substance use issues, and one-third report histories of homelessness.[27] Key informants note in particular the need for supportive services to address social isolation and mental health issues among persons with HIV/AIDS in independent housing, and report that these are needs are not being addressed by any other system of care. Services identified by key informants as necessary to support persons in independent housing include intensive case management, medical and social day programs, and living skills training.[28] The nature and availability of these and other support service programs are discussed in Section IIF below.

[24] See Section IVF below and Appendix D for examples of consumer budgets.
[25] NYC Department of City Planning. 2002. *Consolidated Plan.* New York, New York.
[26] HNA, Key Informant Interviews (2003).
[27] See Section IIIC below.
[28] HNA, Key Informant Interviews (2003).

2. Supportive Housing Programs for Persons with HIV/AIDS

Development of both congregate and scatter site supportive housing programs for persons with HIV/AIDS began in the late 1980s as part of New York City's response to the crises of homelessness and HIV/AIDS. The City's SRO Loan Program (now the Supportive Housing Loan Program), established in 1987, represented a unique and creative approach to the need for development of new housing units, consolidating and leveraging multiple funding sources into one centrally administered and relatively easily accessed program at New York City's Department of Housing Preservation and Development (HPD). New York State's Homeless Housing Assistance Program (HHAP), also established in the late 1980s, similarly signaled a strong commitment to creating affordable permanent housing units for homeless persons in general, and for persons with HIV/AIDS in particular. These two programs contributed significantly to the creation of a receptive climate for development of permanent dedicated units, and to inducing providers of homeless housing to designate units specifically for persons with HIV/AIDS. As depicted in the map of supportive congregate housing provided at Exhibit IIC-2, many of these units are located in areas of Manhattan that otherwise might be unaffordable to many very low-income renters. HASA's Scatter Site I program, where not-for-profit providers lease private market apartments and provide them, with supportive services, to eligible clients, also was instrumental in establishing high standards of care and housing. As the map of supportive scatter site units indicates, however, because this program relies on the private housing market, units are more concentrated in lower-income areas.

One of the keys to the success of New York City's housing intervention has been the willingness and even requirement by HASA for supportive housing providers to adopt a "harm reduction" or "housing first" approach to program admissions. The concept of harm reduction was developed as a response to the threat of HIV infection and other harms associated with drug use and the fact that traditional abstinence models of housing and service delivery simply failed to reach many persons at risk.[29,30] Currently, programs that receive operating funding and referrals from HASA are not permitted by their contractual agreements to deny placement to applicants on the basis of past or present alcohol or drug use.

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[29] Newcombe, R. 1992. "The Reduction of Drug-Related Harm". *The Reduction of Drug-Related Harm: A Conceptual Framework for Theory, Practice, and Research.*

[30] Sorge, R. 1991. *Harm Reduction: A New Approach to Drug Services.* Health/PAC Bulletin. p. 22.

A harm reduction strategy is cited as a key component of the successful Health, Housing and Integrated Services Network that provides housing, health care and other supports to formerly homeless persons with disabilities in the Bay Area of California.[31] The network describes harm reduction as a "prioritization of goals in which immediate and realizable goals take precedence when dealing with users who cannot realistically be expected to cease their drug use in the near future," but notes that the strategy "does not conflict with an eventual goal of abstention."[32] A resident is not excluded or expelled from housing and services based on substance use alone, but rather "is held responsible for his or her behavior."[33]

An examination of one New York City housing program revealed that its harm reduction approach enabled homeless persons with HIV/AIDS and high rates of substance use (70%) and mental health (50%) issues to achieve not only housing stability (80% remained housed over a 2-year period), but also rates of sustained abstinence from alcohol and drugs (33%) that are comparable to those achieved through traditional drug treatment.[34]

A lack of harm reduction housing opportunities and techniques has been cited in Upstate New York and in other areas of the country as a significant barrier to the provision and maintenance of stable housing for persons with HIV/AIDS.[35,36,37]

The results of the consumer survey conducted as part of this study confirm that existing permanent supportive housing programs facilitate housing stability among a group of persons with significant multiple diagnoses and issues that are associated with housing instability. Respondents who were tenants of supportive housing were no more likely to be unstably housed (3+ moves in the last 3 years) than residents of independent housing, all other factors equal, and 56% of residents of supportive scatter site housing and 40% of supportive congregate residents reported stable housing

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[31] Lenoir, G. 2000. *The Network: Health, Housing and Integrated Services; Best Practices and Lessons Learned.* Corporation for Supportive Housing. http://www.csh.org/.
[32] Ibid., p. 4.
[33] Ibid., p. 4.
[34] Shubert, V. & M. Hombs. Nov.-Dec. 1995. "Housing Works: Housing Opportunities for Homeless Persons." *Clearinghouse Review*. pp. 740-51.
[35] Upstate New York and Long Island HIV/AIDS Housing Needs Assessment. Key Informant Interviews (2004). (Ongoing study being conducted by the Hudson Planning Group).
[36] The AIDS Foundation of Chicago. 2001. *Five Year Chicago Area HIV/AIDS Housing Plan*. p. 49.
[37] AIDS Housing Corporation of Boston, Massachusetts. 2003. *Moving Forward: A Massachusetts HIV/AIDS Housing Resources and Needs Assessment Report.* p. 59.

(0-1 move in the last 3 years), compared to 54% of persons in independent housing.[38] Consumers interviewed indicated that housing placements had enabled them to address a number of issues, some of which were more "pressing" than their HIV diagnosis – such as long -term histories of harmful use of drugs, and repeated involvement with the criminal justice system.[39]

As depicted in Chart IIC-1 at the end of this Section, the City's investment in permanent congregate and scatter site supportive housing, while significant, is clearly inadequate when viewed in relation to the increase in AIDS prevalence in New York City. By the mid-1990s, improved therapies had reduced HIV-related deaths dramatically, and while the incidence of new AIDS cases also declined, the absolute number of persons with HIV/AIDS has grown significantly. The result is a dramatic increase in the number of persons living with HIV/AIDS and in need of housing and services.[40] While the number of persons living with AIDS doubled between 1994 and 2000, the number of new supportive housing units brought on line during that period has increased only slightly. In the last five years HASA has added no new units of Scatter Site I supportive housing, in which the provider agency holds the primary lease and supportive services are ongoing. Instead, HASA is pressing a scatter site model in which clients must be the primary leaseholders and housing related support services are provided for only a limited time, typically six months. The immediate forecast for future production, while significant, pales in comparison to the number of people in need of housing: HPD's Supportive Housing Loan Program has 47 units in construction, and 268 units in the pipeline.[41]

3. Funding Sources for Developing HIV/AIDS Housing

As described above, New York City has demonstrated path breaking initiative in the development of housing for people with HIV/AIDS, and the result has been the creation of an impressive inventory of supportive housing units, primarily sponsored by not-for-profit developers. These housing programs are expensive to develop and do not generate large rental revenues. As a result, they almost always require some form of public subsidy. In most cases, an HIV/AIDS housing program will rely on multiple funding sources to cover predevelopment costs, development, operations, and, in the case of supportive housing programs, service provision. New York City

[38] HNA, Consumer Survey (2003).
[39] HNA, Key Informant Interviews (2003).
[40] See Section IVA below for a detailed examination of current and projected HIV/AIDS housing needs.
[41] HNA, Key Informant Interviews with HPD Staff (2003).

providers have become skilled at navigating and layering complex funding streams. Some projects have involved more than one non-profit, teaming an organization with expertise in housing development and operations with an experienced provider of HIV/AIDS supportive services.[42] A full description and analysis of the various funding resources available to support housing for persons with HIV/AIDS, and the processes through which such funding is awarded, are set out in Appendix E to this report. Section IID below outlines current government spending for HIV-specific housing resources in the EMSA. The following discussion presents a summary of the types of funding needed for the development and operation of a supportive housing project, and highlights some of the most frequently used sources.

The inadequacy of available funding for both capital development and service provision is a serious roadblock to the creation of the new units of affordable and/or supportive housing that will be necessary in order to meet the growing housing needs of persons living with HIV/AIDS in the NYC EMSA. Key informants interviewed by the Assessment Team noted that while there may be more options available to fund HIV/AIDS housing than other special needs housing, current funding falls far short of existing and projected need, and the funding available for all types of affordable and supportive housing has remained stagnant or has been cut significantly in recent years. Key informants from the Tri-County Region, moreover, report that no local HIV-specific resources are available for housing development, and that existing programs have been funded largely with mental health resources and private funding.[43]

Providers seeking to develop housing units for persons with HIV/AIDS must secure funding for predevelopment and acquisition, development, operation, and, if appropriate, supportive services.

Predevelopment

Predevelopment costs include conceptualization, feasibility, and acquisition/preconstruction expenses. Most predevelopment costs ultimately can be reimbursed from capital funding sources, which assume that an organization will cover its early predevelopment expenses out-of-pocket until capital funding is secured. Many organizations, however, do not have the resources to fund these expenses, and, if the contemplated project does not materialize, the organization's predevelopment

[42] These relationships are illustrated in several of the housing profiles included in Section IIE.
[43] HNA, Key Informant Interviews (2003).

expenses will not be reimbursed. As detailed in the discussion of current challenges in Section IVD below, limited predevelopment funding serves as a significant barrier to the development of new housing. A private foundation grant or a recoverable grant functioning as an interest-free loan is often the best option to cover predevelopment. In New York City, funds for predevelopment expenses are available from the Corporation for Supportive Housing (CSH), the Enterprise Foundation, the Local Initiatives Support Corporation (LISC), the Non-profit Finance Fund (NFF), and community development units of banks. In some cases, capital funding sources will advance funds to qualified organizations to cover predevelopment expenses. The New York State Homeless Housing Assistance Program (HHAP) will advance funds to cover most predevelopment expenses for projects for which it has awarded capital funding. The New York State Division of Housing and Community Renewal (DHCR) provides seed money in the form of loans of up to $45,000 to eligible not-for-profits.

Capital Development

Capital development costs can be secured from multiple sources, and most organizations will need to draw on several different types of funding to cover capital costs for a project, such as grant funding, long-term debt, and tax credit financing. Organizations often package capital funding streams strategically, by first securing less competitive funding, to improve the project's chances of attracting additional, more competitive funding. Project start-up costs, such as furniture and equipment, typically are included in capital development funding or supportive services funding. Two important and accessible capital funding sources for developing housing for persons with HIV/AIDS in New York City are the New York City Department of Housing Preservation and Development (HPD)'s Supportive Housing Loan Program and the New York State Homeless Housing and Assistance Program (HHAP).

Operating Costs

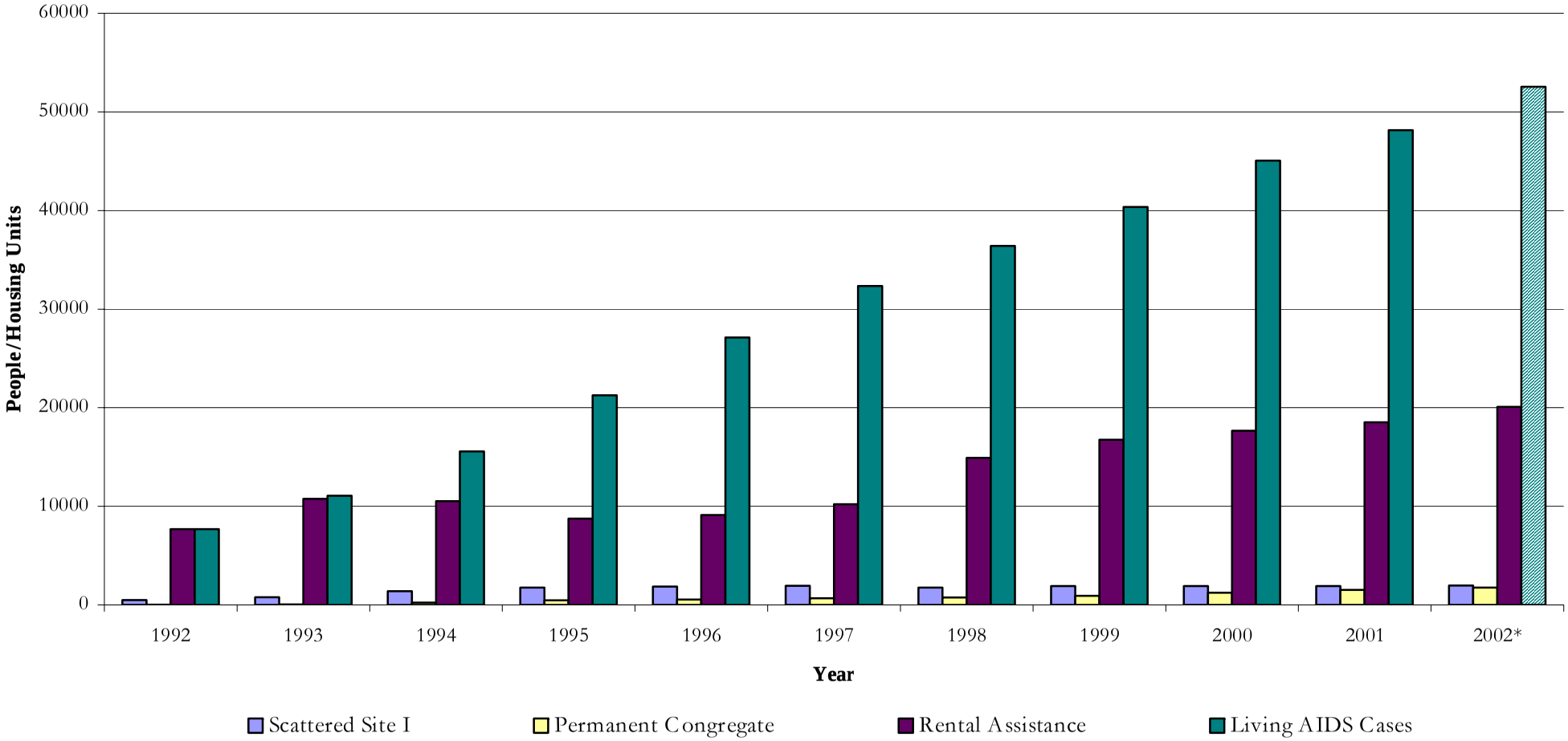
Operating costs, such as maintenance, repairs, and overhead including insurance, legal, and audit fees, are funded by tenant rents: in New York City, most low income persons with HIV/AIDS receive rental subsidies administered by HASA, described earlier in this section. Other government funded rental subsidies include Section 8 Housing Choice Vouchers and Shelter Plus Care, but these subsidies are scarce and competitive, and their eligibility is not limited to persons with HIV/AIDS. Rental subsidies can be project-based (the project owner receives the assistance, and

is required to rent to eligible tenants during a contractual period), sponsor-based (a not-for-profit sponsor receives assistance, and is required to rent units to eligible tenants during a contractual period), or tenant-based (eligible tenants receive assistance, and locate units on their own). When rental subsidies are unavailable or insufficient to cover operating expenses, a few programs, including New York State's Operational Support for AIDS Housing (OSAH), offer additional operating support. As discussed in Section IVD below, insufficient funding to cover operating costs serves as a barrier to the creation of new HIV/AIDS housing.

Supportive Services

HASA serves as the primary source of funding for residential support services for homeless persons living with HIV/AIDS in New York City. The United States Department of Housing and Urban Development's Continuum of Care Homeless Assistance/Supportive Housing Program (SHP) also provides funding for supportive services. If an organization targets a population that falls into other special needs categories (in addition to HIV/AIDS), it may be worthwhile to develop a licensed residential program and access funding through agencies such as the New York State Office of Alcohol and Substance Abuse Services (OASAS) and the New York State Office of Mental Health (OMH). One specific strategy proposed for meeting the service needs of residents is to provide services on site that can be directly reimbursed by Medicaid. This strategy has been achieved by co-locating an AIDS Adult Day Healthcare Program (ADHC) with a residence. More limited services can be brought into a residence by locating a COBRA case management program on-site. COBRA Case Management is an intensive community-based program that is licensed by the New York State Department of Health and reimbursed by Medicaid. Residential programs that are co-located with ADHC programs or COBRA Case Management programs are most appropriate when the target population is difficult to serve and needs intensive supportive services.

Chart IIC-1. HIV/AIDS Housing Units in New York City by Type and Living AIDS Cases (1992-2002)



Data Sources: New York City Department of Health and Mental Hygiene, HIV/AIDS Surveillance Program, Center for Urban Community Services HIV/AIDS Housing Database.

***The NYC DOHMH does not release projections of the number of persons living with HIV/AIDS, so the cross-hatched bar shown here for 2002 did not come from the Department of Health. It is a projection that was calculated as part of this study. A description of the projection methodology is included in Appendix A.

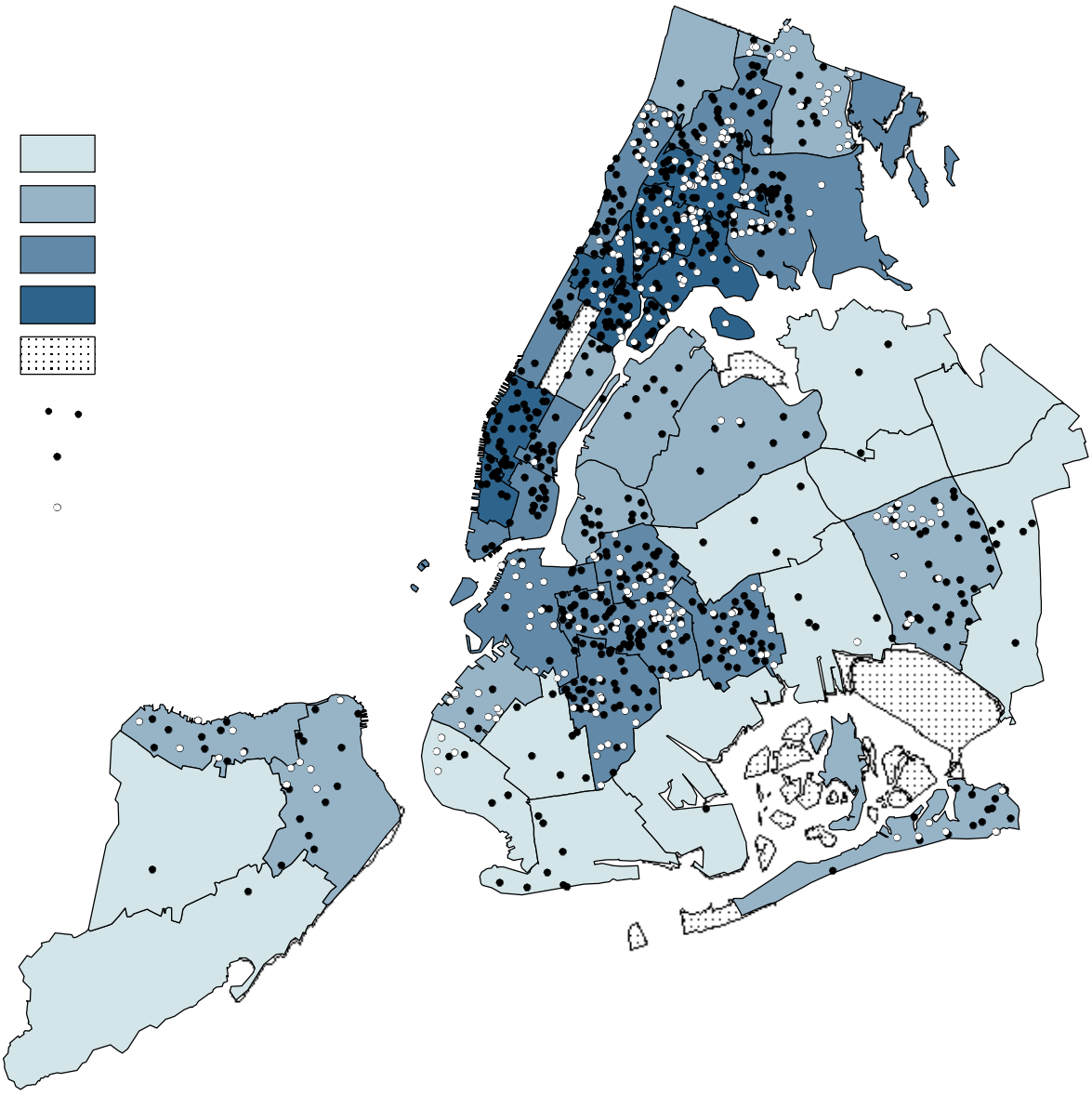
Exhibit IIC-2

City-wide Maps of Independent and Supportive Housing for Persons with HIV/AIDS in New York City

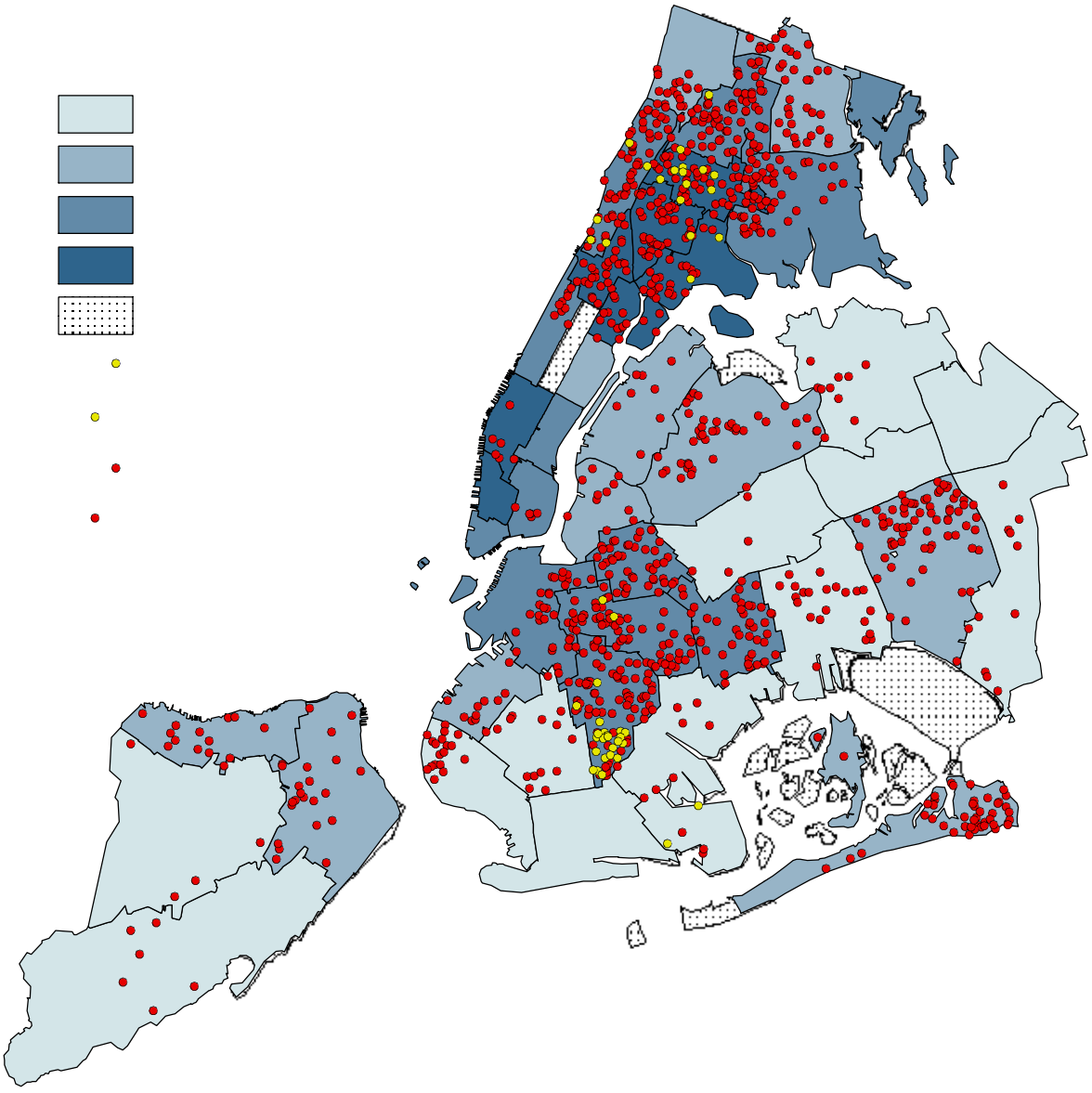
The following three maps depict the distribution of independent HIV/AIDS housing (rental assistance and Scatter Site II), supportive scattered site HIV/AIDS housing (transitional and Scatter Site I), and supportive congregate HIV/AIDS housing in New York City.

Borough- and county-specific maps are provided in Appendix C. Appendix C also includes a detailed methodology describing mapping procedures, as well as a map showing United Hospital Fund (UHF) Neighborhoods, on which the maps are based.

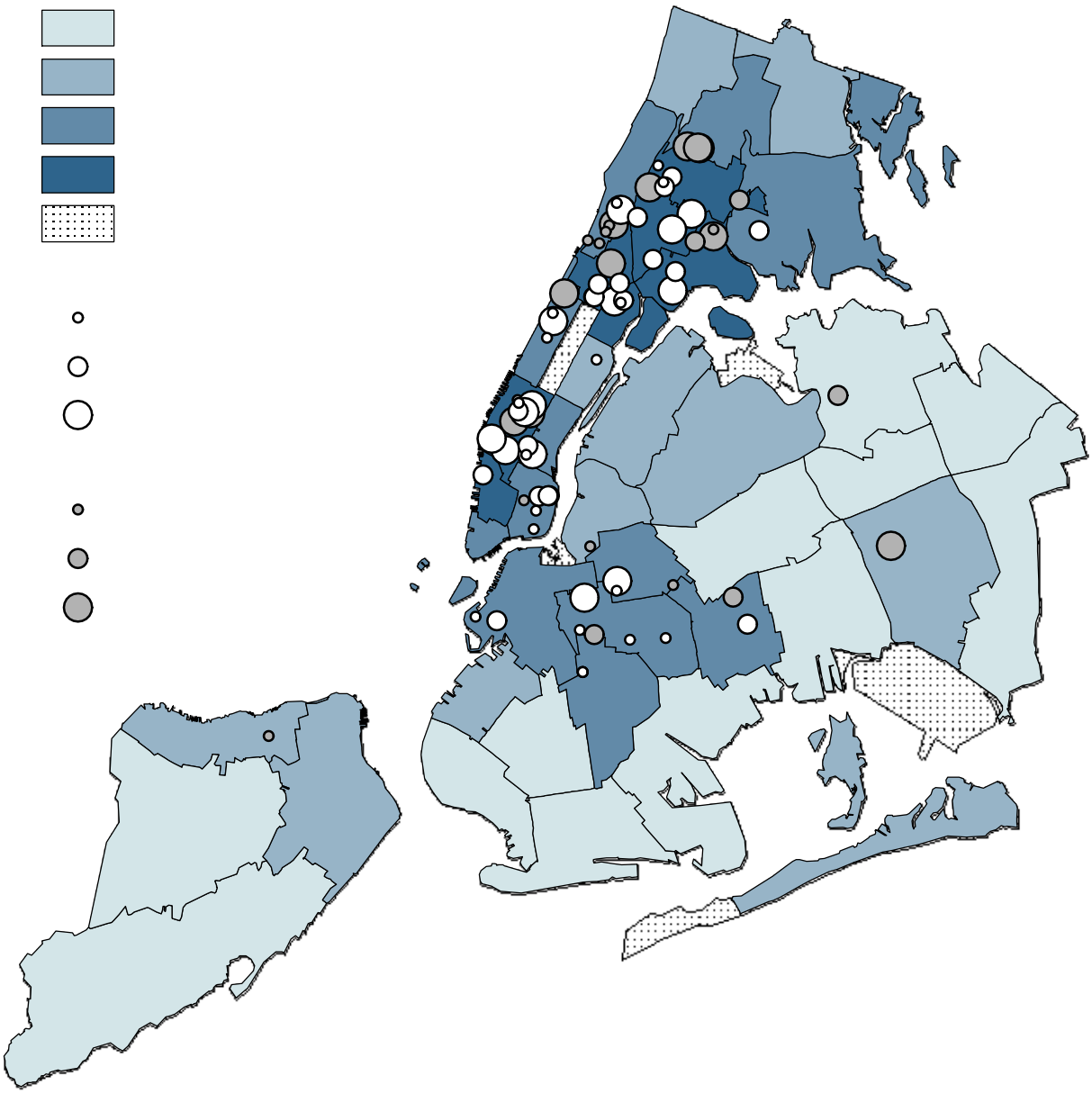
Independent HIV/AIDS Housing and AIDS Prevalence in New York City



Supportive Scattered Site HIV/AIDS Housing and AIDS Prevalence in New York City



Supportive Congregate HIV/AIDS Housing and AIDS Prevalence in New York City



II. D. CURRENT COSTS AND FUNDING FOR HIV-SPECIFIC HOUSING RESOURCES

Substantial federal, state and local funding currently supports the development and operation of housing for people with HIV/AIDS in the New York City EMSA, as well as the delivery of supportive services to many people who use these housing resources. Yet, both government and provider key informants report that the lack of coordination among existing funding sources can serve as a barrier to the creation and delivery of high-quality housing services, and that limited public resources for capital development, operations, and service provision will seriously challenge the ability of the EMSA to meet the growing housing need among extremely poor persons living with HIV/AIDS. These and other barriers to housing development are discussed in Section IVD below.

A complete inventory of funding sources that support the development and operation of housing for persons with HIV/AIDS in the NYC EMSA is provided in Appendix E to this report. Set out below is an analysis of the cost effectiveness of rent supports and supportive housing strategies for housing persons with HIV/AIDS in the NYC EMSA, and a discussion of New York City's current spending for housing for persons with HIV/AIDS, which is weighted heavily towards case management and emergency housing, rather than permanent supportive housing.

The Cost Effectiveness of Existing HIV/AIDS Housing Resources

The HIV-specific housing strategies and programs developed in the NYC EMSA over the course of the last twenty years (described above in Section IIC) are not only effective as a public health intervention, but are also an efficient and cost-effective means of meeting the needs of homeless and unstably housed New Yorkers with HIV/AIDS. At an average cost of $70 to $75 per day to operate supportive HIV/AIDS housing, and $30 per day for an individual rent subsidy at 110% of the HUD fair market rent ($933 in NYC), current HIV/AIDS housing supports are a sound investment in the health of individuals and of the community as a whole; particularly compared to the per day cost of other systems of care also used by extremely poor New Yorkers whose housing instability leads to homelessness and/or poor health outcomes:

- $68 for a cot in a NYC Department of Homeless Services congregate shelter;
- $112 for a City jail;
- $79 for a State prison cell;

- $350 for a State psychiatric hospital; and
- $600 - $1,600 for a City acute care hospital bed.[1]

Not-for-profit organizations in New York and across the country have demonstrated that housing linked to accessible health and mental health care, substance use services, employment and other supports is a cost-effective means of improving individual and community health.[2] Perhaps the most comprehensive examination of the cost-effectiveness of supportive housing is a recent study conducted by the University of Pennsylvania's Center for Mental Health Policy and Services Research that tracked the costs associated with 4,700 New Yorkers with mental illness for two years while they were homeless, and for two years after they were housed through the New York/New York program. The study concluded that supportive and transitional housing created an average annual savings of $16,282 per person by reducing the use of public services: 72% of savings resulted from a decline in the use of public health services; 23% from a decline in shelter use; and 5% from reduced incarceration of homeless people with mental illness. The reduction in hospitalizations, incarcerations, and shelter costs offset 95% of the cost of developing, operating, and providing services in supportive housing. After deducting these reduced costs, the average supportive housing unit cost only $995 per year. Even without attempting to quantify the benefits to consumers and the community, the study demonstrated that supportive housing for persons with high service needs is a sound public investment.[3]

An ongoing study of homelessness and public health costs in San Francisco also has documented the benefits of supportive housing and integrated services, not just for homeless persons, but for the city's public institutions, government, and residents as a whole. This study examines outcomes associated with the Health, Housing and Integrated Services Network, a collaboration of public and private agencies with the goal of integrating housing, health care and support services needed by persons who have been homeless and disabled by mental illness, substance use, HIV/AIDS or other chronic health conditions, to enable them to live in their own housing with stability. Interim results tracking some participants' use of public health systems point to dramatic reductions in hospital

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[1] Corporation for Supportive Housing. *WhySupportive Housing: Supportive Housing Saves Money and Benefits Our Communities!* http://www.csh.org/.
[2] Corporation for Supportive Housing. *Supportive Housing Works; CSH Supportive Housing Fact Sheet.* http://www.csh.org/.
[3] Culhane, D., S. Metreaux, & T. Hadley. 2002. Supportive Housing for Homeless People with Severe Mental Illness. *Leonard Davis Institute of Economic.* p. 7.

inpatient days (57%), emergency room use (58%), and residential mental health care (zeroed out after a year of residency).[4]

New York City's Allocation of Funding for Housing Persons with HIV/AIDS

According to New York City's Independent Budget Office (IBO), in City fiscal year 2003, New York City's expense budget spending on housing and related services for persons with HIV/AIDS totaled more than $189.6 million, a substantial increase from slightly more than $122 million in City fiscal year 1999.[5] This expense budget spending is funded from four principal sources: City tax levy dollars, State general funds, and two federal grant programs – the Housing Opportunities for Persons with AIDS (HOPWA) and Ryan White Comprehensive AIDS Resources Emergency (CARE) Act programs. As described in detail in Appendix E, HOPWA, provided through the U.S. Department of Housing and Urban Development (HUD), is the primary federal program supporting housing for persons living with HIV/AIDS; states and localities with a high incidence of AIDS cases are awarded HOPWA formula grants to provide housing assistance and supportive services to eligible persons.[6] The Ryan White CARE Act funds health and supportive services for individuals and families with HIV/AIDS; its Title I funds can be used to support housing-related services, including emergency and transitional housing, but cannot directly fund construction of HIV/AIDS housing.[7]

According to the IBO, in 2003, approximately 32% of the City's total expense budget spending on HIV/AIDS housing was allocated to case management and other services other than direct housing services: more than 23% was allocated to case management, and nearly 9% was allocated to "other services."[8] The amount of federal HOPWA funding that the City has allocated to case management services provided by the City's HIV/AIDS Services Administration (HASA) has increased significantly over the last few years. In 1999 almost all HASA case management services were

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[4] Proscio, T. 2000. *Supportive Housing and Its Impact on the Public Health Crisis of Homelessness*, Corporation for Supportive Housing. http://www.csh.org.

[5] NYC Independent Budget Office (IBO). 2003. *New York City Spending on Housing and Related Services for People with HIV/AIDS*. New York, New York.

[6] U.S. Department of Housing and Urban Development, Community Planning and Development: Housing Opportunities for Persons with AIDS (HOPWA). http://www.hud.gov/offices/cpd/aidshousing/programs.

[7] U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). 2001. Housing is Health Care – The Current State of HIV/AIDS Housing. *A Guide to Implementing the HIV/AIDS Bureau Ryan White CARE Act Housing Policy*. http://www.ask.hrsa.gov.

[8] NYC Independent Budget Office (IBO). 2003. *New York City Spending on Housing and Related Services for People with HIV/AIDS*. New York, New York.

supported by City and State tax levy funds, and in 2000 less than $7 million in HOPWA funding was directed to case management.[9] In 2003, by contrast, the City allocated nearly $28 million, or close to half of its total HOPWA formula grant, to case management and related services.[10]

As an extremely positive step, the 2004 Proposed Consolidated Plan reflects an allocation of $5 million of the HOPWA formula grant to the Department of Housing Preservation and Development (HPD), to support construction and rehabilitation of new housing units.[11] This is the first time in several years that the City has dedicated a substantial portion of the HOPWA grant to capital development, through HPD's Supportive Housing Loan Program.[12] However, in 2004 the City still proposes to allocate nearly $29 million from the HOPWA formula grant to case management and related services, out of a total of $60.3 million.[13]

The City's HOPWA Advisory Committee (HAC), whose members are dually appointed to serve as the Ryan White Planning Council's Housing Work Group, has urged the City to use HOPWA funds to support housing rather than case management. As stated in the HAC's official comments on the City's proposed HOPWA spending plan for 2004:

> … the City should be using HOPWA dollars to develop new units of AIDS housing and to support housing related services, rather than using over $24 million in HOPWA funds for case management services at HASA. The $24 million that is currently being used to support case management at HASA would be better used to provide funding to HPD and the Master Contractor to develop and support new units of AIDS housing.[14]

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[9] Letter from Molly Wasow Park, NYC IBO, to Terri Smith-Caronia, Housing Works. January 11, 2002. (Copy on file with HPG).
[10] NYC Department of City Planning. December, 2002. *Consolidated Plan 2003*. Volume I: pp. I-8.
[11] NYC Department of City Planning. November, 2003. *Proposed Consolidated Plan 2004.* Volume 4, Supplement: HOPWA Grant, pp. S-I-4. (This allocation is part of a $25 million, 5-year commitment of NYC HOPWA funds to capital development.)
[12] NYC Department of City Planning. December, 2002. *Consolidated Plan 2003*. Volume I, pp.I-8. (In the mid-1990s, approximately $16 million of New York City's HOPWA formula grant went to capital development; by 2003 this amount had dropped to $150,000.)
[13] NYC Department of City Planning. November, 2003. *Proposed Consolidated Plan 2004.* Volume 4, Supplement: HOPWA Grant, pp. S-I-4.
[14] Ibid, pp. S-I-22.

HASA's Expenditures on Permanent, Transitional, and Emergency Housing

Most of the City's expense budget spending for direct housing subsidies for persons with HIV/AIDS is administered by the Human Resources Administration's HIV/AIDS Services Administration.[15] HASA's spending on housing for persons with HIV/AIDS supports scatter site housing, permanent congregate supportive housing, transitional housing, and emergency housing. According to HASA personnel, in 2002 the agency expended:

- $53 million to support 2,457 units of Scatter Site I and II housing;
- $21.4 million to support 1,290 permanent congregate supportive housing units; and
- $11 million for transitional congregate housing, supporting 533 housing units.[16,17]

HASA will not release figures on its expenditures on commercial SROs and hotel rooms used for emergency housing placements, but even conservative calculations show this expense to be significant. While HASA has reported paying as much as $300 per night for emergency rooms in the past, the average expense is conservatively $50 per night.[18] With approximately 1,500 persons with HIV/AIDS currently housed each night in commercial SROs,[19] HASA is expending $75,000 each night, and almost $27.4 million each year, on housing people on an emergency basis in housing that is frequently substandard and dangerous. This conservatively estimated expenditure is more than HASA spends each year on permanent congregate housing.

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[15] NYC Independent Budget Office (IBO). 2003. *New York City Spending on Housing and Related Services for People with HIV/AIDS*. New York, New York.
[16] NYC HRA HASA. *HASA Facts*. New York, New York: December 2002.
[17] HNA, Key Informant Interviews with HASA staff (2003).
[18] HNA, Key Informant Interviews with HASA staff (2003).
[19] NYC HRA HASA. *HASA Facts*. New York, New York: December 2002.

II. E. THE HIV/AIDS SUPPORTIVE HOUSING INVENTORY

The NYC EMSA HIV/AIDS housing system includes a range of housing options to provide individuals and families with emergency housing, short and long term rental assistance, and scatter-site and single-site subsidized rental units that offer supportive services in addition to affordable living.

The NYC EMSA inventory of HIV/AIDS-specific housing includes the following models:

- *Emergency Housing*
  - Commercial SROs
  - Transitional SROs and Other Transitional Congregate Housing

- *Scatter Site Housing Programs*
  - Permanent Scatter Site: Sponsor Based and Tenant Based
  - Transitional Scatter Site

- *Permanent Congregate Housing Programs*

A discussion of each of these types of housing assistance follows. For each model, information is provided about the type of accommodation/physical layout, number and type of units provided, populations served, rent/lease arrangements, services provided, intended length of stay and sources of operating funding. Much of the data reported on the various housing types were produced from the computerized HIV Housing Inventory (HIV HI) that was created for this assessment. The Assessment Team gathered information for this SQL Server database through a written and web-based survey of every HIV-specific housing program in the NYC EMSA, and made follow-up phone calls to more than fifty programs to attempt to clarify or obtain missing information. This information is current as of December 2003. A copy of the housing program survey instrument is attached to the description of the study Methodology set out in Appendix A to this report.

In addition to general model descriptions, this section includes profiles of six individual housing programs that serve persons with HIV/AIDS; these profiles provide examples of the various

models, and illustrate the wide variety of housing and services offered by community-based providers in the NYC EMSA.

The HIV Housing Inventory database includes program-level information on each of the housing models discussed in this section, except the commercial SROs. HASA rents the SRO units from private landlords on an as-needed basis and information about these units has been obtained from HASA reports, key informant interviews and consumer focus groups.

The HIV Housing Inventory includes 147 housing programs that provide a total of 6,488 units of HIV-specific housing with 5,504 units (84.8%) targeted to single adults and 984 units (15.2%) for families. These units for single adults and families are distributed throughout the boroughs/counties as shown in Table IIE-1 and Table IIE-2 below. Table IIE-3 shows the distribution of units for families and single adults by housing model. Chart IIE-4 shows the distribution of available HIV/AIDS Housing by borough/county. Table IIE-5 shows the distribution of housing types by borough/county. Chart IIE-6 shows the available HIV/AIDS Housing by housing model. Charts IIE-7 through IIE-11 illustrate the distribution of different housing types throughout the boroughs.

Table IIE-1. Distribution HIV/AIDS Housing Inventory by Borough/County

	Unit Totals	Bronx	Brooklyn	Manhattan	Queens	Staten Island	Westchester
Number Of Units	6,488 (100.0%)	1,757 (27.1%)	1,415 (21.8%)	2,421 (37.3%)	688 (10.6%)	120 (1.8%)	87 (1.3%)
Family Units	984 (100.0%)	213 (21.6%)	278 (28.3%)	324 (32.9%)	130 (13.2%)	35 (3.6%)	4 (0.4%)
Individual Units	5,504 (100.0%)	1,544 (28.1%)	1,137 (20.7%)	2,097 (38.1%)	558 (10.1%)	85 (1.5%)	83 (1.5%)
Total Number of Programs	147 (100.0%)	29 (19.7%)	39 (26.5%)	58 (39.5%)	12 (8.2%)	5 (3.4%)	4 (2.7%)

Table IIE-2. Distribution of Families and Singles Units Within Borough/County						
	Families		Singles		Totals	
Bronx	213	12.1%	1,544	87.9%	1,757	100%
Brooklyn	278	19.6%	1,137	80.4%	1,415	100%
Manhattan	324	13.4%	2,097	86.6%	2,421	100%
Queens	130	18.9%	558	81.1%	688	100%
Staten Island	35	29.2%	85	70.8%	120	100%
Westchester	4	4.6%	83	95.4%	87	100%
TOTALS	984	15.2%	5,504	84.8%	6,488	100%

Chart IIE-3. Distribution of Family and Single Units by Housing Model Type

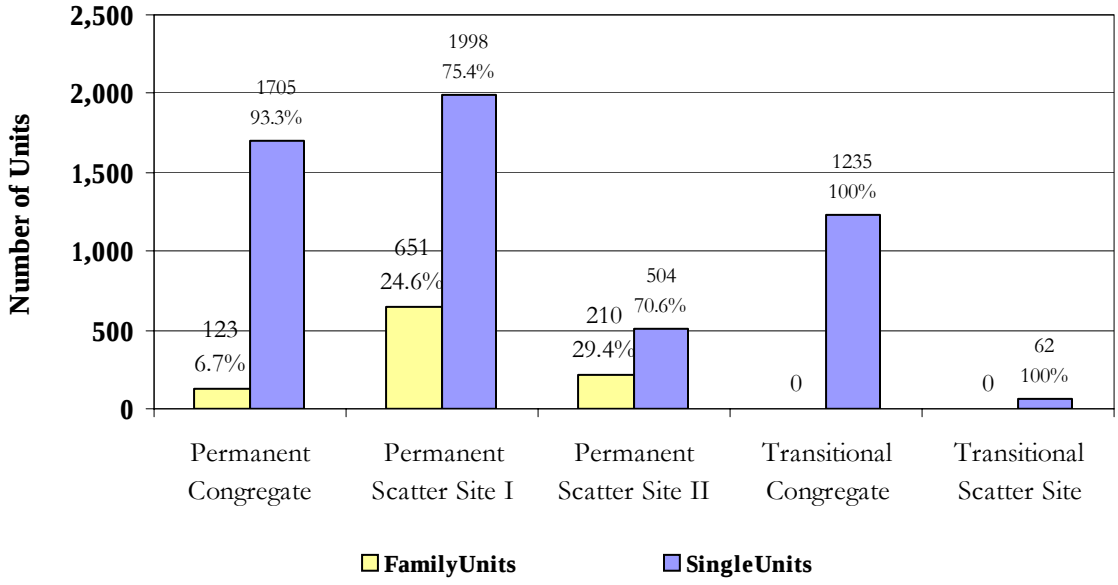


Chart IIE-4. Distribution of HIV/AIDS Housing by Borough

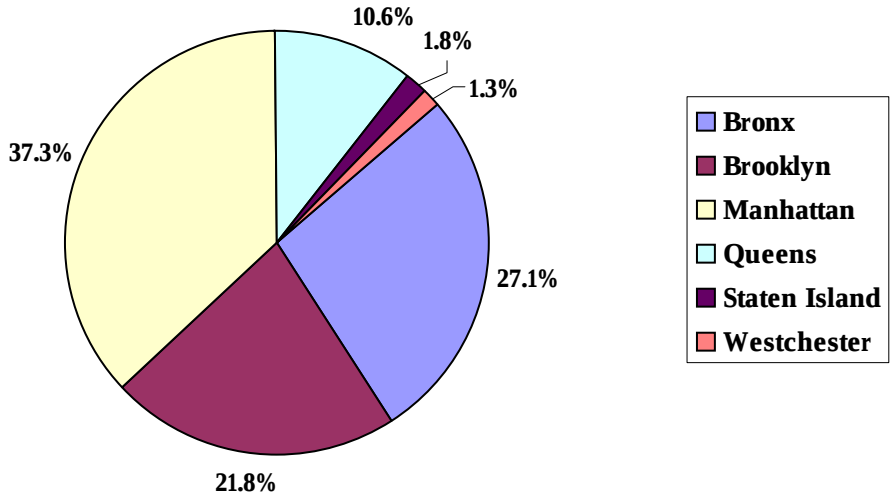


Table IIE-5. Distribution of HIV/AIDS Housing By Model and Borough/County							
Housing Model	**Unit Totals**	**Bronx**	**Brooklyn**	**Manhattan**	**Queens**	**Staten Island**	**Westchester**
Number Of Units	6,488 (100.0%)	1,757 (100.0%)	1,415 (100.0%)	2,421 (100.0%)	688 (100.0%)	120 (100.0%)	87 (100.0%)
Transitional Congregate	1,235 (19.0%)	429 (24.4%)	132 (9.3%)	549 (22.7%)	115 (16.7%)	10 (8.3%)	0 (0.0%)
Transitional Scatter Site	62 1.0%	0 0.0%	32 2.3%	30 1.2%	0 0.0%	0 0.0%	0 0.0%
Scatter Site I/ Sponsor Based	2,649 40.8%	705 40.1%	785 55.5%	685 28.3%	392 57.0%	50 41.7%	32 36.8%
Scatter Site II/ Tenant Based	714 (11.0%)	138 (7.9%)	200 (14.1%)	135 (5.6%)	181 (26.3%)	60 (50.0%)	0 (0.0%)
Permanent Congregate	1,828 (28.2%)	485 (27.6%)	266 (18.8%)	1,022 (42.2%)	0 (0.0%)	0 (0.0%)	55 (63.2%)

Chart IIE-6. Distribution of HIV/AIDS Housing By Model

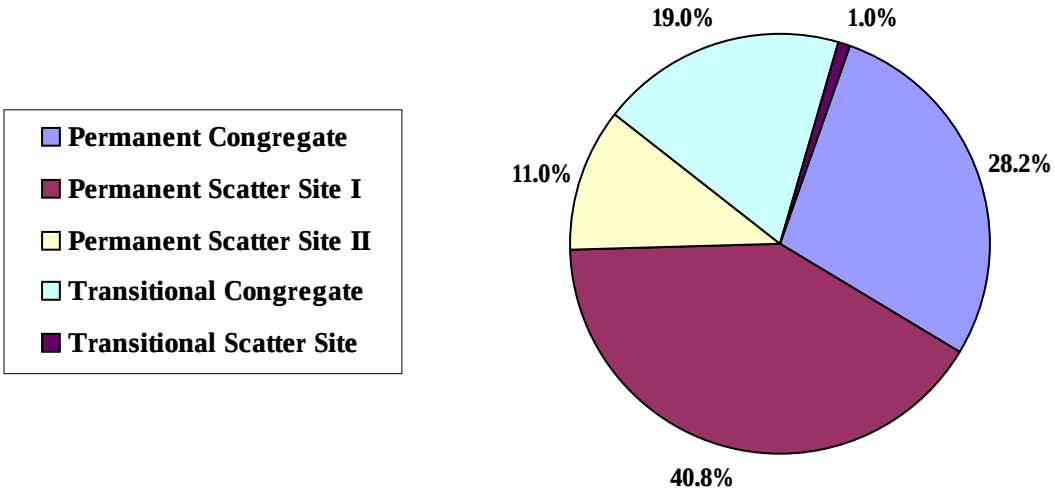


Chart IIE-7. Permanent Congregate HIV/AIDS Housing by Borough

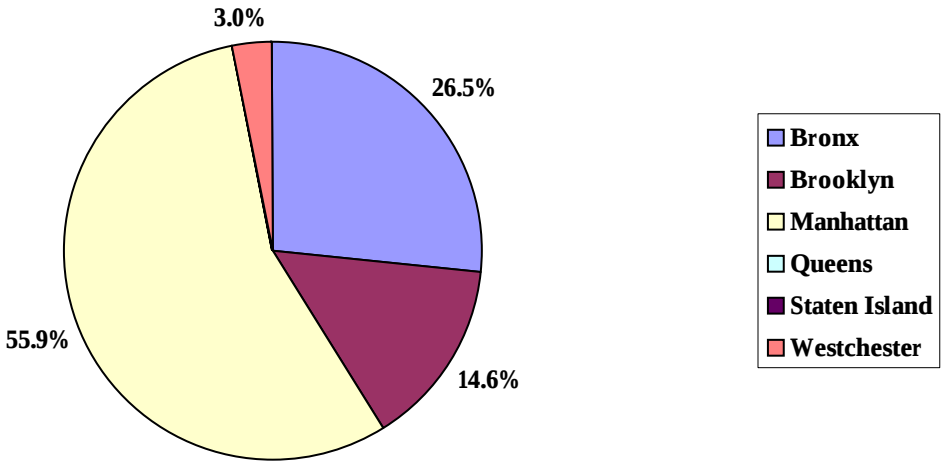


Chart IIE-8. Transitional Congregate HIV/AIDS Housing by Borough

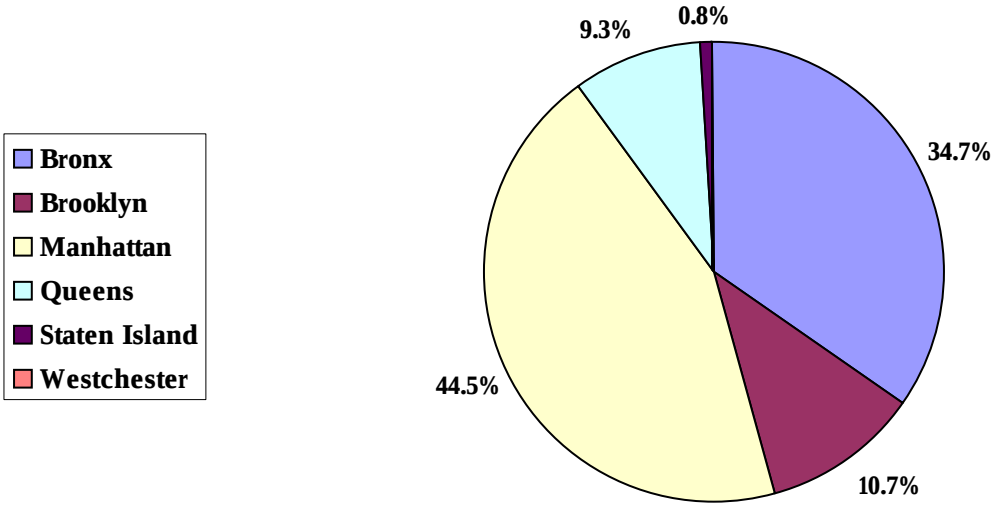


Chart IIE-9. Permanent Scattered Site I HIV/AIDS Housing by Borough

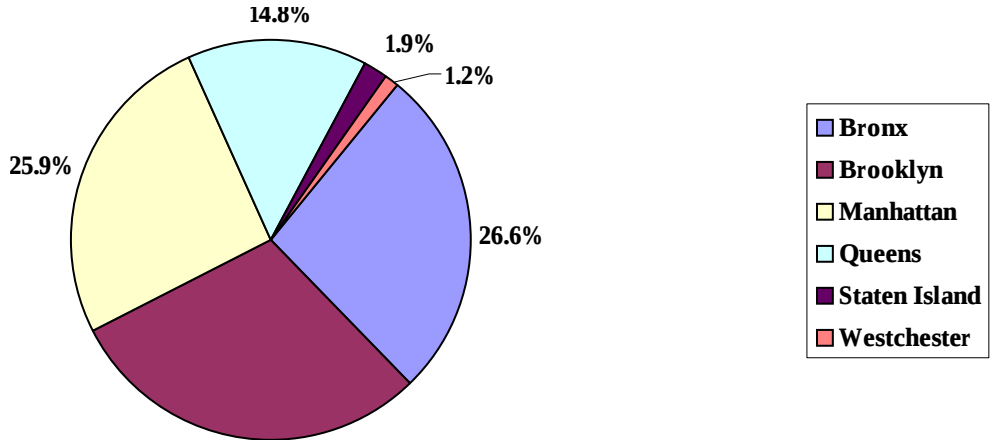


Chart IIE-10. Permanent Scattered Site II HIV/AIDS Housing by Borough

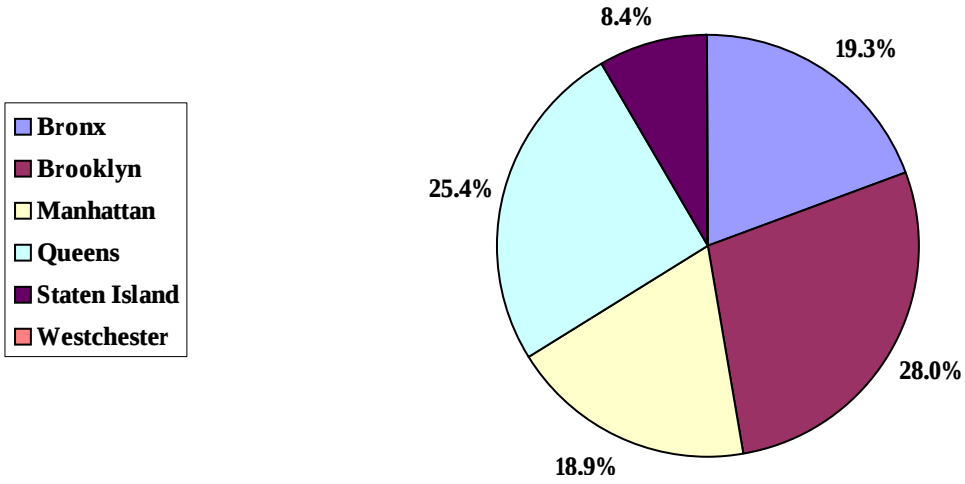
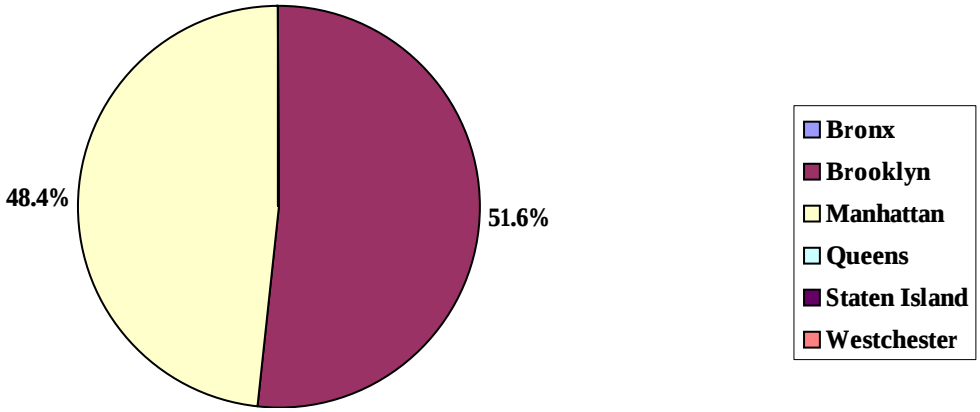


Chart IIE-11. Transitional Scattered Site HIV/AIDS Housing by Borough



Emergency Housing

The emergency housing system for people with HIV/AIDS in New York City includes commercial Single Room Occupancy hotels (SROs) and Transitional Congregate Housing. These settings are for single adults and are intended to be short-term, and to lead to permanent housing arrangements.

Commercial SROs[1]

Commercial SROs provide emergency housing to single adults in Single Room Occupancy hotels rented from private, for-profit landlords.

Type of Accommodation

Commercial SROs provide modestly furnished rooms for single adults where residents usually share bathrooms and kitchens. Conditions vary greatly from SRO to SRO in terms of safety, cleanliness and general building conditions.

Numbers of Units

According to December 2003 statistics from the City's HIV/AIDS Services Administration (HASA), 2,273 placements were made that month into commercial SRO hotels, and 1,567 commercial SRO units were occupied on a given night.[2]

Length of Stay

These units are intended to serve as emergency housing lasting 28 days or less, and stays are usually limited to 28 days to prevent the accrual of tenants' rights. People who do not obtain other housing placements may be moved from one SRO room to another every 28 days and can end up living in this emergency housing setting for months and even years.

Rent/Lease and Occupancy Requirements

Emergency placements in commercial single room occupancy hotels are paid for by HASA and cost between $1,200 and $2,500 per room/per month, although in the past the cost has been as much as $300 per night, and could return to these levels if the housing crisis continues. According to HRA,

[1] The commercial SROs are discussed in more detail in Section IIH below.

the average cost per room/per night is $50 or about $1,500 per month.[3] HASA pays this amount directly to the provider. The requirement that residents pay a portion of any income towards rent is not uniformly imposed or enforced. Leases are not provided unless requested by the resident.[4]

Social Services

Commercial SROs usually provide front-desk coverage around the clock. Very limited or no social services are provided within the commercial SROs. If services are available, they are usually provided by outreach teams or harm reduction service providers. Additionally, staff members from advocacy and legal organizations conduct outreach and education to SRO residents concerning their rights.[5]

Transitional Congregate Housing

Transitional congregate housing programs serve single adults and include temporary Single Room Occupancy (TSRO) hotels and YMCAs that provide furnished rooms with shared kitchens and/or baths. In addition, the HIV Housing Inventory includes other single-site facilities that offer private or semi-private living arrangements in buildings developed specifically to provide transitional housing for people with HIV.

Type of Accommodation

Transitional housing programs provide a furnished room, either a private or shared bath, and on-site staff to assist residents to move from emergency to permanent housing. Sixty-eight percent of the transitional congregate units in the HIV Housing Inventory require residents to share kitchens and/or baths.

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[2] NYC Department of Human Resources Administration (HRA), HIV/AIDS Services Administration (HASA). (2003). *HASA Facts: December 2003*. New York, New York.
[3] NYC HRA HASA. (May 17, 2002). Interview with HASA Representative.
[4] Testimony of Verna Eggleston, Administrator/Commissioner Human Resources Administration before the NYC Council Committee on General Welfare on HIV/AIDS Housing. (November 6, 2002).
[5] Ibid.

Number of Units

There are 30 transitional congregate housing programs providing 1,235 units of housing for single adults in the EMSA. No transitional congregate units are targeted to families.

Length of Stay

Transitional single room occupancy (TSRO) units provide short-term (up to 180 days) stays for single adults. Other transitional congregate housing programs vary in the length of stay from three to eighteen months. Of the eighteen programs in the HIV HI that reported data on length of stay, eleven limit stays to three months, six limit stays to twelve months, and one residence allows stays of up to eighteen months.

Rent/Lease and Conditions of Occupancy

Transitional housing programs usually accept the HASA rental allowance or charge residents 30% of any income received as rent. Eleven of the thirty transitional congregate programs report that residents are not charged rent.

No programs reported issuing leases to residents. In twenty of the programs, participants sign residency or program agreements. Four programs hold the leases for the units and one of these agencies sublets units to residents. Two programs offer no lease or occupancy agreement. Four programs did not answer this question.

None of the programs reporting in the HIV HI allows pets. Six programs allow overnight guests. Seventy percent of programs report involving residents in the program in advisory boards, tenants' councils, boards of directors or as employees or volunteers.

Populations Served

The people served by transitional housing programs are usually coming out of other emergency housing, drug or alcohol treatment facilities, or the corrections system. The TSROs require individuals to be HASA-referred, as do most of the other congregate transitional programs. Eleven programs, however, can accept referrals for individuals who are not HASA-eligible.

All but six of these programs exclusively serve people with HIV, but these six residences account for 235 or nineteen percent of the total number of HIV-specific units in this category. This proportion is a result in large part of the four large YMCAs in this group, which offer units to other populations besides people who have HIV.

Services[6]

Services frequently offered by transitional congregate housing providers include on-site case management, substance use and mental health counseling, job training and placement and linkages to medical care. Of the thirty programs in this group, ninety percent report that they provide case management services. Slightly more than two-thirds provide mental health and substance use services. Forty-seven percent provide job training and/or placement services. Forty-three percent provide access to nursing services.

Sixty percent of the inventoried programs provide meals and ten percent offer homemaker services. Seventy-seven percent offer recreation or socialization opportunities. Forty-three percent of programs offer transportation vouchers and sixty percent provide escorts to appointments. Thirty-three percent of transitional congregate programs either provide legal services directly or help residents to access legal services.

Funding

Transitional housing programs use a variety of sources to fund services and operating costs including HASA, Ryan White, the Housing Opportunities for Persons with AIDS (HOPWA) program, and HUD's Supportive Housing Program (SHP).[7] Of the twenty-one programs reporting funding information, ten reported only one funding source, fourteen had two sources, four programs used three funding sources and two reported four sources. Twenty-one programs report receiving HASA funds, twelve receive Ryan White, eleven receive HOPWA funding and seven receive HUD SHP. Two programs report receiving mental health funds, and two provide services that are reimbursed by Medicaid.

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[6] See Table IIE-12 for a complete breakdown of services provided by housing model.

[7] For a complete description of HIV/AIDS housing funding sources and uses, see Appendix E.

Scatter Site Housing Programs

Scatter site housing programs provide permanent living arrangements and supportive services to people with HIV through the leasing of private market apartments "scattered" throughout the community. Services are provided by nonprofit agencies off-site or in the person's apartment. These programs serve individuals and families. For the purposes of this study, we have categorized three basic types of scatter site apartment programs: 1) Permanent Scatter Site I/Sponsor-Based Scatter Site, 2) Permanent Scatter Site II/Tenant-Based Scatter Site, and 3) Transitional Scatter Site.

Permanent Scatter Site I/Sponsor-Based Scatter Site: Apartments leased by service provider (Includes HASA Scatter Site I and HOPWA Scatter Site)

Type of Accommodation

In this model, not-for-profit agencies lease apartments from landlords in the community, and then sublet them to program participants at affordable rents. (There are three programs in the EMSA, however, where the tenant holds his/her own lease.) Residents have apartments with bedrooms, living space and private kitchens and bathrooms.

Number of Units

There are 44 programs of this type in the EMSA, which provide 2,649 units of housing, including 1,998 units (75%) for single adults and 651 units (25%) for families.

Length of Stay

While this model provides permanent housing with no pre-determined length of stay, many of the programs consider the housing to be interim or transitional and work to help residents move on to housing that affords greater independence.

Rents, Lease and Conditions of Occupancy

In NYC, program participants pay a program fee equal to 30% of any income they receive (such as SSI or SSDI). In all but three of these programs, the nonprofit agency sponsor holds the lease on the units. Residents in twenty-four programs sign program/occupancy agreements. Thirteen programs sublet units to residents. Four programs did not report lease or occupancy information.

Thirty-six of the programs involve residents in advisory boards, boards of directors, tenants' councils or as staff or volunteers. Thirty-eight programs allow residents to have overnight guests, and six do not. Fifteen programs reported allowing pets and 29 do not, although this policy is always dependent on building rules and lease requirements, which can change.

Populations Served

Scatter Site I programs serve both single adults and families. Residents referred to this model are often coming from hospitals, transitional housing settings and the criminal justice system. Thirty-one scatter site programs require residents to be referred by HASA. Thirteen programs can accept residents who are not referred through HASA. Five programs have dedicated units for people with dual-diagnoses of HIV and mental illness.

Services

Support services may be provided at the sponsoring organization's office or in the resident's home. Support services provided by the sponsoring agency to residents include case management, linkage to medical care, substance use and mental health treatment services and employment services.

Thirty-one programs report providing 24-hour emergency beeper coverage and eight do not provide any overnight coverage. Only six Scatter Site I programs provide or arrange for meals, but twenty-two provide food pantry or meal vouchers to residents.

Fully ninety-three percent of programs provide case management. Thirty-four percent ensure access to nursing services. Eighty-two percent of programs offer mental health services and sixty-one percent offer substance use services. Forty-three percent of programs offer job training/placement services and forty-five percent provide harm reduction and safer sex education.

Regarding transportation, thirty-six percent of programs report providing transportation tokens/vouchers and sixty-six percent provide escorts to appointments. Eighty-nine percent of Scatter Site I programs offer recreation and socialization opportunities. Thirty-four percent of programs provide or arrange for legal services for residents. Twenty-five percent of programs provide access to child care services.

Funding

The vast majority of Scatter Site I programs (33 programs of 42 that provided funding information) report using one or two sources of funds to support operating and services costs. Nine programs use three funding programs. Funding sources used by Scatter Site I programs include HASA, Ryan White, HOPWA, HUD SHP and Shelter + Care, the NYS Office of Mental Health and the NYC Department of Health and Mental Hygiene.

More than half of the programs included in the Scatter Site I cohort report receiving services and/or operating funding from HASA and/or Ryan White. Specifically, thirty programs receive HASA funds and twenty-three programs use Ryan White. Sixteen programs receive HOPWA funds and five receive mental health funds from the City or the State. Only two programs report receiving HUD SHP funds, and one has Shelter + Care vouchers.

HARLEM UNITED'S SCATTER SITE PROGRAM FOR WOMEN AND CHILDREN

Neighborhood: Central Harlem and South Bronx
Sponsor(s): Harlem United Community AIDS Center
Unit Mix: 20 family units
Type: Permanent scatter site
Tenancy: Women living with HIV/AIDS and their children

Harlem United Community AIDS Center (Harlem United) is the largest AIDS service provider in upper Manhattan, offering a range of services to people living with HIV/AIDS whose diagnoses are complicated by homelessness, mental illness, and/or substance use. The agency's services include primary medical care, Article 28-licensed Adult Day Health Care, mental health services, substance use services, recreational therapy, and a comprehensive range of other supportive services. Harlem United has provided scattered site housing since 1991, and now serves a total of 235 households through several scattered site housing programs. In 1997, it developed a scattered site program targeted specifically for women living with HIV/AIDS, with an emphasis on immigrant women from Sub-Saharan Africa. The program consists of 20 apartments, including 2- and 3-bedroom units. Many of the residents are undocumented immigrants, with no access to government entitlement systems. All of the units are in Central Harlem and the South Bronx, in close proximity to Harlem United's main offices, where residents have access to all of Harlem United's clinical and supportive services. In addition, all clients receive case management services, most of which are provided in residents' apartments by a Harlem United case management team.

The program originally was structured so that each resident held her apartment lease directly, and received only support services from Harlem United. The agency found, however, that this stucture was not successful in enabling many of the high-risk families targeted by the program to establish and maintain housing stability. The women served by the program are dealing not only with extreme poverty, but with multiple personal and family issues that make it difficult for them to deal with the responsibilities of holding a lease. Now Harlem United holds the primary lease for each apartment, and is primarily responsible for rent payments to the landlord. Program participants sign Program Agreements, which function as apartment subleases, with Harlem United. Harlem United has found this leasing model to be critical to the program's success; temporary crises are less likely to result in housing loss, and, since Harlem United is not only a resident's service provider but also her landlord, case management contact is more regular and offers more opportunity for crisis intervention. The rental market is becoming increasingly tight in Harlem, moreover, and fewer landlords are willing to rent to persons receiving public assistance, particularly formerly homeless individuals with no rental histories. By serving as the leaseholder, Harlem United has been able to overcome these barriers to secure decent apartments, and is able to ensure timely payments to landlords.

Harlem United received $100,000 in grants from the U.S. Department of Housing and Urban Development and the NYC HIV/AIDS Services Administration as "development" funding, which supported initial rent and security deposits, as well as furniture and other essential supplies. The program receives ongoing operating and supportive services funding from the U.S. Department of Housing and Urban Development's Supportive Housing Program, the NYC HIV/AIDS Services Administration, and Medicaid.

Development of Harlem United's Scatter Site Program illustrates the following lessons:

- ∉ The "Scatter Site I" model, in which the provider enters into the lease agreement with the landlord, is an effective inducement for private owners to provide HIV/AIDS housing, even in a tight rental market;
- ∉ The model is also an effective way to prevent housing loss among extremely vulnerable persons, and to ensure regular, ongoing connection to case management and other supports;
- ∉ With case management services, many people living with HIV/AIDS can live independently;
- ∉ Scattered site housing programs targeted to particular populations meet an important need; and
- ∉ Housing resources for undocumented immigrants are critical.

BAILEY HOUSE'S SUPPORTIVE HOUSING APARTMENT PROGRAM

Neighborhood: Citywide
Sponsor(s): Bailey House
Unit Mix: 90 units (single and family)
Type: Permanent scatter site
Tenancy: Individuals and Families living with HIV/AIDS

Bailey House was founded in 1983 by a coalition of clergy, activists, and West Village business persons to address the devastating impact of the AIDS epidemic on the neighborhood. The agency provides a broad range of housing and services to persons living with HIV/AIDS, including scatter site and congregate supportive housing; case management and health care coordination; substance abuse pre-treatment; drop-in emergency services; vocational training; and technical assistance.

Bailey House opened its Supportive Housing Apartment Program (SHAP) in 1983 and now provides 90 apartments in Manhattan, Brooklyn, Queens, and the Bronx to persons living with HIV/AIDS, and their families. The program is structured as a Scatter Site I program, in which Bailey House enters into lease agreements, and is responsible for making rent payments and conducting any related business with the landlords. Program participants sign Program Agreements with Bailey House and pay their rent portions directly to Bailey House. The agency believes that this leasing structure allows for greater outcomes and stability for residents, as it leaves the responsibility of rent payment and communication with landlords to the agency, minimizing the risk of eviction and/or discrimination. Between 2001 and 2002, the agency reported a 94% success rate among the program participants, meaning that 94% of the residents either remained stably housed in the program or went on to independent housing or another stable permanent housing option. Bailey House has received funding from the New York City HIV/AIDS Services Administration to operate the program since its inception. However, because HASA only funds rents at the basic enhanced rental assistance levels ($480 for a single), Bailey House must subsidize rents for program apartments at an annual cost of approximately $250,000.

Today, the 188 residents of Bailey House's SHAP apartments have access to a full range of supportive services that help them live as independently as possible. These services include: substance abuse services, mental health services, case management, medical monitoring, nutritional services, life skills training, job placement, literacy programs, therapeutic recreation, and other services. Bailey House provides these services through regular visits to SHAP participants, and participants also have access to the programs and services that Bailey House offers more widely.

The experience of Bailey House's Supportive Housing Apartment Program illustrates the following lessons:

- The Scatter Site I model is a very effective permanent housing program for persons disabled by HIV/AIDS, and has enabled persons with HIV/AIDS to achieve long-term housing stability despite co-occurring mental health and substance use issues, and to establish the living skills neccessary in order to transition to independent housing;
- The Scatter Site I model enables participants to live independently in most areas in New York City, since it minimizes rental barriers that many participants would face if they were required to secure leases in their own names;
- Access to case management and a range of other supportive services is key to participants' housing stability; and
- HASA's policy of funding rents only at rental assistance levels jeopardizes the long-term viability of the model, and means that providers must raise additional funds to subsidize participant rents.

Scatter Site II/Tenant-Based Scatter Site: Apartments leased by program residents

Type of Accommodation

In this model, the program resident directly holds the lease on his or her apartment, and must apply for rental assistance and an establishment of home grant through HASA.

Not-for-profit agencies that operate Scatter Site II programs are expected to provide housing placement assistance to program participants to help them locate apartments. Residents have individual or family units that include bedrooms, kitchens and bathrooms.

Number of Units

Nineteen Scatter Site II programs reported providing 714 units of housing in the EMSA, 504 units (71%) targeted to single adults and 210 units for families (29%).

Length of Stay

Scatter Site II housing is permanent, with no maximum length of stay. However, supportive services are intended to be transitional and not last more than six to nine months.

Populations Served

Scatter Site II programs house both families and single adults. All programs require that residents be referred through HASA or be HASA-eligible. Residents must be able to manage living on their own, obtaining meals, maintaining their households and accessing services independently in the community.

Rent, Lease and Conditions of Occupancy

Residents typically must pay substantially more than 30% of any income received towards rent, because they pay the difference between the HASA rent allowance and the total rent charged for the unit.[8] Residents hold their own leases for their living units.

[8] As discussed in Section IIIB below, consumer survey results show that respondents in independent housing have, on average, a 49% rent burden even after applying their rent subsidies. See Appendix D for examples of public assistance budgets for persons using the enhanced rental assistance to live independently.

Occupancy requirements and restrictions are specific to the lease for each unit. Only three programs reported allowing pets. Eighteen of nineteen Scatter Site II programs allow overnight guests.

Services

Scatter Site II providers are expected to regularly evaluate the ability of program participants to maintain their apartments, with a view to eventually withdrawing program services and transitioning clients to independent living. Support services are intended to be time-limited to 6 to 8 months, although many providers expect that residents will need services longer and arrange for or plan to provide services as long as needed by the resident.

The nineteen Scatter Site II programs reporting on services provide similar types of support services as those offered to Scatter Site I clients. The level and frequency of services, however, are lower in Scatter Site II than in Scatter Site I. Eleven programs provide 24-hour emergency coverage by beeper; eight programs provide no overnight emergency coverage. Two programs provide meals and eight provide food pantry or meal vouchers. Only one program assists with nursing services, and two programs provide homemakers.

All nineteen Scatter Site II programs report providing case management services. Sixty-three percent of programs report that they provide mental health and substance use counseling services. Seventy-four percent provide harm reduction and safer sex education and fifty-eight percent of programs offer job training/placement. Only three programs, or sixteen percent, provide transportation vouchers or tokens, but seventy-four percent provide escorts to appointments. Sixty-eight percent provide recreation and socialization opportunities. Thirty-seven percent of programs provide access to legal services.

Funding

Seventeen of the nineteen programs that reported funding information identified HASA as a source of support for their programs. Fourteen programs reported HASA as their only funding source.

Three programs receive Ryan White funds and four programs use HOPWA funds in addition to HASA's support. One program uses Shelter + Care and one uses Section 8 Housing Choice

vouchers to supplement the HASA rent subsidy, thereby allowing residents to pay only 30% of any income received towards rent.

PROJECT HOSPITALITY'S SCATTER SITE II PROGRAM

Neighborhood: Staten Island
Sponsor(s): Project Hospitality
Unit Mix: 20 units/75 placements per year (family and single)
Type: Scatter Site II
Tenancy: Homeless persons with HIV/AIDS

Founded in 1982, Project Hospitality is one of only a few organizations on Staten Island serving homeless persons with multiple needs. The agency's clients struggle with multiple, complex needs that contribute to, and are compounded by, homelessness, including susbtance abuse, HIV/AIDS, and serious and persistent mental illness. In 1991, the organization responded to the growing problem of HIV/AIDS among its clients by creating a scattered site housing program. Although many could potentially benefit from a more supportive, congregate setting, the prospect of fierce community opposition led the agency to pursue a scattered site model for its first housing program.

In 1991, the agency received funding from the NYC HIV/AIDS Services Administration (HASA) to operate 40 Scattered Site I apartments, for which it still receives funding. In 2000, the agency sought to expand the program, but HASA no longer was funding Scatter Site I programs and structured the new program as a Scatter Site II model. Residents enter directly into lease agreements with private landlords, and are entirely responsible for timely payment of rent and handling other housing-related matters. The agency provides supportive services to participants, including case management, individual and group counseling, crisis intervention, and life skills training, but is required by HASA to "sunset" these services after six months, to help move residents toward independence. The program functions more as a housing placement program than as permanent supportive housing, and the agency is required to perform 75 "placements" per year.

Project Hospitality's scattered site programs are a crucial resource for homeless persons living with HIV/AIDS on Staten Island, allowing for the rehousing of long-term SRO residents. However, the Scatter Site II program presents a number of challenges. First, agency staff cite discrimination as a significant problem faced by persons living with HIV/AIDS and persons of color when they attempt to secure apartments on their own. Because securing apartments is a challenging process, HASA has been flexible with program placement requirements. Further, requiring residents to enter directly into lease agreements with landlords eliminates the agency's ability to make rent payments and prevent eviction in the event that a resident encounters financial difficulties. Relatedly, while some residents are able to attain independence after a six-month period, not all program clients can make this transition, and removing essential support services after such a brief period of time places residents at risk of instability and eviction.

Those residents of the Scatter Site II program that have been able to maintain stable housing are able to do so primarily because Project Hospitality is able to offer intensive case management, HOPWA-funded housing placement assistance and independent living skills, and social day program services, which help residents to address the isolation of living in an independent apartment, improve independent living skills, eat regularly and well, and receive HIV prevention and treatment education and support.

Project Hospitality's Scatter Site II program illustrates the following lessons:

- ∉ Scattered site programs can serve as a valuable resource in the event of community opposition;
- ∉ Scatter Site II programs can expose clients to discrimination and other aspects of the private housing market from which they are buffered in the Scatter Site I model;
- ∉ The Scatter Site II model makes it more difficult for the sponsoring agency to intervene in housing crises, increasing the risk of housing loss;
- ∉ Not all residents can transition out of housing-related support services after six-months.
- ∉ Wrap-around services such as social day programs are critical to the housing stability of many persons with HIV/AIDS who live in independent housing situations.

Transitional Scatter Site

Type of Accommodation

In this model, a not-for-profit agency leases apartments from landlords in the community, and then sublets them to program participants at affordable rents. All programs provide supportive services to residents.

In three of the four Transitional Scatter Site programs in the HIV Housing Inventory, residents have private accommodations and do not have to share kitchens or bathrooms. In one program, residents share both kitchens and baths with unrelated adults.

Number of Units

There are four transitional scatter site programs in the HIV Housing Inventory that offer 62 housing units, 100% of which are provided to single adults.

Length of Stay

The length of stay in most transitional scatter site housing ranges from six to twelve months. Of the four programs reporting information on maximum length of stay, two limit stays to six months and two limit stays to one year.

Populations Served

All but one of these programs requires all residents to be HASA eligible. Transitional scatter site programs serve single adults. Residents in these programs are frequently coming from hospitals or community-based organizations and need services to build life skills and achieve greater independence.

Rent/Lease and Occupancy Requirements

Rent or program fees are either 30% of income received or the HASA rental allowance. In three of the four programs reporting, the sponsoring agency holds the lease for the units and creates occupancy agreements between the sponsoring agency and the resident. One program reports issuing only sublease agreements to residents.

Three of the four programs involve residents in advisory boards, boards of directors, tenants' councils or as staff or volunteers. All programs report that overnight guests are allowed.

Services

Support services may be provided at the sponsoring organization's office or in the resident's home. Frequently offered services in Transitional Scatter Site programs include on-site case management, substance abuse and mental health counseling, job training and placement and linkages to medical care. Transitional scatter site programs focus on building residents' skills to enable them to live in housing that affords greater independence.

One of the four programs provides 24-hour emergency beeper coverage by staff. Twenty-five percent of the programs arrange for meals and seventy-five percent provide food pantry or meal vouchers. In terms of other specific services, of the four programs reporting, one-hundred percent provide case management services. Mental health services are provided by one hundred percent of the programs and seventy-five percent offer substance use support groups. One hundred percent provide harm reduction and safer sex education and seventy-five percent provide job training/placement services.

One hundred percent of the programs report providing escorts to appointments and fifty percent provide transportation vouchers. One hundred percent offer recreation/socialization opportunities and the same percentage offer access to legal services. Child care services are offered by fifty percent of programs.

Funding

Transitional Scatter Site programs are funded primarily by HASA and Ryan White. Three programs receive HASA funds; all of these receive Ryan White support in addition to HASA; one program receives only Ryan White funds.

Permanent Congregate Housing

Permanent Congregate Housing programs provide affordable living arrangements in single-site facilities with supportive services available on site. Programs range from those that are very small with limited staffing, to large, very well staffed facilities. These programs primarily serve single

adults although some do serve families where at least one person has HIV/AIDS. Permanent congregate housing programs may be exclusively targeted for people with HIV, but there are also permanent congregate settings that serve other groups including older adults, low income households, formerly homeless people and/or other special needs populations such as people with mental illness or substance use issues.

Type of Accommodation

Permanent congregate housing programs offer comprehensive social services and a structured living environment in one residence, building or freestanding facility. Congregate housing programs offer furnished private bedrooms, primarily in efficiency studios or apartments. Of the fifty permanent congregate living programs in the inventory, all but nine offer private bathrooms. Thirty-nine programs offer kitchen facilities within residents' living units.

Number of Units

There are 50 permanent congregate housing programs in the HIV Housing Inventory that provide a total of 1,828 housing units: 1,798 units (93.2%) for single adults and 123 units (6.8%) for families. Twenty of the permanent congregate housing programs are "mixed use," meaning they serve other populations besides people with HIV. These programs comprise forty-five percent of the total number of HIV-specific units in this category and provide a total of 819 units of housing within mixed use projects.

Rent/Lease and Occupancy Requirements

Residents typically sign leases or program agreements, and pay rent equal to 30% of any income received. In sixty-four percent of these programs, residents hold their own leases for their units; in twenty percent of these programs, residents sign occupancy or program agreements. In the remaining sixteen percent of these units, the agency holds the lease for the units and sublets units to residents or has those residents sign occupancy agreements.

Overnight guests are permitted in eight-four percent of programs and eight percent allow pets. Fifty-six percent of programs reported that they involve tenants in advisory boards, boards of directors, tenants associations or as staff or volunteers.

Populations Served

Most people who choose or need to live in permanent congregate housing require some level of support with health issues or daily living skills or can benefit from a shared sense of community. Permanent Congregate Housing providers report increasing numbers of people with dual and triple diagnoses of HIV, mental illness and/or substance use issues.

All but eight of the permanent congregate housing programs require HASA-eligibility for their HIV-specific units. The eight programs that do not require HASA eligibility provide 235 units of housing.

Services

Permanent Congregate Housing programs provide a range of services that may be of fairly high intensity. On-site staffing allows for frequent (sometimes daily) interaction between staff and residents. Of the forty-four programs that provided information regarding overnight staff coverage, only nine percent or four programs offer no overnight coverage. Thirty-four programs or sixty-eight percent have 24-hour front desk staff; two programs have 24-hour coverage by clinical staff. The balance of Permanent Congregate Housing programs have staff on emergency beeper coverage after hours.

Supportive services provided often include case management, meal programs, support groups, substance use and mental health services, and employment services. Specifically, ninety-four percent of these programs provide case management services. Sixty percent provide mental health services and seventy-two percent offer substance use support groups. Forty percent of programs provide job training/employment services. Forty-two percent offer safer sex education and fourteen percent offer access to needle exchange. Forty-four percent of programs provide nursing services.

Meals are provided by forty-eight percent of Permanent Congregate Housing programs; twenty-two percent offer homemaker services and thirty-eight percent assist with food pantry or meal vouchers. Escorts to appointments are provided by sixty percent of programs and twenty-six percent offer transportation vouchers. Fully eighty-six percent of programs provide recreation/socialization opportunities.

Funding

Permanent Congregate Housing programs use a variety of funding sources to support operating and service delivery costs. Programs also tend to blend multiple funding streams within one program. Forty-six percent of programs report using 3 or more funding sources; twenty-six percent identified two funding sources; fourteen percent use one source and 10% did not report this information.

Funds from HASA, Shelter + Care, the DHS SRO Support Subsidy, Ryan White, Section 8 and HOPWA are the most commonly used funding sources to support congregate supportive housing. Specifically, thirty-three programs or sixty-six percent of programs receive HASA funds; thirty-four percent use Shelter + Care rent subsidies; twenty-eight percent receive the SRO Support Subsidy; eighteen percent use Ryan White funds; eighteen percent have Section 8 and fourteen percent use HOPWA.

THE PRINCE GEORGE

Neighborhood: Manhattan's Flatiron District
Sponsor(s): Common Ground Community
Center for Urban Community Services
Unit Mix: 416 studio apartments
Type: Permanent congregate
Tenancy: Mixed-use (formerly homeless, including PLWH/A, and low-income)

The Prince George, a rehabilitated former luxury hotel, is sponsored by Common Ground Community (Common Ground) and the Center for Urban Community Services (CUCS). Common Ground is a nonprofit housing and economic development organization founded to address joblessness and homelessness; CUCS is a citywide service provider whose mission is to improve the quality of life of homeless and low income individuals. The agencies partnered to develop the Prince George, which provides permanent affordable housing and a range of supportive services for 416 adults. Common Ground spearheaded the project's development and oversees building operations; CUCS developed and provides supportive services to Prince George tenants.

The project includes 208 apartments for formerly homeless individuals, of which 45 are set aside for persons living with HIV/AIDS and 100 are designated for persons with serious and persistent mental illness. The remaining 208 apartments house low-income working adults. The project is the second-largest supportive housing facility in the United States. The building includes community spaces, a computer learning center, an arts studio, and roof garden. Rehabilitation of the Prince George was completed in 1999 and cost $14 million, funded by the NYC Department of Housing Preservation and Development's Supportive Housing Loan Program (which included HOPWA and HOME funds), the NYS Office of Mental Health, the NYS Homeless Housing and Assistance Program, Low Income Housing Tax Credits, and private foundations. Building operations and supportive services are supported by tenant rents (which do not exceed 30% of resident income), the NYS Office of Mental Health, the U.S. Department of Housing and Urban Development's Housing Choice Voucher (Section 8) program, the NYC HIV/AIDS Services Administration, and the NYC Department of Homeless Services.

All Prince George tenants hold rent stabilized leases and have on-site access to a broad range of services, including counseling, substance abuse services, case management, HIV/AIDS services, recreational therapy, vocational education and job training. Tenants are not required to participate in services, although CUCS designed them carefully to encourage participation.

Although the size of the project initially raised concerns among community residents, Common Ground and CUCS worked closely with the Community Board, the Business Improvement District, and other neighborhood groups, pointing to the success of their prior collaboration, The Times Square. Eventually, the project gained the endorsement and support of the community.

Development of the Prince George illustrates the following lessons:

- Larger projects offer critical economies of scale;
- Successful projects, particularly those with mixed populations, must leverage multiple funding sources for development, operation, and services, and coordination of this funding is important;
- Voluntary participation in support services within the context of a permanent lease arrangement can enable persons with multiple complex needs to maintain stable housing and connection to care;
- Providers must be prepared to develop and sustain sophisticated responses to community opposition; and
- Partnerships between housing developers and service providers enhance organizational capacity.

THE GIBB MANSION

Neighborhood: Brooklyn's Bedford-Stuyvesant
Sponsor(s): Pratt Area Community Council
Unit Mix: 71 units
Type: Permanent congregate
Tenancy: Mixed-use (PLWH/A and low-income singles)

Pratt Area Community Council (PACC), a Brooklyn-based housing and community development agency, serves residents of Fort Greene, Clinton Hill, and Bedford-Stuyvesant. In 1997, using a recoverable grant from the Corporation for Supportive Housing (CSH), the agency purchased an abandoned historic mansion in Bedford-Stuyvesant. Aware of the steep increase in AIDS prevalence in Bedford-Stuyvesant, and encouraged by the availability of capital funding under the Housing Opportunities for Persons With AIDS (HOPWA) program and the NYC Department of Housing Preservation and Development's (HPD) Supportive Housing Loan Program, PACC designated 50 of 71 planned units in the Gibb Mansion for persons living with HIV/AIDS.

Completed in 2002, the restored Gibb Mansion and a newly constructed annex now offer 71 studio apartments, 50 for formerly homeless persons living with HIV/AIDS and 21 for very low income single adults, all of whom were previously neighborhood residents. All residents have rent-stabilized, renewable two-year leases. The building has a large dining area, community spaces including a lounge and library with internet access, a front porch, and a front yard/garden. Construction and rehabilitation cost roughly $10 million, funded by HPD's Supportive Housing Loan program (which also repaid the CSH acquisition funding), Low Income Housing Tax Credits, the Federal Home Loan Bank's Affordable Housing Program, and the New York City Landmark's Conservancy. Building operations and supportive services are supported by tenant rents, which do not exceed 30% of residents' incomes, the U.S. Department of Housing and Urban Development's Shelter Plus Care program, and the NYC HIV/AIDS Services Administration. Because PACC is not an AIDS service provider, it partnered with Services for the Underserved (SUS), a citywide service provider with more than 25 years of experience, to ensure that all residents have access to appropriate HIV/AIDS services on-site. SUS offers case management, individual and group counseling, HIV counseling and education, crisis intervention, entitlements assistance, substance abuse treatment, vocational development, and recreational activities. Residents receive one hot meal a day.

PACC struggled with numerous barriers. Members of the Community Board sued PACC to prevent the project's development, but the lawsuit was dismissed as baseless. Rehabilitating the mansion was much more expensive than initial estimates, forcing the agency to apply for Low Income Housing Tax Credits when it was well into the development process. The project encountered unforeseen construction delays, particularly when the building's façade fell down and had to be painstakingly restored. PACC drew upon the expertise of various consultants during the course of the development: for project management, in establishing its collaboration with SUS, and in the development of the project's service components. From conceptualization to occupancy, the project took more than five years; according to PACC, it would have taken even longer had the organization not received technical assistance from outside consultants, some of which was funded by the organization's reserves and some of which was grant-funded.

Development of the Gibb Mansion illustrates the following lessons:

- Grant-funded technical assistance for housing and service development is vital, particularly for smaller community-based providers without relevant experience;
- Acquisition funding allows smaller providers to secure sites and initiate projects;
- Designation of HOPWA funding for capital development serves as an inducement for development of housing for people with HIV/AIDS;
- Organizational capacity is significant to the success of a project; and
- Rehabilitation of existing housing often is more expensive than anticipated.

THE FORTUNE ACADEMY

Neighborhood: West Harlem
Sponsor(s): The Fortune Society
Unit Mix: 33 units (single)
Type: 27 permanent (single), 6 transitional (shared)
Tenancy: Formerly incarcerated homeless persons

The Fortune Society provides a broad range of services to incarcerated, formerly incarcerated, and at-risk persons in New York City. It has gained national recognition for its programs designed to help people who have been through the criminal justice system make the transition to stable, productive lives and break the cycle of crime and incarceration.

In 1997, Fortune's agency-wide strategic planning process revealed that its clients' most pressing, unmet need was stable housing, particularly for those transitioning out of incarceration. The agency decided to undertake a housing development project, and, within a year, using its own unrestricted funds, purchased a former school in a dramatic location overlooking the Hudson River in West Harlem. The agency's vision entailed a mix of unit types for its clients' range of needs: the project would offer some emergency units for individuals coming out of prison who simply needed a place to go and a brief period of stability before moving on, but would also provide "phased permanent units" for clients who would benefit from a longer stay and ongoing access to Fortune's comprehensive array of services.

Although it was a tremendous risk for Fortune to purchase the building with its own funds before securing any other funding, site control was pivotal to the agency's efforts to secure other funding. In 1999, Fortune received a capital grant from the New York State Homeless Housing and Assistance Program and, shortly thereafter, a Supportive Housing Program grant from the U.S. Department of Housing and Urban Development that offered both capital and operating support. The following year, the agency applied for Low Income Housing Tax Credits and Historic Preservation Tax Credits and used the proceeds of the syndication to fund the last of the capital costs, which totaled $7.1 million, much higher than originally expected because of the extent of the damage the building had sustained while vacant.

Fortune pieced together a complex set of operating and service funding sources, which included: the Housing Opportunities for People With AIDS (HOPWA) Special Projects of National Significance (SPNS) program; HOPWA funding through the Master Contractor; Ryan White Title I; HUD's Supportive Housing Program; and the NYC Department of Homeless Services. Fortune's funding strategy sought to maintain the flexibility to house a broad range of clients, not just those with specific special needs identified by funders, such as HIV/AIDS or mental illness. Fortune has been able to provide a comprehensive array of services on-site, including substance abuse treatment, HIV/AIDS case management, independent living skills training, education, career development, counseling, family services, nutritional services, and recreation. The program opened its doors in April 2002, and has proven to be a central component of Fortune's innovative continuum of services.

Development of the Fortune Academy illustrates the following lessons:

- Organizations must be able and willing to act promptly to compete effectively in the private market for development sites; Fortune was fortunate to be large enough, with sufficient funding, to secure a very desirable site before capital development funding was in place;
- Site control is critical to secure public funding for development and operations;
- It is often difficult for providers to serve populations that do not fall within priorities designated by funding agencies;
- Providing different types or levels of housing within a single program provides the flexibility needed to address residents' changing needs; and
- Rehabilitation of existing structures often includes significant unanticipated expenses.

Services Provided by Housing Model

Table IIE-12 provides a full listing of the services provided by various housing models. The descriptions set above of the specific models list the most commonly provided services. Case management (94%), recreation (83%), substance support groups (74%), mental health services (69%), and transportation escort (65%) are the most common overall. Hospice (5%), needle exchange (12%), and child care (14%) are the least common.

Table IIE-12: Types of Services Provided by Housing Model

Housing Model	Nursing Services	Hospice	Case Mgmt.	Mental Health	Needle Exchange	Substance Use Services	Substance Support Groups	Harm Reduction	Safe Sex / Safe Injection
Transitional Congregate N=30	43% (13)	0% (0)	90% (27)	67% (20)	10% (3)	57% (17)	67% (17)	60% (18)	60% (18)
Transitional Scatter Site N=8	50% (2)	0% (0)	100% (4)	100% (4)	25% (1)	75% (3)	100% (4)	100% (4)	100% (4)
Scatter Site I / Sponsor Based N=44	34% (15)	11% (5)	93% (41)	82% (36)	9% (4)	61% (27)	80% (35)	45% (20)	45% (20)
Scatter Site II / Tenant Based N=19	5% (1)	5% (1)	100% (19)	63% (12)	11% (2)	63% (12)	74% (14)	74% (14)	11% (2)
Permanent Congregate N=50	44% (22)	2% (1)	94% (47)	60% (30)	14% (7)	42% (21)	72% (36)	42% (21)	42% (21)
Totals N=147	**36% (53)**	**5% (7)**	**94% (138)**	**69% (102)**	**12% (17)**	**54% (80)**	**74% (109)**	**52% (77)**	**52% (77)**

Table IIE-12 (continued): Types of Services Provided by Housing Model

Housing Model	Meal(s) Provided	Food Pantry / Vouchers	Job Training / Placement	Child Care	Recreation	Home Maker Services	Legal Services	Trans-portation Vouchers	Trans-portation Escort
Transitional Congregate N=30	60% (18)	33% (10)	47% (14)	17% (5)	77% (23)	10% (3)	33% (10)	43% (13)	60% (18)
Transitional Scatter Site N=4	25% (1)	75% (3)	75% (3)	50% (2)	100% (4)	0% (0)	100% (4)	50% (2)	100% (4)
Scatter Site I Sponsor Based N=40	14% (6)	50% (22)	43% (19)	25% (11)	89% (39)	18% (8)	34% (15)	36% (16)	66% (29)
Scatter Site II Tenant Based N=19	11% (2)	42% (8)	53% (10)	11% (2)	68% (13)	11% (2)	37% (7)	16% (3)	74% (14)
Permanent Congregate N=50	48% (24)	38% (19)	40% (20)	2% (1)	86% (43)	22% (11)	20% (10)	26% (13)	60% (30)
Totals N=147	**35% (51)**	**42% (62)**	**45% (66)**	**14% (21)**	**83% (122)**	**16% (24)**	**31% (46)**	**32% (47)**	**65% (95)**

Key Informant and Consumer Survey Results Regarding Housing Models

Key informants and consumer survey results provide important qualitative information about the various housing models, their advantages and disadvantages, and consumer and provider preferences.[9]

Transitional Housing

Key informants identified transitional housing as a critical resource for certain populations, such as persons coming out of jail or prison, transgendered persons, and youth aging out of foster care. These persons face particular barriers to access to permanent housing: parolees cannot be discharged to an emergency placement and youth and transgendered persons are at great risk in many emergency housing settings. Providers reported that consumers are not always ready for a permanent placement and that a transitional placement allows a client to stabilize and identify needs. Identified benefits of transitional placements included the quality of the housing, the fact that placements are not limited to 28 days (like many SRO placements), the ready access to needed supports, and the fact that residents receive consistent assistance with housing placement.[10]

Some key informants questioned the need for transitional programs. They stressed that required participation in services should not become a barrier to housing. They suggested instead an approach in which transitional services would be layered on permanent housing. Some consumers stated that they were not willing to participate in transitional housing programs, or had failed in those placements as a result of their inability to abide by program rules. Consumers and advocates expressed concern that consumers get "stuck" in transitional programs for long periods of time due to a lack of appropriate permanent housing options.[11]

Scatter Site I Housing

Providers and consumers strongly support the continued availability of scatter site housing in which the provider holds the primary lease. Providers observe that this model requires ongoing engagement in support services, and makes it possible to work with clients on complex life issues without the risk of housing loss. Providers also note that a key factor in the success of the Scatter Site I model has been the ability to build trust with landlords who know that the rent will always be

[9] This section does not include information about the commercial SROs, which are discussed in detail in Section IIH.
[10] HNA, Consumer Survey Focus Groups. (2003).

paid on time. Providers point out that many private landlords are unwilling to rent directly to consumers with poor credit, histories of incarceration, or other complex life issues. There is concern that requiring clients to hold leases in every case will effective eliminate scatter site housing as a supportive model, leaving clients who are chronically homeless and have complex life issues with no option but to move into congregate settings.

Many persons with HIV/AIDS in need of supportive housing prefer to live in apartments "scattered" throughout the community, and to receive necessary support services from a sponsoring not-for-profit agency off-site. The benefit of these programs is that they permit persons with HIV/AIDS who require support services in order to maintain housing to live as independently as possible in the community. Because support services are provided off-site, residents have less limiting program rules and staff oversight than residents of supportive congregate facilities. Consumers report that they enjoy receiving services off-site, and are able to protect their anonymity around their HIV status.

As explored in more detail in Section IIIC, consumer survey responses indicate that scatter site housing is serving consumers who are dually and triply diagnosed. Of the respondents in scatter site housing, 71% have substance use issues, 52% have mental health issues and 39% have co-occurring substance use and mental health issues. These results confirm that many of the consumers living in scatter site housing are in need of the services offered. Both consumers and providers report that it is critical that consumers have access to services in times of crisis as well as on-going services to ensure stability and continued connection to health care. Moreover, there are consumers who are unable to maintain their own lease, but benefit from living in a scatter site apartment. Providers report that they serve consumers who would fail in a wholly independent setting because they are unable to maintain a lease, but can manage day-to-day living in their own apartments with appropriate supports. According to both providers and consumers, the creation and maintenance of housing stability is the greatest benefit of the program.[12]

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[11] HNA, Key Informant Interview. (2003).
[12] HNA, Key Informant Interviews. (2003).

In addition to mental health and substance use issues, 52% of consumer survey respondents living in scatter site housing have been in jail or prison, and 43% have been convicted of a felony. The scatter site model houses model housing consumers who face housing barriers and discrimination; many landlords will not rent apartments to persons with histories of incarceration.

Landlords report that they prefer to rent apartments to not-for-profit agencies instead of renting directly to consumers. Landlords indicate that timely rent payments and the security of knowing that an agency is responsible for a housing unit make working with not-for-profits appealing. They also cited delayed or interrupted HASA rent payments, and the risk of renting to consumers with limited rental histories who may have difficulty making timely rent payments as reasons why landlords prefer to rent to not-for-profits.[13]

Consumer survey respondents indicated a high level of satisfaction with scatter site housing. As detailed in Section IIID below, seventy-nine percent of respondents in scatter site housing indicate that they were "satisfied" or "very satisfied" with their housing. Residents of scatter site housing had the lowest percentage of consumers who indicated that they wanted to move. Of the respondents in scatter site housing, 40% indicated that they would prefer to move from their current housing compared to 71% of consumers in the commercial SROs and 52% of consumers in congregate housing. Consumers reported that they enjoyed the independence of having their own apartments, while also benefiting from the ability to access services when needed. Consumers and providers noted that the scatter site model provides an important balance between independence and the ability to access services.

In addition to satisfaction with the housing model, consumers living in scatter site housing also indicated that they are satisfied with the cost or their housing. Eighty-three percent of consumers reported that they were either "satisfied" or "very satisfied" with the cost of their housing. This is consistent with the requirement that consumers in scatter site housing pay no more than 30% of their income in rent.

Critics of the Scatter Site I model of housing point out that apartments rented to not-for-profits are no longer subject to rent regulation, and thus may be lost as permanently affordable units. Critics

point out that the scatter site model does not create new housing units, yet is an expensive model of housing.

Scatter Site II Housing

Both government and provider key informants report that because some consumers now referred to Scatter Site II programs in fact require on-going supportive services to maintain housing stability, the time-limited nature of support services available through the Scatter Site II program are inadequate for some residents and increase their risk of housing loss and a return to homelessness. Key informants report that these consumers feel "abandoned" by the withdrawal of supports.[14] At least one Scatter Site II provider acknowledged that there was pressure on the program to choose the most independent housing applicants, in order to be able to focus limited services funding to support those program clients with high service needs.[15]

Key informants also noted that some consumers referred to Scatter Site II programs are unable or not yet ready to maintain a lease on their own. HASA representatives stated that they share the concern that the Scatter Site II model may not be appropriate for some consumers, noting that a number of persons referred to these programs have been unable to maintain the housing and have cycled back through the HASA emergency housing system.[16] This process can be demoralizing and harmful to consumers. Furthermore, it is an inefficient use of housing resources. Key informants differed on whether the Scatter Site II model should be considered part of the supportive housing system. Many took the position that the model is an effective housing placement assistance program that offers important transitional supports, but the program is not appropriate for consumers in need of ongoing supports in order to maintain housing.

Some Scatter Site II providers noted that clients with complex needs required substantial supports provided through other programs in order to remain stably housed. These providers were able to keep residents engaged in intensive case management, independent living skills programs, or social day programs. Both providers and government administrators expressed concern that the Scatter Site II model results in significant housing loss, because the resident either is unable to manage a

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[13] HNA, Key Informant Interviews (2002). Apartments rented by not-for-profits are not subject to rent regulation.
[14] Ibid.
[15] Ibid.
[16] Ibid.

lease obligation on his or her own, lacks living skills, or cannot tolerate the social isolation of living alone. They reported that a significant number of Scatter Site II clients lose or abandon these placements and re-enter the emergency housing system. Providers suggested that HASA recognize that some scatter site clients will never be able to hold leases in their own names without facing substantial risk of housing loss, and that a procedure be established for Scatter Site II providers to demonstrate the need for the agency to hold the lease on a case-by-case basis. Providers referred to a need to closely monitor length of stay and placement outcomes for the model to make sure it does not "tip out" vulnerable persons into housing loss and homelessness.[17]

Congregate Supportive Housing

As outlined in Section IIIC below, the results of the consumer survey show that residents of congregate supportive housing live experience multiple complex life issues. Seventy-two percent of congregate supportive housing residents identified as having a substance use issue, and 54% reported a mental health issues. Forty-two percent reported co-occurring mental health and substance use issues. In addition, according to survey results, 53% of congregate residents have been in jail or prison and 44% have been convicted of a felony. Like the Scatter Site I model, the congregate model of housing is serving consumers who are multiply diagnosed and may benefit from access to an array of intensive supportive services. This housing model also serves consumers who would face obstacles in obtaining housing because of their history of incarceration. In addition to serving persons with these complex life issues, providers stated that congregate housing is also effectively housing persons who are mobility impaired.[18] Almost all congregate housing is Americans with Disability Act (ADA) compliant and is appropriate for persons in wheelchairs.

Key informants reported that access to on-site services can be extremely beneficial to residents. One provider noted that because case managers can interact with consumers on a daily basis and can observe clients in their home setting, interventions and treatment can be more effective.[19] Moreover, consumers report that it is comforting to know that someone in their buildings can help in the case of a problem or crisis.[20]

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[17] HNA, Key Informant Interviews. (2003).
[18] HNA, Key Informant Interviews. (2003).
[19] HNA, Key Informant Interviews. (2003).
[20] HNA, Consumer Focus Groups. (2002).

While many praised the services available in congregate settings, some providers, consumers and advocates observed that mandatory participation in services served as a "turn-off" to clients, and was often the source of conflict between housing providers and their residents. Some key informants stressed that it is the philosophy of permanent supportive housing to make services readily available but voluntary in nature.[21] HASA-funded supportive housing programs require case management interactions with clients and resident compliance with treatment plans. Housing providers interviewed reported that they require residents to sign and abide by program agreements that require compliance with program service components. Some key informants pointed out that, in these situations, clients with the most complex needs do not receive the services they need because they are unable to comply with program requirements. All key informants believed that services should be available to all clients, but most acknowledged that the need for services varied tremendously from person to person, and also at different points in each client's life. Some providers suggested that the system of housing and services should allow for greater input from consumers to ensure that clients can receive the flexible services that they need. Some housing providers felt that services should be easily accessible to clients, with no paperwork, stigma, or barriers.[22]

According to the consumer survey results, consumers living in congregate housing are quite satisfied with their housing. Seventy-nine percent of the survey respondents living in congregate housing reported that they were either "satisfied" or "very satisfied."[23] Consumer focus group results regarding satisfaction were more mixed. Consumers indicate that they enjoy the sense of community that exists in congregate housing. Some congregate residents report that they do not want to live alone and liked the social networks created in this setting. In addition, consumers report that they enjoy having easy access to services. Some describe congregate housing as the best of both worlds: "when you want company you can go to the lounge and when you want to be alone, you go to your apartment and shut the door." Others, however, report that they feel that "big brother is watching" and yearn for greater independence. Some key informants expressed the opinion that can be "infantilized" in congregate settings that have a multitude of house rules that limit consumer freedom and independence.[24]

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[21] HNA, Consumer Focus Groups. (2003).
[22] HNA, Key Informant Interviews. (2003).
[23] See Section IIID below.
[24] HNA, Consumer Focus Groups. (2003).

II. F. HOUSING-RELATED SERVICES

Housing Placement Assistance

Funding is available to community-based organizations through the federal Housing Opportunities for Persons with AIDS (HOPWA) program, and Title I of the Ryan White CARE Act, to assist to persons living with AIDS and symptomatic HIV infection to locate and secure appropriate housing. Housing placement assistance includes locating and securing apartments, obtaining rental assistance entitlements, and providing training in the skills for daily living as needed and appropriate to prevent homelessness once housed.

Housing placement assistance providers receive referrals from hospitals, treatment centers, prisons, churches, single room occupancy hotels (SROs), the HIV/AIDS Services Administration (HASA), the streets, and through word of mouth from other consumers and providers. Housing Placement providers place consumers in both supportive housing and independent housing. Successful housing placement providers cite strong relationships with landlords and an understanding of, and ability to navigate, the HASA housing placement system.[1]

Challenges to Placement

Providers report serious barriers when attempting to place persons living with HIV/AIDS in independent housing. Housing placement providers report that they struggle with inefficiencies and barriers within the housing placement system, both in dealing with HASA to make the placement happen, as well as wrestling with external obstacles in dealing with landlords and an expensive housing market.[2] See Section IVE below for a more detailed discussion of barriers to efficient and effective HIV/AIDS housing placement in New York City.

Because HASA does not conduct an assessment of consumers entering the system, housing placement providers sometimes struggle to find the most appropriate placement for consumers. Without information on consumers' histories of mental or physical illness, homelessness or substance use, consumers often are placed in housing that has a greater or lesser degree of service intensity than actually required by the consumer. Consumers may then become dissatisfied with the

[1] Housing Needs Assessment (HNA) Key Informant Interviews. (2003).
[2] Ibid.

placement and/or fail. Housing placement providers reported that a thorough, completed consumer assessment would greatly improve their ability to properly place consumers.

In addition to the lack of a comprehensive consumer assessment, housing placement assistance providers report that HASA's processing of housing applications can be problematic. While the housing placement provider works with a client to locate and obtain an apartment, the housing application must be approved by HASA and each client must navigate through the application process before securing the lease. This process is lengthy and frustrating for consumers. Housing placement providers report that it is challenging to find landlords who are willing to rent to HASA clients. Because of delays in issuance of security deposits and rent payments, many landlords will only rent apartments to not-for-profits, and not directly to consumers.

Consumers with criminal justice histories often face discrimination when applying for supportive or independent housing. Housing placement assistance providers report that clients with histories of arson or weapons charges have trouble obtaining an apartment and there is little they can do to help. Furthermore, even when a landlord is willing to rent an apartment to a person with a criminal history, the applicant is often required to obtain evidence of the disposition of each conviction on his or her criminal record. This is an expensive and labor intensive undertaking, and clients often cannot afford the fees associated with the process, or lose the apartment in the time it takes to complete.

Housing placement assistance providers also report that it is particularly difficult to assist undocumented consumers. Because undocumented persons are ineligible for rental assistance programs such as HASA rental assistance, Section 8 or Shelter Plus Care, they are forced to rely on the Sustainable Living Fund for assistance with security deposits and ongoing rental assistance. The Sustainable Living Fund provides emergency and short-term rental assistance to a limited number of people and assists in securing and maintaining housing. The goal of the fund is to serve consumers who are not eligible for HASA rental assistance and benefits. However, providers report that because of HASA's delays in processing security deposit and first month rent payments, they tap into the Sustainable Living in order to expedite payments to landlords in order to secure leases for HASA eligible clients. Unfortunately, the Sustainable Living fund is always oversubscribed and there is a long waiting list for assistance. Providers report that there are many undocumented

persons unable to rent apartments because of the lack of rental assistance, and that undocumented persons living with HIV/AIDS often must turn to the Department of Homeless Services for shelter.

Other Critical Services / Wrap-Around Services

Medicaid and grant funded support services – such as case management, medical and social day programs, harm reduction programs for active substance users, and mental health care – are providing essential "wrap around" services necessary to keep many persons in independent housing stable and connected to health care.

Wrap-around support services provide the essential supports that keep many people in independent housing stable and connected to health care. These services are increasingly important as consumers' health status changes because of aging, prolonged HIV treatments, and co-occurring substance use and mental health issues.

Independent Living Skills Training

Independent Living Skills Training employs a HOPWA-developed life skills curriculum with community-based organizations providing training to clients in the skills needed to avoid homelessness, such as budgeting, paying rent in a timely manner, and home/apartment maintenance. The NYC HOPWA Master Contractor is in the process of merging this program with Housing Placement Assistance. Providers report that many consumers have such disorder and chaos in their lives that they cannot focus on completing the basic tasks of daily living, much less tackle getting a job or an education. Consumers express a need for services that will help them live more independently: they need to learn or improve basic life skills that such as financial management, cooking and cleaning. Both providers and consumers observed that consumers who master these day-to-day tasks are able build the confidence to move forward to live more independently, entr an educational program, or even secure employment.[3]

Harm Reduction Outreach in Commercial SROs

These HOPWA-funded Harm Reduction programs, funded through the NYC Master Contractor, provide critical services to consumers living in the commercial SROs. Community-based

[3] HNA, Provider focus group. (2003).

organizations reach out to residents of commercial SROs in efforts to engage marginalized persons in life skills training, and in referrals to medical, substance abuse, case management, reconnection to medically appropriate housing, and other services to assist such clients in achieving readiness for independent living.[4] For many consumers, these harm reduction programs serve as their only connections to service provision.

COBRA Case Management

COBRA, or the Community Follow-up Program, is a New York State Department of Health AIDS Institute initiative, begun in 1990, establishing family-centered, community-based psycho-social case management services for Medicaid-eligible HIV-infected individuals throughout New York State. The Community Follow-up Program utilizes a team model of service delivery, including home visitation, provided by case managers and paraprofessionals who together work to provide comprehensive, intensive services. The program is designed for HIV+ persons with a variety of service needs, who often require frequent contact with care providers and have had difficulty gaining access to care and retaining services. The goals of the Community Follow-up Program are to increase universal access to HIV-related services, promote early intervention, prevent or delay institutionalization, and foster independence and self-sufficiency. There are currently 48 approved Community Follow-Up Program providers throughout New York State. Providers include AIDS service organizations, community health centers, certified home health agencies, hospital outpatient centers specializing in HIV/AIDS, and other community-based social service organizations.

Adult Day Health Care (ADHC)

The ADHC programs are New York State Department of Health Article 28-licensed health care facilities, funded through Medicaid reimbursement. The purpose of the ADHC model is to ensure that dually and triply diagnosed clients have access to the best possible anti-retroviral treatment and all the support that they need for adherence. To be eligible to participate, consumers must be HIV symptomatic or asymptomatic on treatment, or treatment ready, in need of health care and supportive services, and Medicaid eligible. The principal modality is interdisciplinary care planning performed by medical, mental health, substance use, and expressive therapy professionals. The ADHCs provide comprehensive wrap-around services with psychosocial support groups, treatment education, directly observed therapy, medication monitoring, case management, and expressive

[4] NYC Department of City Planning. (2004). *Consolidated Plan.* New York, New York.

therapies. Many ADHC services include hot breakfast and lunch, nursing care, transportation, medical education, primary care linkages, entitlements assistance, pastoral/spiritual counseling, nutrition counseling and education, substance use and harm reduction services, medication monitoring and adherence assistance, mental health services, fitness programs, and holistic services. Client are encouraged to attend meetings, support groups, meals, and other programs frequently in order to create an intimacy between provider and client that breaks through barriers to care to improve health outcomes for this traditionally difficult to engage population.

Social Day Care Programs

The New York State Department of Health AIDS Institute and Ryan White Title I funding support the Social Day Care model, which provides supportive services to high need individuals to allow them to develop independent living skills. At the same time, the program provides critical substance use, mental health, nutritional, and psychosocial services.[5] The goal of these programs is to provide flexible services for hard to reach consumers such as homeless and marginally housed persons. Social Day Care programs are an essential support for many persons living independently, particularly those persons who lack skills and/or experience in maintaining a home. Providers report that social isolation presents a formidable challenge to housing stability for many clients with co-occurring mental health and substance use problems. One provider of Scatter Site II housing observed that the service needs of the clients of that program are ongoing and sporadic, and that her agency's social day program had enabled a number of clients to remain stable in that program who would otherwise have failed. Providers reported this low-threshold, non-threatening program helped keep consumers connected to care. Consumer focus group participants reported that it was important that they be able to access services with "no strings attached."[6]

Ryan White Programs

Each year, more than 75,000 people in nearly 200 organizations, from small food pantries to large hospitals, are enrolled in Ryan White Title I programs funded through MHRA/NYC HIV Care Services. The services provided are diverse and include: more than 2,000,000 congregate and home delivered meals and 500,000 pantry bags; 80,000 primary medical care visits; legal services tailored to the needs of people living with HIV/AIDS; and 65,000 transportation trips to medical and social

[5] New York State Department of Health AIDS Institute. (2000). Fact Sheet.
[6] HNA, Consumer focus group. (2003).

service appointments. Last year, 350,000 acupuncture and other complementary visits were provided to active and recovering drug users in harm reduction and substance abuse treatment programs, as well as other health and human service settings.

II. G. OTHER SYSTEMS OF SPECIAL NEEDS HOUSING

Neither mental health housing, public housing, nor any other supportive/subsidized housing system is a significant source of housing assistance for New Yorkers living with HIV/AIDS.

As the population of people living with HIV/AIDS increasingly includes individuals who experience other co-occurring disorders (mental illness, chemical dependency) and/or are homeless, the Assessment Team attempted to assess the applicability and suitability of housing subsidies and/or supportive housing programs that are provided by these other housing systems to people with HIV. Additionally, the team sought information regarding the extent of HIV infection among the residents of these programs.

Key informant interviews with social services and housing providers as well as government representatives from the mental health, substance use and homeless systems were central to this assessment. Programs sponsored by these informants include shelters, transitional and permanent housing for homeless people; residential substance use treatment and scatter site housing programs; and mental health housing programs including various types of community residences, scatter site apartments and supported housing. All providers interviewed operate mid-size to large nonprofit organizations that offer a variety of housing and services programs that are funded for the most part with public funds.

Interviews with State, City and county government agency representatives included the NYC Housing Authority (NYCHA), NYC Department of Housing Preservation and Development (HPD), the NYC Department of Health and Mental Hygiene (DOHMH, formerly DMHMRSAS), the NYC Department of Homeless Services (DHS), the Rockland and Westchester County Departments of Social Services and the NYS Office of Alcoholism and Substance Abuse Services (OASAS). Additionally, the assessment team reviewed the Consolidated and Continuum of Care Plans for the communities in the EMSA.

A major finding of the assessment is that "other" supportive/subsidized housing systems are not a significant source of housing assistance for persons living with HIV/AIDS. Key informants reported serving only a limited number (5-10%) of people known to be living with HIV/AIDS. Many of these programs, however, rely on self-disclosure and therefore may not be aware of persons

with HIV/AIDS in their care. Additionally, in many of these settings, when people learn that they are HIV positive, they are referred or self-refer to the HIV-specific housing system.[1]

Overall, key informants from non-HIV-specific housing programs identified a number of gaps in services including: HIV-specific housing for women with children; peer support; employment support; entitlements assistance; health care support, especially for undocumented immigrants; permanent housing; resources for young adults; and housing for people who are actively using drugs. Informants who provide services in scatter-site apartments noted that access to public transportation is an ongoing challenge as apartments that are affordable with available subsidies are often less convenient to public transportation.

The Substance Use Housing System

Most beds in the residential system for people with substance use issues are located in long-term residential drug treatment programs, termed "Intensive Residential" by OASAS. These are licensed facilities funded by OASAS that provide housing for 12 to 24 months in highly structured and routinized living environments. Generally, the model consists of large congregate facilities of 50 to 200 beds, and programs require abstinence and participation in drug treatment and employment as conditions of occupancy. Services provided include counseling, peer group counseling, supportive services, educational services, structured activities, recreation, and orientation to community services. At graduation, residents may move into halfway houses or transitional housing programs, out on their own, or into apartments subsidized by HUD through the McKinney Shelter+Care program or through other sources. There are 5,527 Intensive Residential slots in the EMSA, with 5,473 in New York City, 346 in Westchester County, 28 in Rockland County, and none in Putnam County.[2]

Halfway houses, termed "Community Residential" programs by OASAS, offer semi-structured living for three to eighteen months for individuals coming out of residential drug treatment programs who need more support and additional training in independent living skills. Most of these programs promote abstinence and require program participation and work as conditions of

[1] New York City Housing Needs Assessment (HNA), Key Informant Interviews. 2003.
[2] New York State OASAS, Data Management and Analysis Unit. 2003. List of Residential Services and Capacities.

occupancy. Beds in these programs are extremely limited, with only 227 in New York City, 27 in Westchester County, 18 in Rockland County, and none in Putnam County.[3]

In New York City, the homeless service system also includes transitional housing programs for substance users coming out of residential treatment who were homeless at admission. There are 608 units for single adults and 74 units for families. These congregate housing programs are run primarily by nonprofit substance abuse agencies and provide similar services to the community residential programs described above. Residents must be enrolled in outpatient substance use treatment and generally pursuing abstinence. Most of these programs are funded with HUD McKinney Supportive Housing Program (SHP) funds, and have intended stays of 18 to 24 months.[4]

Permanent Supported Housing units for people with substance use issues include units subsidized by Shelter+Care or Section 8 with supportive services provided by nonprofit agencies. These units may be located in permanent congregate housing that serves mixed populations or in apartments rented from landlords in the private market, similar to the Scatter Site I model described in Section IIE above, in the discussion of the HIV-specific housing inventory. In NYC, there are 1,544 units of permanent supportive housing for people with substance use issues: 1,353 for single adults and 191 for families.[5]

All of the substance use programs interviewed for the assessment offer HIV testing, education and counseling as part of their general menu of services, but are largely dependent on self-disclosure and referral information to identify people with HIV within their programs. One substance use program indicated that approximately 10% of people in its residential programs were living with HIV. Another provider reported the rates of HIV at less than 5%. A statewide program reported that approximately 35% of people in its methadone programs were diagnosed with HIV or AIDS.[6] In general, the assessment found that, for a variety of reasons, substance use programs serve persons known to be living with HIV/AIDS primarily through HIV-specific housing and services programs.

Providers of substance use services noted that it can be difficult for persons with HIV disease who are ill to participate in substance use services, and that once individuals test positive and are

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[3] Ibid.
[4] NYC Department of Homeless Services. 2003. *Continuum of Care Plan*. U.S. Department of Housing and Urban Development.
[5] Ibid.
[6] HNA, Key Informant Interviews. 2003.

symptomatic, they are generally referred for HIV-specific housing and services. Providers also reported that HIV-related stigma continues to be a barrier to self-identification and that many people they serve avoid HIV testing until they become ill. Additionally, it was noted that there is a shortage of HIV-specific housing for women with children, with only 890 permanent units available as of December 2003.[7,8] Permanent supportive housing for substance using women with children, however, is an even more limited resource, with only 191 units in NYC and no designated units for this population in the Tri-County Region.[9] The dominance of the abstinence-based model in the substance use housing system, finally, has meant that those people who need harm reduction approaches have had no options beyond being served by AIDS housing providers, or not receiving services.

Key informants expressed the opinion that because substance users have relatively high rates of HIV and traditional substance abuse residential programs currently serve fairly low percentages of people with HIV, people with HIV and substance use issues are, and may best be, served in HIV-specific housing with substance use services layered on. Indeed, in terms of volume, the HIV system has more than three times as many permanent supportive housing units as the substance use system. The complex medication regimens required by people with HIV also present significant challenges to substance use providers given their structured program scheduling and limited experience in this area.[10]

The Homeless Services System

The homeless service system in NYC is extensive and includes more than 15,000 emergency bed/units on a given night. More than 12,000 of these are for single adults and the balance are for families. These emergency units consist of congregate facilities with dorm-style accommodations for single adults; "Tier 2" shelters for families where families have individual living units including kitchenettes and baths; and units in hotels, motels, and apartments rented by the NYC Department of Homeless Services (DHS) from landlords and realtors in the private market. NYC's shelter system is funded by DHS and the NYS Office of Temporary Disability Assistance (OTDA).[11]

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[7] Ibid.
[8] HIV Housing Inventory. 2003.
[9] NYC, Westchester and Rockland County Department of Homeless Services. 2003. *Continuum of Care Plans.* U.S. Department of Housing and Urban Development.
[10] HNA, Key Informant Interviews. 2003.
[11] NYC Department of Homeless Services. 2003. *Continuum of Care Plan.* U.S. Department of Housing and Urban Development.

The majority of congregate shelters for single adults are run by nonprofits under contract with DHS. These are referred to as "program shelters" by DHS and frequently as "transitional housing" by providers. Slightly more than 7,000 of these beds have targeted populations and provide related support and/or employment services. Specifically, there are 1,935 beds for substance users, 705 for those with mental illness, 368 beds for MICA (mentally ill and chemically addicted) populations, and 403 beds for people with medical problems. There are also special shelters that focus on assessment and facilities for working people. The family side of the system does not have units targeted to special needs or disabled groups, except for survivors of domestic violence.[12]

In NYC, any person who has HIV, is symptomatic, and is in a shelter has a right to be moved into other emergency housing that is not a shelter. Given the stigma and other challenges of living in a shelter with HIV, key informants expressed the opinion that once people in NYC find out that they are HIV-positive, the majority move into the HASA emergency housing system. Further, they believe that those HIV-positive individuals who remain in NYC shelters tend to keep their HIV status to themselves (or do not know their status) and do not receive treatment until they are already ill.[13]

Homeless persons with asymptomatic HIV infection, however, are referred to the City shelter system. New DHS policies allow the agency to exclude persons violating an "independent living plan" from emergency shelter for a minimum of 30 days. Each homeless person's independent living plan is based on an assessment, and may include participation in services such as drug treatment. HIV-positive persons in the shelter system could be excluded from shelter based on this policy. Key informants suggested that shelter providers would probably hesitate to "pull the trigger" in such a case, but were concerned that many do not know the HIV status of most residents.[14]

The largest homeless system outside NYC is in Westchester County, which has a total of 1404 units: 540 for individuals and 864 for families with children. Westchester County has more than 593 emergency beds/units on a given night. More than 400 of these are for single adults and the balance are for families. These emergency units consist of congregate facilities with dormitory-style accommodations for single adults. Of these emergency units, only 19 are targeted to individuals

[12] Ibid.
[13] HNA, Key Informant Interviews. 2003.
[14] Ibid. This DHS policy is discussed in more detail in Section IVB below.

living with HIV/AIDS; 49 are targeted to family survivors of domestic violence. The homeless service system in Westchester County also includes 140 units of transitional housing for single homeless adults and 671 units for families, comprising a total of 811 transitional units. None of these units is targeted to individuals living with HIV/AIDS or survivors of domestic violence.[15]

The homeless system in Putnam County includes 213 emergency shelter units for single adults and 32 units for families. Putnam also has 54 units of transitional housing for homeless single adults.[16] Rockland County has only 10 emergency shelter beds for single adults and 5 for families, and it has 212 units of transitional housing for single homeless adults.[17] Tri-county programs indicated that there is no preference or special emergency housing program for persons with HIV/AIDS who are experiencing homelessness. Echoing NYC informants, tri-county providers reported that many shelter residents do not receive HIV/AIDS services until they are sick.[18]

In spite of long stays, the emergency shelter systems in the EMSA are meant to provide short-term occupancy and to move people into independent housing or supportive housing based on special needs and preferences. As such, the assessment found that the shelter systems in the EMSA are not adequately equipped to serve people who have HIV. Key informants from shelters and transitional programs estimated that between 2 and 10% of their clients were living with HIV/AIDS. New York City shelters offer HIV testing and rely on self-disclosure to identify people with HIV/AIDS; programs in Westchester and Rockland Counties also rely on self-disclosure, but do not offer testing. All homeless programs refer persons who self-identify as HIV-positive to community-based agencies to receive HIV housing and services.[19]

Key informants noted consistently that the difficulty of maintaining an anti-retroviral medication regimen in a shelter served as a barrier to adequately serving people with HIV. Specifically, the lack of proper storage facilities and the challenges of maintaining privacy and confidentiality in large congregate settings were cited as obstacles to service. Additionally, staff frequently lack the expertise

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[15] Westchester County Department of Homeless Services. 2003. *Continuum of Care Plan.* US Department of Housing and Urban Development.
[16] Putnam County Department of Homeless Services. 2003. *Continuum of Care Plan.* US Department of Housing and Urban Development.
[17] Rockland County Department of Homeless Services. 2003. *Continuum of Care Plan.* US Department of Housing and Urban Development.
[18] HNA, Key Informant Interviews. 2003.
[19] Ibid.

and time to establish the necessary service links to appropriately serve the complex needs of people with HIV.[20]

The Mental Health Housing System

The mental health housing system includes a range of models and programs types. In New York City, there are more than 11,400 units targeted to adults with serious and persistent mental illness.[21] The Tri-County region includes 1,505 mental health units: 96 in Putnam County; 455 in Rockland County; and 954 in Westchester County.[22]

Throughout the EMSA, the NYS Office of Mental Health (OMH) sponsors a range of residential options including Congregate Treatment, Apartment Treatment, CR/SROs, and Supported Housing. In NYC, in addition to OMH units, units are jointly sponsored by the NYC Department of Health and Mental Hygiene (DOHMH), DHS, and the NYC Department of Housing Preservation and Development (HPD). These units are called Supported SROs and are congregate housing programs serving mixed populations.

Congregate Treatment programs, also known as "Community Residences," are small facilities (12 to 24 units) that provide structured living and intensive services to help people with mental illness build life skills and work on recovery from their illnesses. In these programs, residents usually share bedrooms and baths, and meals are prepared "family-style" by residents and staff. These programs have staff on-site 24 hours a day, seven days a week, and are meant to be transitional, moving residents on to less structured living arrangements within 18 to 36 months. Some of these programs are dedicated specifically to housing individuals who are dually diagnosed with mental illness and chemical addiction (MICA). In NYC, there are 1,357 Congregate Treatment units and 483 MICA Congregate Treatment units.[23] In the Tri-County Region, there are 276 Congregate Treatment units (14 in Putnam County, 158 in Rockland County, and 104 in Westchester County), and 27 MICA

[20] Ibid.
[21] Center for Urban Community Services. 2003. Residential Placement Management System Mental Health Housing Database.
[22] NYS Office of Mental Health. 2003. OMH Housing Unit.
[23] Center for Urban Community Services. 2003 Residential Placement Management System Mental Health Housing Database.

Congregate Treatment units (all in Westchester County). There are an additional 136 State Operated (RCCA) Congregate Treatment units in Rockland County.[24]

CR/SROs are congregate facilities licensed by OMH that house fewer than 100 individuals with mental illness. A focus of these programs is helping individuals build skills and eventually move on to less intensive service programs. A full range of skill building and mental health treatment services is available to residents. Individuals have private bedrooms and baths, and low-cost meals are offered in communal dining rooms. This model is very popular with consumers and in high demand. Currently, there are 820 units of CR/SROs in NYC.[25] There are no CR/SROs in the Tri-County Region.[26]

OMH Apartment Treatment and Supported Housing programs both use a scatter site housing approach. Nonprofits rent apartments from private landlords, and then sublet them to residents. Services are provided in residents' apartments or in the agency's community-based offices. The primary differences between these two models are the intended lengths of stay and the intensity of services. Apartment Treatment programs are meant to be transitional and to provide intensive services (up to seven visits per week). Supported housing units are permanent and intended to serve people who have sufficient skills to require service visits only once or twice a month. In NYC, there are 1,921 Apartment Treatment units and 3,980 Supported Housing units.[27] The Tri-County Region has a total of 284 Apartment Treatment Units, with 40 in Putnam County, 86 in Rockland County, and 158 in Westchester County. There are a total of 766 Supported Housing units in the Tri-County Region, with 42 in Putnam County, 75 in Rockland County, and 649 in Westchester County.[28]

Finally, in NYC, there are a significant number of units targeted to people with mental illness through housing programs called Supported SROs. These permanent housing units are located in congregate facilities that range from 20 units to 600+ units in size, and use an innovative financing package to enable them to serve a mix of populations in a single program. Funded by HPD, DOHMH, and DHS, among others, through HPD's Supportive Housing Loan Program, these

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[24] NYS Office of Mental Health. 2003. OMH Housing Unit.
[25] Center for Urban Community Services. 2003. Residential Placement Management System Mental Health Housing Database.
[26] NYS Office of Mental Health. 2003. OMH Housing Unit.
[27] Center for Urban Community Services. 2003. Residential Placement Management System Mental Health Housing Database,
[28] NYS Office of Mental Health. 2003. OMH Housing Unit.

programs combine mainstream and homeless housing assistance funding to acquire, develop, and operate their projects. All programs use Section 8, Shelter + Care, or OMH Supported Housing funds for rent subsidies. Populations served include people with mental illness, HIV/AIDS, and other disabilities as well as non-disabled homeless and low-income people. (Some of these units are included in the HIV-Specific Housing Inventory and are described in the "Permanent Congregate" model described above.) In Supported SROs, individuals have private bedrooms and most of the buildings offer private baths and kitchenettes as well. There are 2,476 Supported SRO units for people with mental illness in NYC.[29] In the Tri-County Region, there are 16 Supported SRO units, all in Westchester.[30]

Mental health providers interviewed for the assessment estimated the percentage of people living with HIV/AIDS in their programs as between 5% and 10%. These agencies rely on self-disclosure and program referrals to identify people with HIV/AIDS; few programs provide HIV testing.[31]

For people dually diagnosed with HIV and serious mental illness, such as schizophrenia, schizoaffective and other psychotic disorders, the mental health housing system is widely regarded as a better resource than the HIV/AIDS housing system, because some HIV providers do not have the requisite knowledge and experience to effectively address these types of illnesses. Additionally, many of these individuals require supervised living arrangements and the behaviors that can sometimes accompany these psychotic disorders can make it difficult for them to integrate into congregate settings that exclusively serve persons with HIV.

One provider of intensive community-based mental health services (Assertive Community Treatment), however, reported that approximately 10% of the program's participants had HIV disease and were living in HIV-specific housing.[32] Combining mental health resources with HIV housing can be an effective model with the seriously mentally ill population. Serving people with HIV in mental health housing must include assuring access to all specialized services, including medical services, medication, employment and substance use treatment.

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[29] Center for Urban Community Services. 2003. Residential Placement Management System Mental Health Housing Database.
[30] NYS Office of Mental Health. 2003. OMH Housing Unit.
[31] HNA, Key Informant Interviews. 2003.
[32] Ibid.

Reported challenges to serving people with HIV in the mental health housing system include staff's lack of knowledge about HIV disease and related community-based services and ensuring adherence to extremely complicated regimens that include a number of psychotropic medications as well as anti-retrovirals and other HIV medications. Additionally, providers noted the difficulty of providing home care in small or shared living arrangements and helping people remain in recovery (from both mental health and substance use) when they experience failing health.[33]

The Public Housing System

The public housing system, which includes both bricks-and-mortar public housing projects as well as tenant-based rental subsidies, is not a special needs housing system *per se,* but because it strictly limits income eligibility of its tenants and limits their rent payments to 30% of income, it has the potential to serve as a significant housing resource for many special needs groups.

In New York City, public housing is developed, owned, and operated by the New York City Housing Authority (NYCHA). NYCHA's public housing program provides 181,000 units in 345 housing developments. Because of the affordability and relatively high quality of these units, NYCHA currently maintains a waiting list of 146,000 households for these units.[34] Currently NYCHA prioritizes as emergency applicants homeless households, victims of domestic violence, and intimidated witnesses referred by the District Attorney. NYCHA does not maintain any preferences for persons with HIV/AIDS, and can provide no estimate of the number of persons with HIV/AIDS currently living in its public housing projects.[35]

The federal Housing Choice Voucher (HCV) program, also known as Section 8, is a tenant-based subsidy that subsidizes tenant rents, up to a defined payment standard, above a tenant share of 30% of household income. In New York City, NYCHA, the New York City Department of Housing Preservation and Development (HPD), and the New York State Division of Housing and Community Renewal (DHCR) operate Section 8 programs. NYCHA's program, which subsidizes rents in more than 85,000 housing units, is by far the largest. NYCHA's waiting list for its Section 8 program is made up of 149,000 households. Currently NYCHA is only accepting Section 8 applications from homeless households, victims of domestic violence, and intimidated witnesses,

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[33] Ibid.
[34] New York City Housing Authority. December 2003. NYCHA Fact Sheet.
[35] HNA, Key Informant Interviews. 2003.

and it maintains no preferences for persons with HIV/AIDS.[36] While HPD has no preference for persons with HIV/AIDS, it dedicates a number of vouchers to its congregate supportive housing system, and persons with HIV/AIDS receive these vouchers when they are referred to supportive housing projects.[37]

Overall, other systems of subsidized housing are not a significant resource for people with HIV/AIDS. Some agencies report that they currently provide a continuum of services for people with HIV, but few are able to combine resources to create a truly comprehensive services package. However, the supportive housing system is moving in this direction, and a number of mixed population housing programs have successfully blended different funding streams to enable them to effectively serve the full range of residents' needs. Some agencies have formed successful partnerships with other agencies to provide a wider range of services. Not all providers, however, are aware of how to access other existing systems of care. Mechanisms to coordinate planning across systems and cross train staff are needed.

[36] New York City Housing Authority. December 2003. NYCHA Fact Sheet.
[37] HNA, Key Informant Interviews. 2003.

II. H. CONTINUED USE OF THE COMMERCIAL SROS

Despite the size and scope of currently available HIV/AIDS housing resources, more than 1,500 persons with HIV, many with serious co-occurring substance use and mental health issues, remain relegated to substandard commercial SRO housing that is short-term, provides no supportive services, and costs, on average, from $50 to $80 per night.

Since the early 1900s, single-room housing in New York City has played an important role as a source of cheap housing for poor single adults and childless couples. In 1960 there were approximately 129,000 single-room housing units in New York City – single-room occupancy (SRO) facilities and residential hotels, typically with shared kitchens and bathroom facilities. By the 1970s single-room housing had become the "housing of last resort" for poor single adults, many of whom were disabled, elderly, chronic drug users, or formerly incarcerated.[1] A combination of development restrictions and public and private incentives has resulted in a substantial reduction in the SRO housing stock, and conversion or demolition of this housing continues. As noted in Section IIA above, a rapid decline in the availability of SRO housing has been cited as one reason for the dramatic increase in visible homelessness during the mid to late 1980s. Currently it is estimated that there are fewer than 47,000 units of single-room housing remaining. Moreover, much of the existing stock is being used by City homeless housing programs paying $50 or more per night, and is therefore no longer available as permanent housing for low-income wage earners or elderly or disabled persons living on fixed incomes.[2]

Commercial SRO hotel units have been used as emergency housing placements for homeless New Yorkers with AIDS and HIV-illness since the late 1980s when it was recognized that congregate City shelters are inappropriate and unsafe for persons with HIV-related immune suppression.[3] It has also been New York City's stated intent since at least 1990 to end its reliance on commercial hotels as emergency placements for persons with HIV/AIDS by creating more appropriate permanent and transitional housing options.[4] Commercial SROs are inappropriate for persons with HIV illness (most units lack private bathrooms and cooking facilities), they are expensive to use (at $50 or more

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[1] Blackburn, A. J. 1996. *Single Room Living in New York City.* New York City Department of Housing Preservation and Development. New York, New York.
[2] New York City Housing Needs Assessment (HNA), Key Informant Interviews. 2003.
[3] City of New York. 1990. *Continuum of Housing and Services for the Medically Frail and HIV-Ill.*

a night), they provide no services, and many can be predatory and dangerous environments for persons whose HIV illness is complicated by co-occurring mental health and substance use issues.[5] The results of the consumer survey conducted as part of this study confirm the reports of key informants that the commercial SROs are housing many of the most vulnerable New Yorkers with HIV/AIDS – persons at the highest risk of continued housing instability due to histories of homelessness, substance use, incarceration and mental health problems.[6] Yet, providers of outreach, advocacy and harm reduction services in the SROs are frequently the only consistent connection between residents and necessary supportive services. Moreover, residents of the SROs and other key informants report substandard and unsafe building conditions, lack of security, and atmospheres that foster illegal activities such as drug dealing and loan sharking.

The proportion of persons in the HIV/AIDS housing system that are placed in commercial SROs has certainly been reduced – from 17% of all placements in 1990 (800 of 4700 units) to about 6% of all placements currently (1,500 of 27,000 units). Yet despite the size and scope of available HIV/AIDS housing resources, there are still more than 1,500 HIV/AIDS Services Administration (HASA) clients living in commercial hotels.[7] HASA rents these units from landlords at average rates of at least $50 per room/per night.[8] At the current level of 1,500 consumers housed in the commercial SROs, and at $1,500 per month, HASA can expect to spend at least $27,000,000 on the use of commercial SROs this year.

Throughout the course of this needs assessment, government officials, providers, and consumers all expressed concern about New York City's continued reliance on SROs. For many SRO occupants, this "emergency placement" becomes a long term "chaotic situation" as they move from hotel to hotel every 28 days.[9] However, key informants also noted the important role played by low-income single room housing, which, if improved and properly managed, could once again be a viable

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[4] Ibid.
[5] National Development and Research Institutes. 1997. Abridged Ethnographic Evaluation and Executive Summary of SRO Harm Reduction Outreach of the Center for AIDS Outreach and Prevention.
[6] See Section IIIB below.
[7] City of New York. 1990. *Continuum of Housing and Services for the Medically Frail and HIV-Ill.* New York City Human Resources Administration HIV/AIDS Service Administration (NYC HRA HASA). December 2003. *HASA Facts.* New York, New York.
[8] HNA, Key Informant Interviews. 2003.
[9] See Section IVE for a discussion of steps needed to improve housing placements for persons in emergency housing.

permanent housing option for many poor and disabled New Yorkers, including people with HIV/AIDS.

Indeed, despite the multitude of problems associated with the commercial SROs, nearly 64% of the consumer survey respondents living in SROs reported that, overall, they were satisfied with their current housing. Though this was the lowest rate of satisfaction among housing models, it is surprisingly high. Key informants and consumers suggested a number of reasons for this finding. Most significantly, an SRO room provides an essential private housing situation for persons whose histories of poverty, homelessness and incarceration have left them in crowded institutions or on the streets, some for years. Key informants also noted a preference by some persons for the central location of many of the hotels over housing options in areas where supportive services and networks are less accessible; a need for the sense of community provided by hotel living; an inability to manage the responsibility and/or isolation of independent living; a desire to be "left alone"; and reliance on the underground economy that characterizes the hotel settings.[10]

Key informants stressed the need to immediately address problems with SRO conditions and management, while also calling for broader steps to preserve what remains of the SRO housing stock, creating a "higher functioning SRO model" of housing, meaning SRO housing that is decent, affordable and assures access to support services.

The immediate priority is that the City enter into formal contract agreements with landlords of the commercial SROs in order to hold landlords accountable for the condition and security of buildings and to ensure access by providers of low-threshold harm reduction and outreach services. In addition to better contractual agreements, key informants suggested that HASA create a set of uniform "house rules" and procedures for the residents of the SROs.[11]

HASA reports that in the spring of 2004 it began to engage its portfolio of commercial SROs in new Memorandums of Understanding, and that it expects to complete this process by the end of the calendar year. It also reports that the 28-day relocation policy was discontinued in the spring of

[10] HNA, Key Informant Interviews. 2003.
[11] Ibid.

2004. It has a goal of having 40% of HASA emergency housing stock under contract by the end of 2006, with the balance of the stock subject to the new MoUs.[12]

HASA additionally has made the following comments about the conditions in commercial SROs:

> …it is important to note that all emergency housing is subject to inspections by the HASA Housing Inspection Unit, which inspects these facilities on a quarterly basis. HASA has a protocol for placing facilities on non-referral status or discontinuance of use status. We are also in the process of increasing our monitoring unit staffing to ensure that quarterly inspections and corrective action plan follow-ups take place in a timely manner, and inspectors have been provided with digital cameras to record serious violations to minimize disputes/appeals by landlords arguing that conditions are not as serious as depicted in the written reports. In addition to our own monitoring, HPD inspection report results are provided to HASA. All type C violations, the most serious violations, are followed up on immediately by HASA inspectors, and that follow up is documented.[13]

It is worth noting, however, that key informants reported serious conditions in the SROs, and that a report issued by the New York City Council in June 2004 found that many transitional and emergency facilities for HASA clients were substandard. The report found that at least 73% of the facilities had open violations issued by HPD in the last year, and 33% of the facilities had Class C violations. It found that 57% of rooming house facilities had more than one HASA client sharing bedrooms.[14]

Key informants also presented more broad-ranging ideas on how to convert the SRO housing stock into a viable housing alternative for poor persons. Key informants suggested that the City acquire these buildings and transfer title to not-for-profit organizations to rehabilitate and manage the properties.[15] Since most not-for-profits do not have the financial resources to purchase the high priced SROs (one five-story SRO is on the market for $5 million, and another three-story, 16 unit building is selling for $1.6 million), public funding would have to be used to acquire and rehabilitate the remaining units. Certainly, this would be an ambitious and expensive undertaking. However, the potential loss of what remains of this affordable housing requires a bold and timely intervention.

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[12] Comments of the New York City Human Resources Administration On An Assessment of the Housing Needs of Persons with HIV/AIDS, September 2004

[13] Ibid.

[14] The Council of the City of New York, Transitional and Emergency AIDS Housing: In Urgent Need of Repair, June 2004.

[15] HNA, Key Informant Interviews, 2003.

III. Persons Served by the HIV/AIDS Housing System

III.A. CONSUMER SURVEY OVERVIEW

Data regarding the housing and support service needs and preferences of people living with HIV/AIDS in New York City and the Tri-County Lower Hudson Region were gathered through the distribution of an extensive consumer survey, which was developed and analyzed by the University of Pennsylvania Center for Mental Health Policy & Services Research (U Penn Center).[1]

Survey results confirm that New York's "housing first" approach to the intersecting crises of HIV/AIDS and homelessness has been tremendously successful. New York's system of HIV/AIDS housing resources serves persons whose HIV/AIDS diagnoses are complicated by histories of extreme poverty (45% of consumers surveyed have experienced a stay in a shelter or on the street) and prior incarceration (43% have been in jail or prison, and 31% report a felony conviction), as well as very high rates of past or present substance use and/or mental health issues (reported by 80% of all respondents). The majority are male, black or Latino, and rely on federal disability benefits. Most live alone (64%), although 13% report that they are doubled up with another household.

Yet, despite the presence of multiple destabilizing life issues, the great majority of persons who use HIV-specific housing resources in the NYC EMSA report that they are stably housed (stably housed survey respondents outnumber the unstably housed by a margin of almost 5 to 1), satisfied with their housing (71% report being satisfied or very satisfied), and receiving the support services that they need (71% report that they receive case management services). This stability and satisfaction translates into connection to health care (95% have a relationship with a primary care provider) and participation in HIV treatment (77% report participation in HAART).

Survey analysis reveals marked differences among the persons served in different models of HIV/AIDS housing. Consumers living in supportive scatter site and congregate housing, as well as those in SROs, have much more significant histories of homelessness and incarceration, as well as substance use and mental health issues. Even without an appropriate system for triaging applicants

[1] Details of the methodology employed to collect and analyze the consumer survey data are set out as part of Appendix A to this report.

for HIV/AIDS housing, the analysis indicates that persons with more troubled histories and complex life issues are, appropriately, represented in much greater numbers in supportive housing. Indeed, supportive housing provides an essential resource for persons with histories of incarceration, felony convictions, and mental health hospitalization, who face substantial barriers to entry into the private rental market and are underrepresented in independent housing. Persons living independently report the highest rate of housing stability. Significantly, however, analysis reveals that people with HIV/AIDS living in supportive housing, who experience much higher levels of destabilizing life issues than persons in independent housing, are just as stable as those living independently, and are more satisfied with their housing. One reason for greater satisfaction among residents of supportive housing may be the significant difference in rent burden by housing model, with residents of independent housing paying a much higher proportion of their incomes out of pocket towards rent (49%), than residents of supportive housing programs (34%) where rent burden is calculated as a percentage of income.

Consumers' high rate of overall satisfaction (71%) with their housing, even among residents of the SROs (64%), must be viewed in light of the fact that before establishing eligibility for HIV-specific housing resources, many of these consumers experienced poverty, homelessness, and incarceration. For many consumers, the enhanced rental assistance available to persons with HIV/AIDS has made it possible for them to enter a housing market that otherwise would be closed to them. When asked to make choices about future housing, consumers expressed strong preferences for living "in their own place," for integration into the community, and for enhanced safety. The results do reveal some obstacles to securing housing, most notably for persons who were previously incarcerated, which show why a segment of the population needs and will continue to need HIV-specific supportive housing that does not rely on the private housing market.

Despite overall stability and satisfaction, however, the survey results highlight a substantial minority of consumers of HIV/AIDS housing resources who are dissatisfied with their housing (28%) and experience a high level of housing instability (18%). These persons report the highest rates of prior homelessness and co-occurring mental health and substance use issues, yet they are concentrated predominantly in SRO housing, much of which is substandard, temporary and lacks on-site support services. These findings reveal a significant unmet housing need, and underscore the importance of

looking more closely at this housing model, and of ensuring that consumers' needs are assessed before they are placed in housing.

Methodology

A working group of consumers, providers and other policy experts, working under the direction of the U Penn Center, created a 118-question consumer survey instrument. The purpose of the survey was to collect relevant information on six survey objectives: personal information, current living arrangements, income benefits and expenses, housing history, housing preferences, and supportive services.

The Hudson Planning Group (HPG) distributed approximately 6,500 consumer survey instruments, and collected more than 2,000 completed surveys, 1,836 of which were useable for the U Penn Center's analysis. To ensure that responses were anonymous and confidential, HPG distributed surveys solely through participating providers of housing, health and social services for persons with HIV/AIDS, who then distributed the survey instrument to their service clientele. Fifty-five New York City and Tri-County service providers participated in survey distribution, which was conducted in two waves. The first wave consisted of bulk distribution by mail or hand to the clients of participating agencies; in the second wave, HPG coordinated the efforts of ten peer survey workers who administered the survey to individuals and groups at agencies targeted to reach populations underrepresented in first wave responses, hard-to–reach consumers, and consumers with language or literacy barriers. An on-line version of the survey was posted on the U Penn Center's website, and consumers were given the option of submitting survey responses via the website. Completed survey responses were sent to the U Penn Center for data entry and ongoing evaluation of the representativeness of survey respondents. The U Penn Center conducted the data analysis presented in this section.

Representativeness of Survey Respondents

The 2,088 New Yorkers living with HIV/AIDS who responded to the survey approximates by borough/county of residence, gender, and race, the demographics of the HIV/AIDS epidemic in the NYC EMSA, as presented in AIDS surveillance data. A special effort was made to improve the geographic representativeness of the survey, which mitigated the initial underrepresentation of persons living in Brooklyn and the overrepresentation of persons living in Manhattan. Though still biased toward persons receiving services, the sample was found to be representative by gender when compared to the New York Department of Health's AIDS Surveillance Data. However, this comparison did reveal a geographic and race/ethnicity bias that compromises the ability to extrapolate the survey results to the larger population of persons living with HIV/AIDS in the NYC EMSA.

As with other vulnerable and hard-to-reach populations, particularly where confidentiality issues are paramount, this survey was necessarily based on a "convenience sample." As demonstrated in Appendix A, a targeted outreach strategy enabled the Assessment Team to obtain a sample of respondents that was more geographically representative of persons with AIDS in the NYC EMSA than the initial sample. The issue of bias toward service-engaged persons, however, was more difficult to overcome. The final sample does include persons who receive few or low-intensity services and explores what services they would like to receive, but the sample could not be construed as proportionately representative of persons receiving no or few services, as that was a constraint of the sampling frame. This remains an important qualification of study results.

Table IIIA-1a. Distribution of All Survey Respondents by Borough and County

	Surveys	AIDS Surveillance Data	Difference
Bronx	25.06%	21.05%	4.01%
Brooklyn	24.60%	24.89%	-0.29%
Manhattan	32.31%	32.12%	0.19%
Queens	9.01%	14.30%	-5.29%
Staten Island	2.38%	1.76%	0.62%
Putman County	0.67%	0.14%	0.53%
Rockland County	0.73%	0.97%	-0.24%
Westchester County	5.23%	4.44%	0.79%

	Observed N	Expected N	Residual
Bronx	484	407.8	76.2
Brooklyn	475	482.2	-7.2
Manhattan	624	622.3	1.7
Queens	174	277.0	-103.0
Staten Island	46	34.1	11.9
Putman County	13	2.7	10.3
Rockland County	14	18.8	-4.8
Westchester County	101	86.0	15.0
TOTAL	1931		

Chi-square = 99.676, p < .001

Table IIIA-1b. Distribution of All Survey Respondents by Gender

	Surveys	AIDS Surveillance Data	Difference
Females	29.40%	28.00%	1.40%
Males	70.60%	72.00%	-1.40%

	Observed N	Expected N	Residual
Female	540	514.9	25.1
Male	1299	1324.1	-25.1
TOTAL	1839		

Chi-square = 1.697, p = .193

Table IIIA-1c. Distribution of All Survey Respondents by Race/Ethnicity

	Surveys	AIDS Surveillance Data	Difference
White	15.20%	20.84%	-5.64%
Black	45.70%	44.15%	1.55%
Hispanic	31.90%	34.31%	-2.41%
Other	7.20%	0.70%	6.50%

	Observed N	Expected N	Residual
White	279	383.2	-104.2
Black	841	811.9	29.1
Hispanic	586	631.0	-45.0
Other	133	12.9	120.1
TOTAL	1839		

Chi-square = 1153.591, p < .001

Interpreting Survey Responses

Survey responses presented here and in the Appendices to this report indicate either percentages of people who selected a response or means/averages of the responses. These percentages and means/averages only represent the people who answered the question. Responses are presented by gender and/or race/ethnicity only where these factors have a statistically significant effect on the responses. The U Penn Center also conducted regression analyses to examine the factors associated with certain outcomes. Regression is a way to find out which of a set of predictor variables help explain a certain response. These regression analyses control for the impact of a number of independent variables, such as race and age. The "effect" describes the extent to which a predictor variable increases the odds of an outcome. The tables presented here list only statistically significant predictor variables.

Data and analysis by the U Penn Center presented in the body of the report are presented, in most cases, on an aggregate basis for the EMSA. Tables showing certain survey results by borough/county are set out in Appendix C. The following tables only include respondents who reported that they had AIDS or were HIV-positive, and had not stated that they had completed the survey before.

Demographic Profile of Respondents

Table IIIA-2. Gender

	Male	Female	Transgender
Gender	71%	27%	2%

Table IIIA-3. Age

	20-24	25-29	30-39	40-49	50+
Age	1%	3%	23%	42%	31%

Table IIIA-4. Race/Ethnicity

	White/ Caucasian	African-American/ Black	Asian/ Pacific Islander	Hispanic/ Latino(a)	Other
Race/Ethnicity	16%	45%	2%	32%	5%

The demographics of the survey sample accurately reflect the HIV/AIDS epidemic in the NYC EMSA, and are also reflective of the persons currently served by New York City's HIV/AIDS Services Administration (HASA). In December 2003 HASA reported that 62% of clients currently served were male and that 86% were African American or Latino.[2] HASA does not include an age breakdown in its monthly Fact Sheet, but the New York City Department of Health and Mental Hygiene reports that approximately 53% of persons living with AIDS at the end of 2001 were 40 years or older.

Table IIIA-5. HIV Status and Gender

	Female	Male	Transgender	Total
AIDS	31%	40%	36%	37%
HIV-positive with symptoms	36%	34%	34%	34%
HIV-positive without symptoms	33%	27%	36%	29%

Table IIIA-6. HIV Status and Race/Ethnicity

	White/ Caucasian	African American/ Black	Asian/ Pacific Islander	Hispanic / Latino(a)	Other	Total
AIDS	51%	32%	40%	39%	38%	37%
HIV-positive with symptoms	25%	35%	26%	36%	32%	34%
HIV-positive without symptoms	24%	33%	34%	24%	33%	29%

[2] NYC HRA HASA. December 2003. *HASA Facts*. New York, New York.

Table IIIA-7. HIV Status and Age

HIV Status	13-19	20-24	25-29	30-39	40-49	50+
AIDS	-	27%	13%	32%	41%	44%
HIV-positive with symptoms	100%	23%	43%	34%	33%	31%
HIV-positive without symptoms	-	50%	45%	35%	26%	25%

Current Living Arrangements of Respondents

Table IIIA-8. Current Living Arrangements

	House / Apartment	SRO Hotel	Transitional / Nursing Home	Homeless
Living Arrangements	78%	13%	6%	2%

Table IIIA-9. Housing Type

	Independent (including SRO)	Supportive Housing
Housing Type	64%	36%

Table IIIA-10. Household Composition

	Alone	Spouse / Partner	Child or Children	Parent or Family Member	Unrelated Adult(s)
Lives With	64%	15%	11%	5%	9%

Table III-A11. Households with Children

	Female	Male	Transgender	Total
Lives with Child or Children	33%	3%	6%	11%

Over three quarters of respondents live in a place where they have a private kitchen and bathroom, and 64% of respondents report that they live alone. A little over one-third of respondents describe their housing as supportive. As expected, many more female respondents report living with children than men, and just over 10% of households consist of families with children. Thirteen percent of respondents report being "doubled up" with another household. Respondents who are HIV-asymptomatic are most likely to be part of the group that is doubled up.

Income Sources of Respondents

Table III-A12. Income Sources by Race

Income Source	African American	Asian / Pacific Islander	Hispanic / Latino	White	Other	Total
Supplemental Security Income (SSI)	42%	29%	38%	30%	21%	**38%**
Social Security Disability Income (SSDI)	25%	32%	25%	41%	22%	**28%**
Paycheck from Work	7%	18%	7%	15%	19%	**9%**
TANF Public Assistance for Families	4%	-	5%	2%	8%	**4%**

About two-thirds of survey respondents report receipt of federal disability benefits; white respondents report the highest rate of receipt of Social Security Disability Income (SSDI), which is premised on a history of working "on the books."

Complex Life Issues

Consumers surveyed report high rates of complex and often co-occurring issues that substantially increase their risks of homelessness and housing instability. Consumers have histories of homelessness, mental health hospitalizations and substance use, and histories of incarceration. These complex life issues all serve as predictors of housing instability, which is discussed in Section IIIB.

History of Homelessness

45% of survey respondents have a history of "literal" homelessness, sleeping in a shelter or on the streets.

Table III-A13. Experience of Homelessness by Race

	African American	Asian/ Pacific Islander	Hispanic/ Latino	White	Other	Total
Experience in a Shelter and/or Place Not Intended for Sleeping	53%	21%	45%	27%	50%	45%

As shown in Table IIIA-13, 45% of survey respondents have a history of "literal" homelessness, defined as a stay in a homeless shelter or on the street or other place not intended for sleeping. This overall rate is extremely high, and a history of homelessness was much more common among African American (53%) and Hispanic/Latino (45%) respondents, than Whites (27%) and Asian/Pacific Islanders (21%). Fifty-three percent of those with histories of homelessness report at least one episode before their HIV/AIDS diagnosis, and 56% report at least one episode after diagnosis. Respondents reported a number of causes for their most recent stay in a shelter or on the street:

- 21% cited no income from work or benefits;
- 27% report they were using drugs or alcohol;
- 18% were forced to move by family or roommates; and
- 17% had just been released from jail or prison.

Table III-A14. Predictors for Homelessness among Survey Respondents

Predictors of Having a History of Homelessess	Effect
History of Incarceration	1.8
Lives in Scatter Site Supportive Housing	1.6
Lives in Single Room Occupancy (SRO) Hotel	1.6
Hospitalized for Mental Health Issues	1.8
Substance Use Issues	1.7

Table III-A14 shows that history of incarceration, mental health hospitalization, and substance use issues each, independently, almost double the risk of homelessness.

Mental Health and Substance Use Issues

Analysis of substance use and mental health issues among survey respondents was based on two sets of questions contained in the survey. The presence of substance abuse issues was determined by a "yes" response to at least one of the following questions:

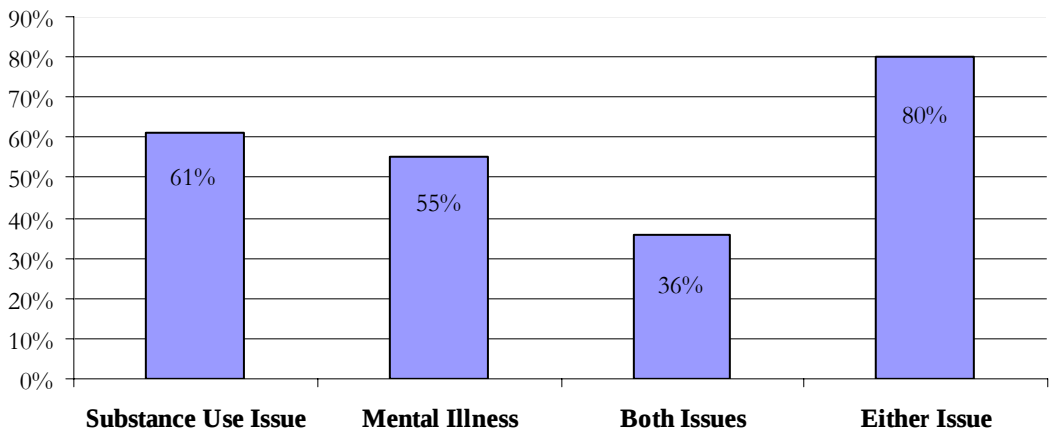
- Have you ever received treatment for alcohol or drug use problems?
- Do you consider yourself to be "in recovery" from an alcohol or drug use problem?
- Do you feel that you need treatment for alcohol or drug use now?

Similarly, the presence of mental health issues was determined by a "yes" response to at least one of these questions:

- Have ever been in the hospital for mental health issues?
- Have you ever received mental health services in a clinic or outpatient setting?
- Do you feel you need services for a mental health issue now?

Co-occurring mental health and substance use issues were considered to be present if a respondent answered yes to at least one question in both of the sets.

Chart IIIA-15. Extent of Substance Use and Mental Health Issues among Housing Survey Respondents (n=1,475)



Four out of five survey respondents (80%) report a substance use problem or mental health issue in the past or present.

The results presented in Chart IIIA-15 indicate that both substance use and mental health issues are widespread among persons with HIV/AIDS in the NYC EMSA. Four out of five survey respondents reported some type of substance abuse or mental health issue in the past or present, with majorities indicating they had experienced a substance abuse (61%) or mental health (55%) issue and 36% indicating they had experienced both. These percentages represent the number of respondents who have ever experienced substance abuse and mental illness, so their responses did not necessarily mean that they currently have substance use or mental health problems. Nevertheless, the prevalence of these issues was far higher than what is generally found in the US population. The Surgeon General has estimated that during a one-year period, 6% of all Americans have had an addictive disorder, 19% have had a mental disorder, and 3% have had both.[3] While the exact nature of the respondents' substance use and mental health issues is unclear without clinical assessments, the presence of these issues among the respondents is clear.

[3] U.S. Department of Health and Human Services. 1999. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Criminal History

Almost half of survey respondents (43%) have histories of incarceration, and 31% have felony convictions.

Table IIIA-16. History of Incarceration by Gender

	Female	Male	Transgender	Total
Been in jail or prison	38%	45%	44%	43%

As Table IIIA-16 shows, almost half of all survey respondents (43%) report a history of incarceration. Of those persons who report a history of incarceration, two-thirds have been convicted of a felony (31% of all respondents). Twelve percent of all respondents reported being released from jail or prison within the twelve months prior to completing the survey.

Differences by Race/Ethnicity

Table IIIA-17. Life Issues by Race/Ethnicity

Life Issues	White/ Caucasian	African American/ Black	Asian/Pacific Islander	Hispanic/ Latino(a)	Total
Been in Jail or Prison	22%	51%	24%	42%	**43%**
Felony Conviction	14%	37%	22%	30%	**31%**
Substance Use Issues	41%	71%	24%	59%	**61%**
Mental Health Issues	68%	51%	59%	56%	**56%**
Co-occurring Mental Health and Substance Use Issues	29%	39%	21%	38%	**37%**

Report of complex life issues varies significantly in most cases by race/ethnicity, with African American and Latino(a) respondents reporting significantly higher rates of prior incarceration, felony convictions, substance use issues, and co-occurring mental health and substance use issues than White and Asian/Pacific Islander respondents. Only mental health issues were reported more frequently by White respondents than by survey respondents overall.

III.B. HOUSING STABILITY AND CONNECTION TO CARE

The U Penn Center's analysis of the consumer survey results revealed residents overall to be extremely stable and well-connected to both primary care and medication regimes. Importantly, residents of supportive housing, who present significantly more complex histories and issues, are no less stable than residents of independent housing.

Housing stability is a key determinant of entry into and continuation of primary health care and access to HIV/AIDS treatments, and also has been shown to be an important HIV prevention intervention.[1] It is connected to consumer satisfaction, as described in below in Section IIID. Stability should be considered as a key measure of appropriate housing. Multiple moves suggest inappropriate or unsatisfactory living situations, while if a person has remained in a particular residence for an extended period of time, it is likely that the living situation is affordable and livable. Connection to healthcare, similarly, is critical to an assessment of the success of HIV/AIDS housing as a public health intervention, and as an important element of HIV prevention.

Stability

Stability was determined by the U Penn Center based on the number of times respondents reported that they had changed residences during the past three years. If a respondent reported that he or she had changed residences three or more times during the past three years, he or she was considered to have unstable housing. Stable housing was defined as having changed residences one time or less during the past three years. Respondents who reported that they had moved two times during the past three years were excluded from this analysis, to highlight the differences between persons with stable and unstable living conditions.

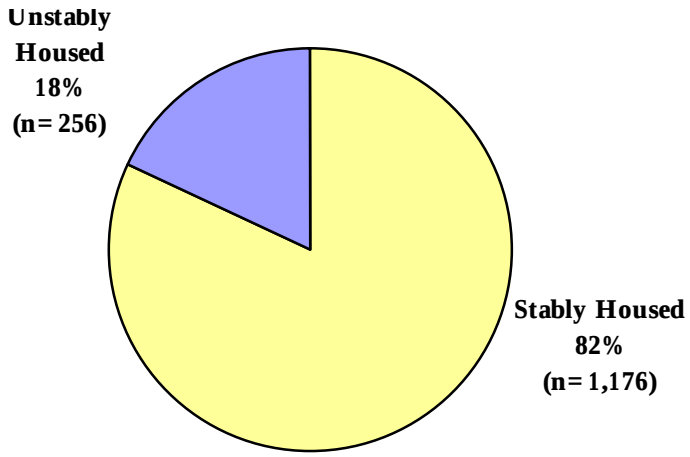
A large majority of survey respondents demonstrate stable housing.

The overwhelming majority (80%) of survey respondents included in this analysis are stably housed (0-1 move in the past 3 years). While 44% of these respondents report some experience of homelessness, stably housed persons outnumber unstably housed persons by 4.6 to 1. More

[1] See Section IIB above, "Housing is Healthcare."

frequent housing movement appears to occur among younger males, although this movement may become less frequent as they age. The results indicate that histories of homelessness and incarceration, as well as substance use and mental health issues, impact housing stability significantly. The risk for housing instability appears to increase as HIV progresses from asymptomatic infection toward AIDS.

Figure IIIB-1. Distribution of Persons Considered Stably Housed (0-1 moves) and Unstably Housed (3+ moves).



As shown in Figure IIIB-1, the number of stably housed respondents substantially outnumbered those unstably housed. Among the 1,432 persons included in the analysis, the number of respondents who were stably housed exceeded their unstably housed counterparts by a ratio of 4.6 to1. Nonetheless, those who were unstably housed constituted a substantial minority, and it is important to understand and address the reasons for this instability.

Factors Associated with Stability and Instability

A Consumer Survey Work Group of Housing Needs Assessment Advisory Group members identified certain characteristics as potentially relevant to the housing stability of persons with HIV/AIDS. The 885 respondents who provided information for all of the factors identified were included in the U Penn Center's further analysis of housing stability. By comparing the rate of certain characteristics among stably and unstably housed persons to the rate overall, the analysis

examines which of these factors are most strongly associated with housing stability and with housing instability. Tables IIIB-2 to IIIB-4 below present demographic, income, and housing factors that were found to be significantly associated with housing stability and instability.

The examination of stability also used logistic regression analysis to assess which characteristics had statistically significant ($p < .10$) influences on housing stability. The tables show only the characteristics found to be statistically significant predictors of housing stability and instability after controlling for the effects of many other factors. The estimated effects of these factors are expressed as odds ratios, which estimate the effect a one-unit increase of a factor (being a year older, for example, or living in an SRO rather than independent housing) has on probability of an outcome occurring. These results are presented in Table IIIB-5.

Table IIIB-2. Demographic characteristics of respondents stably or unstably housed

Characteristics	Total (n=885)	Stably Housed	Unstably Housed
Male	71%	69%	79%
Age in years (mean)	45.36	46.22	41.43
Has experienced homelessness	44%	38%	73%
Substance use issues	59%	55%	76%
Has AIDS	38%	37%	40%

Table IIIB-3. Income characteristics of respondents stably or unstably housed

Characteristics	Total (n=885)	Stably Housed	Unstably Housed
Receives a paycheck	10%	11%	5%
Receives SSI or SSDI	58%	60%	47%

Table IIIB-4. Housing characteristics of respondents stably or unstably housed

Characteristics	Total (n=885)	Stably Housed	Unstably Housed
Number of other people in residence (mean)	1.13	1.19	.84
Lives with unrelated persons	8%	7%	11%
SRO resident	17%	13%	36%
Supportive Scatter Site resident	19%	19%	21%
Supportive Congregate resident	16%	16%	17%
Independent housing	48%	52%	26%

Table IIIB-5. Selected logistic regression results testing respondent characteristics for their effect on housing stability and instability.

Predictors of Housing Stability	
Predictor Variable	**Effect on the odds of being stably housed**
Age	1.08
Number of people in residence	1.11
Receives a paycheck	2.12
Receives SSI or SSDI	1.67
Predictors of Housing Instability	
Predictor Variable	**Effect on the odds of being unstably housed**
Male*	2.00
Lives in an SRO**	2.95
Has been homeless	2.99
Lives with unrelated persons	2.75
Substance use issues	2.00
Has AIDS***	1.83

* Compared to being female or transgendered
** Compared to living in Independent Housing
*** Compared to being HIV positive with no symptoms

Younger males are at risk of housing instability.

Age and sex were the only demographic characteristics that were found to have significant associations with housing stability. Each year of increased age was associated with a .08 (or 8%) increase in the likelihood of being stably housed. This means that, with all other factors kept equal,

a ten-year age difference would correspond to an 80% higher likelihood of being stably housed. Being male doubled the odds of being unstably housed when compared to female and transgendered respondents.

Complex life issues are major factors contributing to housing instability.

Not surprisingly, a prior crisis of homelessness was strongly associated with instability. Respondents who said they had ever been homeless were three times more likely to be unstably housed (3+ moves in the last 3 years) than respondents who had not. Respondents with past or current problems with substance use were twice as likely to be unstable in their housing as those who did not. Respondents with AIDS were 83% more likely to have experienced housing instability than respondents with asymptomatic HIV.

The presence of a steady income is important for the maintenance of stable housing.

Respondents who received a disability check were 67% more likely to have moved only once during the past three years than respondents who did not. Respondents who earned their income from a "regular paycheck" were more than twice as likely to have lived stably during the past three years.

Housing situation impacts stability, with SRO residents experiencing the greatest housing instability.

Type of housing impacted significantly on respondents' recent histories of residential stability. Table IIIB-5 shows that over half of the stably housed group lives in independent housing, and that the rate of housing instability among those in independent housing is much lower than the rate of instability for the total group. Conversely, the odds of housing instability among SRO residents were three times higher than the odds for persons living in independent housing, even after controlling for the possibility that these higher rates were due to individual factors. This difference may be a result of poor housing conditions and little or no services. It may also be due in part to the systematic movement of SRO residents to prevent the accrual of tenants' rights, which could not be controlled for in this analysis.

Supportive scatter site and congregate housing facilitate housing stability among persons who are at risk for housing instability or homelessness.

The survey analysis suggests that permanent supportive housing is an effective means of facilitating stability among persons at greatest risk of housing instability and homelessness. As described below in Section IIIC, permanent supportive housing programs serve a population with much higher rates of co-occurring life issues than residents of independent housing. Significantly, however, the rates of instability among residents of supportive scatter site and supportive congregate programs are no greater than the rate for the group as a whole. When controlling for factors associated with instability, such as histories of homelessness and substance use issues, residents of permanent supportive housing were no more likely to be unstably housed than persons in independent housing.

Living in a larger household with family members has a positive impact on housing stability.

Living in a larger household seems to contribute to housing stability, but only if the members of the household are family. The number of people living with a respondent contributed to his or her housing stability – every additional person in the household increased stability by 11%. This finding may be a result of the cost savings from sharing a residence, and would help explain the trend toward doubling up. The composition of the household seemed to matter, however. Respondents who lived with unrelated persons were 2.75 times more likely to have moved three times or more during the past three years.

Connection to Health Care

Ninety-five percent of respondents have a relationship with a primary care provider.

HIV/AIDS housing clearly facilitates residents' connection to health care. Respondents report a significant level of connection to primary health care and participation in HAART, although the results reveal differences by housing model and race/ethnicity. Ninety-five percent of survey respondents report a relationship with a primary care provider, with only 5% reporting receipt of health care from emergency rooms or other sources. Ten percent of residents of SROs report, however, that they need but do not receive primary health care.

African-American respondents reported the lowest participation in HAART among ethnic groups, and non-white respondents were almost twice as likely as white respondents to not be on HAART.

Table IIIB-6. HAART Receipt by Race/Ethnicity

	African American	Asian/ Pacific Islander	Hispanic/ Latino	White	Other	Total
Taking HAART	73%	77%	77%	86%	82%	77%

This table reveals statistically significant differences in HAART receipt by race/ethnicity. The largest gap in HAART receipt by race/ethnicity is between respondents who identified themselves as white and those who identified themselves as black. African-American respondents reported the lowest participation in HAART among ethnic groups, and non-white respondents were almost twice as likely (23% to 27%) as white respondents (14%) to report non-participation in HAART. Follow-up focus groups with consumers suggested that the gap in HAART participation was due not to lack of access, but that perceptions about the efficacy of the treatment may contribute to the lower rate of participation among these consumers.

III.C. CONSUMER SURVEY RESULTS BY HOUSING MODEL

High rates of former homelessness, substance use, mental health issues and criminal history demonstrate that there is a substantial amount of adversity concentrated in direct housing programs, especially SROs.

Consumer survey results were analyzed by housing type in order to compare characteristics of persons served in various models of housing and service delivery. For purposes of this analysis respondents' living situations were grouped into four general models of housing: single-room-occupancy units (with a shared kitchen and/or bath), supportive scatter site housing (where the housing program holds the lease and services are ongoing), supportive congregate housing (where support services are provided on-site), and independent housing. Detailed descriptions of each of these housing models can be found in Section IIE above.

The analysis of housing models reveals that there are significant differences among the models in terms of the population that is being served. Even without an appropriate system for triaging applicants for HIV/AIDS housing, as discussed below in Section IVE on inefficiencies in the existing housing system, persons with more complex life issues are, appropriately, represented more significantly in supportive housing. Persons with complex life issues are probably most appropriately housed in supportive housing. However, the particularly high concentration of such persons in SRO housing suggests the need for more supportive housing than is presently available. In addition, there are significant differences in rent burden by housing model, with residents of independent housing contributing much higher proportions of their incomes towards rent.

Each respondent's housing type was determined based on survey questions that asked about the physical nature of the respondent's housing; who owns the housing; the presence of services accompanying the housing; whether subsidies help pay for the housing; and the presence of other residents and their relationship to the respondent. Independent housing is a residual category consisting of living situations not covered by the first three types. Respondents in independent housing may live in (and pay for) their own housing, may share housing with relatives, or may have living arrangements with others. Such housing is generally not tied into any type of support services program. However, 85% of respondents in independent housing reported that they use rent subsidies for which eligibility is dependent upon their HIV diagnosis.

Demographics by Housing Model

Table IIIC-1. County of Residence by Housing Model

Borough / County	SRO	Supportive Scatter Site	Supportive Congregate	Independent	All Models
Bronx	28%	22%	14%	25%	23%
Brooklyn	16%	33%	25%	25%	25%
Manhattan	50%	28%	41%	24%	33%
Queens	3%	13%	6%	13%	10%
Staten Island	1%	2%	2%	3%	2%
Putnam County				2%	1%
Rockland County				2%	1%
Westchester County	1%	1%	12%	8%	6%
TOTAL	100%	100%	100%	100%	100%

Table IIIC-1 shows these housing type distributions broken down geographically for respondents to the consumer survey. This table shows that more than 80% of the respondents live in three New York City boroughs, and that among the housing types, SRO housing for these respondents is most concentrated in these three boroughs (half of the SROs are located in Manhattan alone). Conversely, scatter site and independent housing have geographical distributions that are most similar to the overall geographical distribution of the respondents.

Table IIIC-2. Race/Ethnicity by Housing Model

Race/Ethnicity	SRO	Supportive Scatter Site	Supportive Congregate	Independent	All Models
White/Caucasian	10%	9%	12%	23%	16%
African American/Black	48%	54%	51%	38%	45%
Asian/Pacific Islander	2%	1%	0%	3%	2%
Hispanic/Latino(a)	38%	32%	32%	29%	32%
Other	2%	4%	5%	6%	5%
TOTAL	100%	100%	100%	100%	100%

Table IIIC-2 shows differences in racial and ethnic distribution in the various housing types. Approximately 85% of residents of supportive scatter site and congregate housing are African American or Hispanic/Latino(a), as are residents of SROs. Persons identifying as black were more likely to live in SROs and supportive housing and less likely to live in independent housing. Persons identifying as white were more likely to live in private housing and only half as likely to live in supportive housing. Hispanics were somewhat more likely to live in SRO housing, but had roughly equal chances of living in independent, supportive scatter site, or supportive congregate housing.

Table IIIC-3. Age Groups by Housing Model

Age	SRO	Supportive Scatter Site	Supportive Congregate	Independent	All Models
20 – 24	.4%	1%	1%	2%	1%
25 – 29	4%	1%	2%	3%	3%
30 – 39	27%	26%	20%	21%	23%
40 – 49	48%	41%	40%	41%	42%
50 or older	21%	31%	38%	33%	31%
TOTAL	100%	100%	100%	100%	100%

Table IIIC-4. Gender by Housing Model

Gender	SRO	Supportive Scatter Site	Supportive Congregate	Independent	All Models
Female	22%	28%	27%	29%	27%
Male	75%	70%	70%	69%	71%
Transgender	3%	2%	3%	1%	2%
TOTAL	100%	100%	100%	100%	100%

Differences among housing models by age and gender are not so apparent in Tables IIIC-3 and IIIC-4. Although SRO housing has a slightly higher concentration of persons aged 40-49 and a smaller concentration of persons 50 and older, this pattern is not distinct enough to characterize any type of housing by age group. More significant is the fact that 73% of all survey respondents are over age 40, and over one third are over 50 years of age. Differences by gender were not statistically significant.

Table IIIC-5. Income Sources by Housing Model

	SRO	Supportive Scatter Site	Supportive Congregate	Independent	All Models
Supplemental Security Income (SSI)	39%	48%	44%	31%	38%
Social Security Disability Insurance (SSDI)	20%	28%	26%	31%	28%
TANF public assistance	3%	7%	2%	3%	3%
Safety Net public assistance for single adults	8%	3%	7%	4%	5%
Food Stamps	55%	63%	52%	52%	55%
Veteran's benefits	3%	4%	4%	2%	3%
Retirement check	0%	1%	1%	5%	3%
Paycheck from work	3%	5%	4%	13%	8%
Peer stipend	2%	4%	6%	6%	5%
Financial assistance from family or friends	7%	2%	4%	9%	7%

Table IIIC-5 breaks down the reported income sources of the respondents by housing model. The absence of SRO residents from the workforce is suggested by the relatively small percentage that receives Social Security Disability Income, an employment-based form of disability insurance. Although a very small percentage of the survey respondents received a paycheck from work, those who live in independent housing were approximately three times more likely to earn income from work than residents of supportive housing and SROs.

Complex Life Issues by Housing Model

There are fundamental differences in the characteristics and situations of the persons who live in independent housing and the other three housing types. Consumers living in supportive scatter site and congregate housing, as well as those in SROs, have much more significant histories of homelessness and incarceration, as well as substance use and mental health issues.

Table IIIC-6. History of Homelessness by Housing Model

	SRO	Supportive Scatter Site	Supportive Congregate	Independent	All Models
Proportion Who Have Ever Been Homeless	65%	52%	56%	33%	45%

Forty-five percent of all survey respondents report ever having experienced an episode of homelessness, defined as a stay in a homeless shelter or on the street or other place not intended for sleeping. This rate of prior homelessness is extremely high, as are the rates broken down by housing type. As shown in Table IIIC-6, however, the rate of prior homelessness for persons in independent housing is substantially lower than the rates for residents of supportive scatter site and congregate housing, and only about half that of persons in SRO housing.

Table IIIC-7. Life Issues by Housing Model

Life Issues	SRO	Supportive Scatter Site	Supportive Congregate	Independent	All Models
Been in Jail or Prison	56%	59%	58%	35%	43%
Felony Conviction	36%	43%	44%	21%	31%
Substance Use Issues	73%	71%	72%	48%	61%
Mental Health Issues	56%	52%	54%	56%	56%
Mental Health Hospitalization	32%	22%	29%	17%	23%
Co-occurring Mental Health and Substance Abuse Issues	45%	39%	42%	29%	36%

Table IIIC-7 shows a number of complex life issues and the distribution of these issues among respondents in each housing type. As with homelessness, substantially high proportions of persons in all four types of housing have experienced these issues. For all of these issues, however, the proportions are similar for SRO, scatter site, and supportive housing tenants, while they are much lower for persons living in independent housing. These findings reflect the relative advantage among persons living in independent housing, and the relative need for supportive services and housing assistance among those in the SROs. They also indicate that supportive housing provides an essential resource for persons with histories of incarceration, felony convictions, and substance use and mental health hospitalizations, who face significant barriers to entry into the private rental

market and are substantially underrepresented in independent housing. While persons with complex life issues are probably most appropriately housed in supportive housing, the particularly high concentration of such persons in SRO housing suggests the need for more supportive housing than is currently available.

Connection to Healthcare by Housing Model

Residents of independent housing report the highest level of HAART participation (82%), and SRO residents the lowest (71%).

Table IIIC-8. Respondents Taking HAART by Housing Model

	SRO	Supportive Scatter Site	Supportive Congregate	Independent	All Models
Taking HAART	71%	77%	72%	82%	77%

A substantially higher proportion of persons in independent housing report participation in Highly Active Anti-Retroviral Treatment (HAART) than persons living in the other types of housing, as depicted in Table IIIC-8. This finding may be linked to the relatively higher level of housing stability among residents of independent housing, as well the lower rates of co-occurring mental health and substance use issues.

Satisfaction by Housing Model

Table IIIC-9. Dissatisfaction with Current Housing by Housing Model

	SRO	Supportive Scatter Site	Supportive Congregate	Independent	All Models
Dissatisfied with Current Housing	36%	21%	21%	30%	28%

While residents of all housing models report high levels of satisfaction with current housing, Table IIIC-9 shows the relative discontent of SRO residents. One-third of all SRO residents were either dissatisfied or very dissatisfied with their current housing. The level of dissatisfaction was much lower for residents of scatter site and supportive housing. Factors contributing to housing dissatisfaction and satisfaction are explored in more detail in Section IIID.

Table IIIC-10. Desire to Move to Another Place by Housing Model

	SRO	Supportive Scatter Site	Supportive Congregate	Independent	All Models
Prefer to Move to Another Place	71%	40%	52%	50%	52%

Not surprisingly, given their relatively high level of dissatisfaction, Table IIIC-10 illustrates that SRO residents express the strongest desire to move to another place rather than stay where they are. Despite high levels of expressed satisfaction with housing, a slight majority of all respondents stated a preference to move. This difference may indicate that a significant group of consumers consider themselves to have as good a situation as is available to them, but ideally would prefer something else. Only residents of supportive scatter site housing stated an overall preference to remain where they are. Housing preferences among survey respondents are discussed in Section IIID.

Housing Cost by Housing Model

The rent burden of survey respondents varied significantly by housing type, with residents of permanent supportive housing reporting an average out-of-pocket rent burden of only 34%, while residents of independent housing pay, on average, 49% of income towards rent.

Table IIIC-11. Housing Cost Burden by Housing Model*

Housing Cost Burden	Supportive Scatter Site	Supportive Congregate	Independent	All Models
Monthly Total Rent or Mortgage (Unsubsidized)	$660	$641	$764	$713
Monthly Out-of-Pocket Rent or Mortgage (Subsidized)	$193	$210	$413	$310
Average Unsubsidized Rent or Mortgage Burden	123%	117%	124%	130%
Average Subsidized Rent or Mortgage Burden	34%	35%	49%	43%

*SRO residents were excluded from this analysis, since SRO housing is in most cases emergency housing, and the requirement that residents pay a portion of any income towards rent is not uniformly imposed or enforced.

Table IIIC-11 shows total and out-of-pocket rent or mortgage costs, and average rent or mortgage burdens, for each of the housing types. Rent or mortgage burden was calculated by dividing the

monthly housing cost by monthly income for each respondent. Respondents were asked to estimate their total monthly rent or mortgage, which was an approximation of their housing costs without subsidies. Respondents were also asked for the amount of their "out-of-pocket" rent or mortgage. The difference between these two amounts represents their subsidy for their rent or mortgage. Rent or mortgage burdens were calculated with both the unsubsidized and subsidized housing cost.

The average ratio of *total* rent to income among survey respondents in independent housing is 124%, meaning that on average unsubsidized rents are greater than income; with available rental subsidies the average *out-of-pocket* rent burden is reduced to 49%.

The vital importance of housing subsidies is evident in the analysis of rent or mortgage burdens. Without subsidies, housing would be out-of-reach, especially for persons in independent housing. According to the U.S. Department of Housing and Urban Development, a household is considered to be "rent burdened" when the ratio is 30% or higher, and "severely rent burdened" if the ratio is over 50%. The average ratio of *total* rent to income among survey respondents in independent housing is 124%, meaning that on average unsubsidized rents are greater than income. However, the ratio of *out-of-pocket* rent to income is 49% on average. While a 49% rent burden still constitutes a severe housing hardship, the difference illustrates that persons with HIV/AIDS who receive rental assistance would not have access to the private market without this subsidy; many would undoubtedly experience homelessness.

The out-of-pocket rent or mortgage burdens for scatter site and supportive residents, at 34% and 35%, are just about at the one-third proportion that tenants are customarily charged for rent in subsidized housing. The average rent or mortgage burden for independent housing is much larger, at 49%, or very nearly "severely rent burdened." This finding suggests that more residents of independent housing may face trouble meeting their housing costs, and may be in danger of losing this housing. It also suggests that while persons in independent housing may have access to the most resources, they also face increased costs to maintain their living situation.

III. D. CONSUMER SATISFACTION, PREFERENCES, AND SUPPORT SERVICE NEEDS

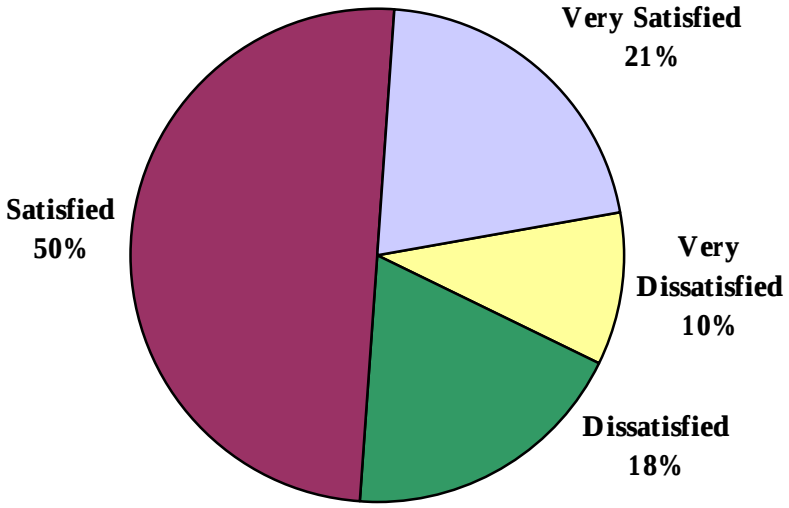
Consumers' satisfaction with current housing, their expressed preferences, and their access to support services were examined in order to better understand consumers' needs. Increased satisfaction with housing is likely to be linked to stability, as is appropriateness of support services.

The U Penn Center's analysis of survey results reveals that overall, consumers are satisfied with their housing, even those who are residing in commercial SROs. This finding is not surprising in light of the complex life issues and histories of poverty, homelessness, and incarceration experienced by consumers in the HIV/AIDS housing system, as explored in more detail above. Even the most imperfect housing, clearly, is preferable to no housing. For some consumers, HIV-specific direct housing services, even in an SRO, represent a move from congregate shelters or the streets. For many consumers, the enhanced rental assistance available to persons with HIV/AIDS has made it possible for them to enter a housing market that otherwise would be closed to them. The vast majority of consumers also report that they are receiving the support services that they need.

Consumer Satisfaction

71% of consumer survey respondents expressed satisfaction with their housing.

Chart IIID-1: Overall Housing Satisfaction (n=1,516)



Respondents were asked to rate their satisfaction with housing on a four point scale from "very dissatisfied" to "very dissatisfied." As Figure IIID-1 shows, almost three-fourths of those surveyed expressed some degree of satisfaction with their housing.

One source of potential dissatisfaction with housing is the type of housing in which a person lives. Expressed satisfaction or dissatisfaction may be based on the general quality of the housing type, or on its configuration and the services provided.

Table IIID-2. Respondents' Satisfaction with Current Housing by Housing Model

Level of Satisfaction	SRO	Supportive Scattered Site	Supportive Congregate	Independent	Total
Very Dissatisfied	15%	6%	4%	9%	**10%**
Dissatisfied	21%	14%	18%	20%	**19%**
Satisfied	46%	52%	54%	50%	**30%**
Very Satisfied	18%	27%	24%	20%	**21%**

Table IIID-2 shows satisfaction and dissatisfaction ratings for the four models of housing identified from survey responses: SRO housing, supportive scatter site housing, supportive congregate housing, and independent housing.

Users of supportive scatter site and congregate housing express the highest levels of housing satisfaction.

These results show that residents of permanent supportive housing expressed the greatest satisfaction with their housing and the least dissatisfaction; 78% of supportive congregate residents and 79% of supportive scatter site residents reported that they are "satisfied" or "very satisfied" with their current housing situation, and only 4% and 6%, respectively, reported that they were "very dissatisfied." As discussed above, however, even residents of SROs express a high level of housing satisfaction (64%), despite the fact, as noted below, that 71% of SRO residents report that they would prefer to move than to stay where they are. These results may reflect the fact that SRO residents experience the highest levels of housing instability and related life issues, such as substance use and histories of incarceration, that may have made it difficult or impossible to secure housing of

any kind prior to an HIV diagnosis. Previous lack of appropriate housing resources may be a factor in the high level of overall satisfaction among the users of HIV/AIDS housing resources surveyed here.

While satisfaction and dissatisfaction are often contingent on very specific details of a particular living situation, the U Penn Center sought to use the survey data to identify more general dynamics and attributes that were associated with satisfaction (or lack thereof) with housing. This was done using a logistic regression model similar to the one described in Section IIIB. In the model used here, the categories of "satisfied" and "very satisfied" were combined to measure satisfaction, and the categories of "dissatisfied" and "very dissatisfied" were combined to measure dissatisfaction. The same set of predictor variables were tested in this analysis as those used for the analysis of housing stability. In addition, the measure of stability (described in Section IIIB) was itself added to the set of predictor variables.

Table IIID-3. Selected Logistic Regression Results Testing Respondent Characteristics for their Effect on Satisfaction with Current Housing Situations.

Predictors of Satisfaction with Current Housing Situation	
Predictor Variable	**Effect on the Odds of Being Satisfied**
Lives in Supportive Scattered Site Housing*	2.97
Stability	1.95
Lives in Supportive Congregate Housing*	2.16

Predictors of Dissatisfaction with Current Housing Situation	
Predictor Variable	**Effect on the Odds of Being Dissatisfied**
Crowding	1.11
Experienced homelessness	1.63
Been in the hospital for mental health issues	1.64
Lives with mother, father or other family members**	2.55

* Compared to living in Independent Housing
** Compared to living alone

Table IIID-3 shows the factors that have significant ($p<.10$) associations with housing satisfaction or dissatisfaction. The differences among housing types shown in Table IIID-2 continue to be

substantial here as well. Holding other factors constant, respondents living in supportive scatter site and congregate housing were three times and two times more likely, respectively, to be satisfied with their housing than respondents living in independent housing. Stability (defined as moving no more than once during the past three years) also doubled the odds of being satisfied, although satisfaction may have contributed to stability.

Crowding was a strong predictor of dissatisfaction. Looking at factors associated with dissatisfaction (and again holding other factors constant), each additional person living in the house, apartment or room of the respondent increased the likelihood of being dissatisfied by 11%. Having had an experience of homelessness increased by 63% the likelihood of being dissatisfied with one's current housing, and a history of hospitalization for mental health issues increased by 64% the likelihood of dissatisfaction. Finally, respondents who lived with their mother, father or other family members (other than partners or children) were two and a half times more likely to be dissatisfied compared to the respondents living alone.

Overall, 71% of the survey respondents expressed some degree of satisfaction with their housing. This percentage rose to 78% and 79% when looking at just supportive scatter site and congregate residents, respectively. This high level of satisfaction remained significant in the logistic regression results and, as explained below, is also supported by the housing preference findings. Supportive scatter site housing in particular appears to engender high levels of satisfaction among its tenants.

Persons with histories of adverse experiences express, as a group, lower levels of satisfaction with their housing. This finding is in addition to (and controlling for) the findings above in Section IIIB that factors including substance use, homelessness, and mental health issues negatively affect stability, and further indicates that additional measures need to be taken to provide appropriate housing and supports for persons dealing with these issues.

Consumer Housing Preferences

The survey also asked respondents to state housing preferences in response to forced choice questions. These responses, presented in Table IIID-4, provide additional information on why some of the factors in the previous subsection on housing satisfaction figure prominently.

Table IIID-4. Responses to Consumer Preference Inquiries Related to Housing

Would you rather:	
Stay where you are	47%
Move to another place	53%
If you had to move next month, would you rather:	
Have your own place, even if you have to pay more	92%
Share an apt. or house w/ others (roommates)	8%
If you had to move next month, would you rather:	
Move into an apt./house without on-site services	58%
Move into a building with on-site services	42%
If you had to move next month, would you rather:	
Live in a housing program only for people w/ HIV/AIDS	24%
Live in a housing program that includes people without HIV/AIDS	76%
If you had to move next month, would you rather:	
Live in housing without automatic eviction for use of alcohol or drugs	25%
Live in housing with the requirement to be clean & sober	75%

Only 43% of respondents said that, given a choice to move, they would rather stay in their current residence. This affirmative response is lower than the rate given for satisfaction, and suggests that there is a substantial group of respondents who are satisfied overall with their housing, but nonetheless would prefer a better housing situation if one presented itself.

Consumers expressed strong preferences for living "in their own place," for integration into the community, and for enhanced safety.

An overwhelming majority of respondents indicated that they would prefer to live in "their own place," even if it meant paying more.

Interestingly, respondents were almost evenly split on their preference for living with or without on-site services. Such a finding supports the viability and importance of both supportive scatter site and supportive congregate housing models, and makes it clear that, in housing persons with HIV/AIDS, one type of housing does not fit all. In contrast, however, most respondents, 76%, did not want their housing to be exclusively with others who are infected with HIV/AIDS, suggesting

that even in supportive housing arrangements, a mix of tenants is preferred. Finally, by three to one the majority of tenants preferred housing that proscribed drug and alcohol use. In follow-up focus groups consumers explained that while they did not think drug use should be a barrier to securing housing, the drug and alcohol use of others raised concerns about safety and maintaining sobriety. This finding appears to indicate a willingness, on the part of respondents, to accept a degree of structure with their housing.

Table IIID-5. Respondents' housing preferences by model.

Housing Preference	SRO	Supportive Scattered Site	Supportive Congregate	Independent
Proportion of Respondents Who Would Rather Move	71%	40%	52%	50%
Proportion of Respondents Who Would Rather Move into a Building without On-Site Services	55%	66%	50%	62%
Proportion of Respondents Who Would Rather Live in Housing that Includes People without HIV/AIDS	65%	82%	69%	84%

In Table IIID-5, three consumer preferences are examined by the four different housing models. Responses varied significantly by housing type. The greatest differences can be seen in the proportion of respondents who would rather move – as discussed above, 71% of SRO residents answered in the affirmative as compared to only 40% of supportive scatter site housing residents. The more telling comparison, however, may be between the 40% of residents of supportive scatter site and the 52% and 50% of residents of supportive congregate and independent housing who stated a preference to move. This finding indicates an overall preference for supportive scatter site housing among survey respondents.

The highest proportions of respondents who prefer to move to facilities without on-site services are those in supportive scatter site and independent housing; i.e., those who already live in situations without on-site services. Similarly, it is the residents of scatter site and independent housing, those most likely to be living in proximity to more diverse neighbors, who most frequently express a preference for living in housing that includes persons who do not have HIV/AIDS. This finding suggests that, to an extent, people's stated preferences are influenced by the housing situation in which they currently reside.

Table IIID-6. Housing Preferences by Neighborhood Attribute

Neighborhood Attribute	Average Ranking (1-4)
Living in a Safe Neighborhood	3.9
Access to a Public Neighborhood	3.8
Living Near Medical or Other Services	3.6
Living Close to Shopping Areas	3.6
Living Close to Family or Friends	3.0
Living Close to a Substance Use Support Group	2.3
Living with people of the Same Racial/Ethnic Background	2.3
Living Close to Child Care, Day Care or Schools	2.1
Living Close to a Drug Treatment Center	2.1

Table IIID-6 illustrates consumer preferences in another way. Consumers were also asked to rank the importance of a number of neighborhood characteristics, using a scale of one to four, with four being of highest relative importance. Respondents ranked safety as most important, followed closely by access to public transportation, proximity to medical care, and living close to shopping.

Results indicate that respondents are split over key issues related to housing configuration such as whether or not supportive services are offered on-site. Respondents show a preference for greater community integration, living in settings that also house persons who are not living with HIV/AIDS, but also indicate a willingness to accept greater levels of structure such as measures that address the harmful use of alcohol or drugs. While none of these findings are necessarily at odds, they demonstrate that a range of housing models and service configurations are required to meet the needs of the persons with HIV/AIDS living in the NYC EMSA.

Support Service Needs

As discussed above in Section IIE, most supportive housing providers offer a full range of supportive services to residents. To gather information on unmet need for housing related support services, respondents were asked to choose the support services that they needed from a list of 18

different services. For each item on the list, a respondent could indicate that he or she does not need the service, that the service is currently received, or that the service is needed but not received. Overall, consumers are receiving the services that they need. For example, 71% of survey respondents indicate that they receive case management, and 45% indicate that they receive meals. The services in which respondents expressed most interest, transportation (Metrocards) and a housing starter kit, are related to their very limited incomes.

Table IIID-7. Supportive Services Needed but Not Received

Supportive Services	Needs service but is not receiving
Transportation	22%
Housing Starter Kit	22%
Legal	17%
Recreation/Social Activity	15%
Homemaker	14%
Meals	14%
Case Management	12%
Visiting Nurse/Home Health Care	11%
Respite Care	11%
Mental Health	10%
After School Programs for Children	8%
HIV Treatment/Adherence Education	8%
Child Care	8%
Primary Health Care	7%
Safe Sex/Safe Injection Education	7%
Substance Use Treatment	6%
Substance Use Support	6%
Harm Reduction/Needle Exchange	5%

Table IIID-7 shows sorted percentages of all respondents who selected the "do not receive service but need it" option. Respondents who did not provide a response to a particular service are assumed to have not needed that service.

To explore the possibility of different service needs by model of housing, the top five requested services were then identified for each housing model. These services are found in Tables IIID-8 through IIID-11.

Table IIID-8. Supportive Services Needed but Not Received – SRO Residents Only

SRO Housing	Needs service but is not receiving
Housing Starter Kit	26%
Transportation	23%
Recreation/Social Activity	16%
Meals	15%
Case Management	15%

Table IIID-9. Supportive Services Needed but Not Received – Supportive Scattered Site Residents Only

Supportive Scattered Site Housing	Needs service but is not receiving
Transportation	19%
Housing Starter Kit	15%
Meals	13%
Legal	12%
Recreation/Social Activity	12%

Table IIID-10. Supportive Services Needed but Not Received – Congregate Supportive Housing Residents Only

Supportive Congregate Housing	Needs service but is not receiving
Transportation	24%
Housing Starter Kit	17%
Legal	14%
Homemaker	12%
Respite Care	11%

Table IIID-11. Supportive Services Needed but Not Received – Independent Housing Residents Only

Independent Housing	Needs service but is not receiving
Transportation	25%
Housing Starter Kit	24%
Recreation/Social Activity	21%
Legal	20%
Homemaker	16%

Transportation was among the five supportive services most requested by all respondents, regardless of the model of housing. This service, when provided, is in the form of Metrocards to be used for public transportation. All respondents also expressed a relatively strong interest in a "housing starter kit," which was described on the survey with examples of "basic furniture and household items." Interest in the housing starter kit and transportation undoubtedly are related to the fact that most survey respondents rely on disability benefits or public assistance to meet all needs, and have access to only limited public support to purchase the essentials necessary to establish a home and pay for transportation.

Recreation and social activities were among the five services most requested for residents of all housing models except supportive congregate housing, and residents of independent housing indicated the greatest unmet need for these services (21%). This finding supports observations by key informants that a significant number of consumers experience social isolation in independent settings, and that low-threshold services are needed to address mental health issues that are not being treated by any other system.

Legal services were a high priority for all respondents except those in SRO housing, although this service was requested by 14% of these residents. Again, the greatest need for legal services was expressed by persons in independent housing who must manage relationships with landlords on their own.

Meals were a high priority for SRO and supportive scattered site residents, but not for residents of supportive congregate housing and independent housing. On the other hand, homemaker services

were among the most requested services for residents of supportive congregate housing and independent housing, and not for SRO and scattered site residents. Only SRO residents considered case management services a high priority, most likely because of the prevalence of complex life issues among these residents and the fact that supportive services are typically not provided in these settings. Respite care was only a high priority for residents of supportive housing.

III. E. OBSTACLES TO GETTING AND KEEPING HOUSING

In order to better understand the obstacles faced by persons with HIV/AIDS in the NYC EMSA who have a housing need, especially those seeking to use the private rental market, respondents were asked to identify several potential kinds of discrimination that had made it difficult for them to get housing.

As the preceding sections have demonstrated, consumers of HIV/AIDS housing overall demonstrate remarkable levels of stability, satisfaction, and connection to care. This analysis reveals, however, that they do encounter obstacles to securing housing. This finding supports continued development of HIV-specific housing units, as that system will provide an essential resource for persons who are unable to secure and maintain housing on the private market.

HIV/AIDS status and history of incarceration are serious impediments to getting housing.

Table IIIE-1. Kinds of discrimination that made it difficult to get housing

Kind of discrimination	Made it difficult to get housing
Race or ethnic background	26%
Income source	25%
HIV infection or AIDS	23%
Bad credit	21%
Landlords' refusal to accept rental assistance payments, Section 8 vouchers, etc.	20%
Disability or handicap	13%
Sexuality: gay, lesbian, bisexual, or transgender	13%
Criminal history or prison record	13%
History of alcohol or drug use	11%
Not married to person living with	8%
Immigration status	7%
Number of children or other persons in the family	7%
Participation in a methadone maintenance program	7%
History of mental illness	6%

Table IIIE-1 contains a list of potential sources of discrimination sorted by the percentages of all respondents who checked each item. The HIV or AIDS status of the respondents was clearly a serious obstacle, creating a problem on the magnitude of racial or ethnic discrimination (only 31% of the non-white respondents said that their race or ethnic background made it difficult to get housing). The source of the respondents' income and their method of payment were also common obstacles, on the same order as HIV or AIDS status.

Table IIIE-2. Obstacles to Getting Housing by Complex Life Experiences

Life Experiences	Status made it difficult to get housing
Formerly Incarcerated	26%
Been Hospitalized for Mental Health Issues	12%
Has Substance Use Issues	17%

Table IIIE-2 shows the housing obstacles encountered only by respondents who were formerly incarcerated, had been hospitalized for mental health issues, or had substance use issues. The percentages represent the number of these respondents who report that they experienced a problem in getting housing because of their particular complex life experiences. Respondents who had ever been in prison or jail were much more likely to report this life experience as an obstacle to getting housing than persons with a history of mental health or substance use issues. For respondents who were formerly incarcerated, the likelihood of experiencing discrimination because of their criminal history was similar to the likelihood for experiencing discrimination based on race/ethnicity or HIV/AIDS. Not surprisingly, these respondents are disproportionately living in supportive housing: as discussed in Section IIIC, 59% of residents of congregate supportive housing have been in jail or prison, and 43% have felony convictions, as had 58% and 48% of residents of supportive scatter site housing, respectively, compared to independent housing, where 35% of residents report histories of incarceration and only 20% report felony convictions. One of the roles that supportive housing plays is to provide housing for a population that otherwise faces serious obstacles.

IV. Challenges to the Existing HIV/AIDS Housing System

IV. A. ANTICIPATED HOUSING NEEDS FOR PERSONS WITH HIV/AIDS

Despite the size and success of New York City's housing system for persons with HIV/AIDS, 1,500 persons with HIV/AIDS remain inadequately housed in emergency and transitional settings. These New Yorkers with HIV/AIDS represent a current unmet need for housing resources. Meanwhile, the recent growth in the number of persons using HIV/AIDS Services Administration (HASA) housing resources (up 65% in the five-year period from 1998 to 2003), and projected increases in total New Yorkers living with HIV/AIDS indicate that housing need in the future will be even greater. This section includes an epidemiological overview of HIV/AIDS in the NYC EMSA, estimates of current and projected housing needs, and some initial concepts for meeting the anticipated demand for housing for persons with HIV/AIDS.

1. Epidemiological Overview and Projections

This epidemiological overview includes a demographic profile of cumulative AIDS cases in the New York City Eligible Metropolitan Statistical Area (EMSA). More detailed information about persons living with HIV/AIDS in each borough of New York City and in the Tri-County/Lower Hudson Valley region is set out in Appendix C.[1] This information was compiled not only to provide important contextual information about the HIV/AIDS epidemic, but also to provide a basis for estimates of the current and projected need for HIV/AIDS housing in the region.

The AIDS epidemic in the New York City EMSA is more severe, complex, and entrenched than in virtually any other part of the country. The New York City Department of Health and Mental Hygiene (DOHMH) reports that 82,132 persons in New York City had been diagnosed and reported to be living with HIV/AIDS as of December 31, 2002. The DOHMH also notes that the true number of persons living with HIV/AIDS is significantly higher, as it is estimated that 25% of persons living with HIV have never been tested and thus do not know that they are infected. Of those whose illness had been diagnosed, 55,685 were living with AIDS and an estimated 26,447 were living with HIV.[2] Although there was a 67% reduction in newly reported AIDS cases between 1993

[1] All data included in this section, except that which is cited otherwise, were obtained from New York City Department of Health and Mental Hygiene HIV/AIDS Surveillance Program (2001). The NYC DOHMH also provided unpublished data for new HIV/AIDS cases for the purpose of compiling this report.
[2] Data provided by NYC DOHMH in attachment to letter to HPG dated June 1, 2004. NYC DOHMH HIV Epidemiology Program, 3rd Quarter Report, July 2004.

and 2002 (from 12,693 to 4,167 cases), the rate of new AIDS cases in New York City in 2002 is still substantial.[3]

Since the first AIDS cases appeared in New York City more than twenty years ago, the City has developed a comprehensive, far-reaching network of AIDS service organizations that offer housing, health care, prevention, and a broad range of supportive services to improve and prolong the lives of New Yorkers infected and affected by HIV/AIDS. Despite this response, however, the epidemic continues to have a profound impact upon the City.

The demographic characteristics of the populations living with HIV/AIDS have shifted considerably since the first cases were reported. Today, although men account for a majority of the cumulative AIDS cases in the City (76%), women comprise 33% of the new cases reported in 2002, and the proportion of all AIDS cases occurring among women has increased from 17% in 1991 to 24% in 2001.

The AIDS epidemic has had an increasingly disproportionate impact upon minority populations, particularly African American and Hispanic/Latino persons. The percentage of cumulative AIDS cases occurring among African American persons has grown steadily from 37% in 1991 to 42% in 2001, and among Hispanic/Latino persons from 28% in 1991 to 31% in 2001. Almost 85% of new AIDS cases in 2001 and 2002 occurred among African American or Hispanic/Latino individuals. Relatedly, the communities most profoundly affected by the epidemic are increasingly communities of color: of the eight neighborhoods with the highest rates of new AIDS cases, six are located in community districts whose populations are least 75% African American or Latino.[4] Not surprisingly, these community districts are also extremely affected by poverty: while 21% of all New York City residents are below the poverty line, the percentage of residents below the poverty line in all but one of the neighborhoods with the highest rates of new AIDS cases ranges from 35% to 46%.[5] The distribution of living AIDS cases in communities of color, and in relation to poverty rates, is depicted in the maps attached to this section as Exhibit IVA-13.

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[3] HIV Epidemiology Program, NYC DOHMH, HIV/AIDS Surveillance Statistics 2002.
[4] New York City Department of City Planning. 2000. Community District Profiles (which include data from the U.S. Census for Year 2000). http://www.nyc.gov/html/dcp/home.html.
[5] Ibid.

Table IVA-2. New York City AIDS Cases by Race and Gender (Cumulative through 12/2001)

	White	Black	Hispanic	Other
Male	29%	39%	31%	1%
Female	12%	54%	33%	< 1%
TOTAL	25%	42%	31%	1%

The epidemic in New York City is fueled by numerous risk factors. Injection drug use remains the primary risk factor in New York City, accounting for at least 44% of all AIDS cases through 2001. Of the new AIDS cases among men for which a means of transmission is known, 42% cite sex with other men as their primary risk factor. Heterosexual sex accounts for 38% of all new AIDS cases for which a means of transmission is known: 26% among men and 65% among women.

Table IVA-3. New York City AIDS Cases by Major Risk Group (Cumulative through 12/2001)

Risk Group	Male	Female
Men Having Sex with Men	40%	----
Injection Drug Use	43%	48%
Heterosexual Contact	7%	36%
Transfusion	1%	1%
Perinatal	< 1%	< 1%
NIR/Under Investigation	10%	15%
TOTAL	100%	100%

At the same time that the annual number of reported AIDS cases has decreased, the proportion of deaths among persons diagnosed with HIV/AIDS has declined even more dramatically. The number of annual deaths, which peaked at 7,910 in 1994, had dropped to 1,080 deaths by 2001. Similarly, the cumulative mortality rate dropped from 83% in the first decade of the epidemic (1981 – 1991) to 43% in the second decade (1992 – 2001). This change is due to the efficacy and increased availability of modern HIV/AIDS treatment, particularly HAART, which has improved and prolonged the lives of many people living with HIV/AIDS. As a result, there has been a steady increase in the number of persons living with HIV/AIDS in the City: between 1995 and 2000, the

number of persons living with AIDS more than doubled, and has not slowed since. This translates into a corresponding increase in the need for continued treatment and associated services to prolong the lives and maximize the health of New Yorkers with HIV/AIDS.

Although advances in medical treatment have extended the lives of persons living with HIV/AIDS, the needs of infected and affected populations in the City have grown increasingly complex. Most of the communities that have borne the most profound impact of the AIDS epidemic are also among the lowest-income neighborhoods in the city, and an increasing number of persons living with HIV/AIDS struggle also with poverty and/or unemployment, chronic substance use, mental illness, and/or homelessness.

A majority of people with HIV/AIDS report a history of frequent use of cocaine, crack, and/or heroin, and one-third of all clients receiving services from the City's Ryan White Title I-funded programs are substance users or in recovery.[6] The relationship between substance use and HIV infection and transmission is complex and multi-faceted. First, there is a direct correlation between substance use and high-risk sexual behavior. According to multiple studies, women who use crack cocaine are more likely to engage in unprotected sex in exchange for money or drugs; men who use crack cocaine are more likely to engage in unprotected sex with casual male contacts; and alcohol intoxication has been associated with high-risk sexual behavior as well as increased needle-sharing among drug users.[7] Further, substance use can affect the management of HIV illness and AIDS, particularly if it contributes to the loss of housing or employment, increasing the risk of homelessness. In addition, little is known about the interaction between HIV medications and other substances, despite the potentially enormous impact of this interaction on the lives and health of many people living with HIV/AIDS.

In addition, an increasing number of persons living with HIV/AIDS struggle with mental illness, which can range from clinical depression and anxiety to schizophrenia, personality disorders, and other forms of serious and persistent mental illness. A study conducted by the Community Health Advisory and Information Network (C.H.A.I.N.) in New York indicated that of 900 individuals

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[6] Ryan White Title I Year 13 Application for New York City.

[7] Edlin, B.R., et al. 1994. *New England Journal of Medicine 33(21),* pp. 1422-7; Astemborski, J., et al. 1994. *American Journal of Public Health 84(3)*, pp. 382-87; DeSouza, C.T. et al. 2002. Journal of Acquired Immune Deficiency Syndrome *29(1)*, pp. 359-63; Rees, V. 2001. *Substance Abuse Treatment 21*, pp. 129-34.

living with HIV/AIDS followed in the study, 45% presented "clinically relevant symptoms" of mental health issues, and roughly half of those with symptoms were not receiving any mental health services.[8] The results of the consumer survey conducted as a part of this study demonstrate this issue further: 55% of the persons living with HIV/AIDS who participated in the survey self-identified with mental health issues and 23% reported a prior mental health hospitalization.[9]

There is also a dramatic correlation between the impact of the AIDS epidemic and the criminal justice system. Although many incarcerated persons are unaware of their HIV status, it is estimated that thousands of persons living with HIV/AIDS cycle through New York City's correctional system every year. One voluntary test among incarcerated persons in New York City indicated that 22% of women and 9% of men were HIV-positive.[10] The consumer survey conducted as part of this Needs Assessment showed that 43% of respondents (all of whom were living with HIV or AIDS) had previously been incarcerated.[11]

These multiple factors combine to make the AIDS epidemic in New York extremely complex and entrenched. Poverty, homelessness, mental illness, substance use, incarceration, and other complex health and life issues create tremendous barriers to life-sustaining prevention, medical, and supportive services, and make it increasingly difficult for service providers to address the mounting needs of their clients.

HIV/AIDS in New York City Neighborhoods

The New York City cumulative rate of AIDS cases is 1,830 cases per 100,000 persons, but there are significant disparities in the prevalence of AIDS between different neighborhoods. For instance, while there are 260 cases per 100,000 persons in Bayside/Little Neck, Queens, there are 4,768 cases per 100,000 persons in East Harlem. These differences mean that the need for HIV/AIDS housing, medical care, and social and community services also differs dramatically from community to community, and borough to borough. Borough and county analyses of HIV/AIDS data are presented in Appendix C.

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[8] Aidala, A. & Lekas, M. 1998. "Top Client-Identified Unmet Needs for Medical and Social Services." Community Health and Advisory Information Network (CHAIN), Update Report #16, p. 3.
[9] See Section IIIA above.
[10] AIDS Action. 2001. Incarcerated Populations and HIV/AIDS, p. 1. *Policy Facts.* http://www.aidsaction.org.
[11] See Section IIIA above.

2. Current and Projected Unmet Housing Need

There is no established method for estimating current unmet need or for projecting the future need for housing assistance among people with HIV/AIDS. This report attempts to measure the extent and nature of these needs using existing data as the basis for an informed estimate. The following estimates of need are based on epidemiological data from the New York City Department of Health and Mental Hygiene (DOHMH), housing services data from the New York City Human Resources Administration's HIV/AIDS Services Administration (HASA), and data collected through the consumer and provider surveys conducted as part of this study. Summary charts of current and projected unmet need are presented below, followed by explanations of the methodology used. The total current need (capacity plus current unmet need) has been used to project the amount and type of housing that will be required to meet the anticipated housing needs of persons with HIV/AIDS at the end of 2004, 2007 and 2010.

Current Unmet Need by Housing Type

The analysis below shows that the following additional housing resources would be required in order to appropriately meet current total housing need among New Yorkers currently living with HIV/AIDS:

- **900 fair market rent tenant-based rental subsidies** to secure private market rental housing for persons currently in the HIV emergency and transitional housing systems, or over-serviced in the permanent supportive housing system; and

- **1,500 permanent supportive housing units**, to meet the needs of persons currently in the HIV emergency and transitional housing systems, and persons currently living independently who require a greater level of housing related supports to maintain stability and connection to care.

- These additional housing resources would make it possible to house more appropriately over **1,500** persons living with HIV/AIDS who are currently housed in commercial SRO units. Although they would be most appropriately served in permanent housing, these persons represent an **immediate need for appropriate transitional housing**, including housing that meets the special needs of certain populations such as undocumented persons, transgendered persons, and persons recently released from incarceration.

Current unmet need is conservatively estimated as the number and type of permanent housing units that would more appropriately serve persons that have identified themselves as HIV-ill and in need of housing assistance. The results of the consumer survey and key informant interviews are used to determine the number of persons currently in HIV-specific emergency and transitional settings that require permanent supportive housing (with ongoing housing-related supports) and the number that are able to live independently in the community with the support of a rent subsidy and "wrap-around" community based services. The calculation also reflects estimates of persons currently "over-serviced" in permanent supportive housing and persons in independent housing whose stability is threatened by a lack of housing-related supports.

It is important to note that this calculation *does not* include estimates of persons with HIV/AIDS that either are unaware of their HIV status or have not yet identified themselves as HIV-positive and in need of housing assistance. Conservative estimates would indicate that almost 900 single adults in New York City Department of Homeless Services (DHS) shelters are HIV-positive, and either unaware of, or not reporting, their status.[12] In addition, growing numbers of persons with HIV/AIDS are being released from prison or jail to homelessness or unstable housing situations;[13] and 14% of the respondents to the consumer survey conducted as part of this study indicated that they were living "doubled up" with family or friends. Moreover, while the housing need of undocumented persons is difficult to quantify, key informants to this study noted the growing numbers of persons in need of housing that do not quality for housing assistance that is premised on eligibility for public assistance benefits.[14] For this estimate, it is assumed that, at minimum, the existing HIV-specific transitional housing units (1,297) are required to provide emergency housing for members of these groups and other persons first entering the HIV/AIDS housing system, or who have left or been terminated from one permanent housing placement and must secure another.

[12] According to DHS shelter census reports there were 8,500 singles and 13,300 adult family members in DHS City shelters in December 2003. Using the assumptions employed by DHS in its 2003 HUD Homeless Housing Assistance application, 7% of homeless singles, or 595 persons, and 2% of adult family members, 266 persons, are conservatively estimated to be living with HIV/AIDS.

[13] See Section IVB for a discussion of emerging housing needs among persons with HVI/AIDS being released from prison and jail.

[14] See Section IVB for a discussion of emerging housing needs among undocumented persons living with HIV/AIDS.

The estimate of current unmet need set out below assumes that additional permanent housing would make it possible to house more appropriately the 1,567 persons living with HIV/AIDS who are currently placed in commercial SRO units.[15] However, these persons would be most appropriately served in permanent housing, it must be noted that their situation represents an immediate need for appropriate transitional housing, including housing that meets the special needs of certain populations such as undocumented persons, transgendered persons, and persons recently released from incarceration.

Estimated Current Unmet Need: Persons with AIDS and HIV-Related Illness	
Rental Subsidies	
For persons currently in the HIV emergency housing system	423
For persons currently in the HIV transitional housing system	713
For persons currently over-serviced in supportive housing	519
Total persons in need of a rental subsidy	1,655
Less persons living independently that require supportive housing	(721)
Total unmet need for additional rent subsidies	**934**
Permanent Supportive Housing	
For persons currently in the HIV emergency housing system	705
For persons currently in the HIV transitional housing system	584
For persons living independently who require supportive housing	721
Total persons in need of permanent supportive housing	2,010
Less persons over-serviced in supportive housing	(519)
Total unmet need for permanent supportive housing	**1,491**
Total Current Unmet Need (for subsidies and housing units)	**2,425**

[15] New York City Human Resources Administration, HIV/AIDS Service Administration (NYC HRA HASA.) *HASA Facts.* New York, New York: Dec. 2003.

Methodology

Persons with HIV/AIDS in need of rental subsidies.

This number was reached by:

- Determining the number of persons in HASA emergency hotel placements in December of 2003 (1,567). Based on the results of the consumer survey conducted as part of this study, it is estimated that 27% of such SRO residents, or **423**, have no substance use or mental health issues and thus can live independently with the assistance of a rent subsidy.

- Determining the number of persons in HIV specific transitional housing placements in December of 2003 (1,297). Based on the results of the consumer survey conducted as part of this study, it is estimated that 55% of transitional housing residents, or **713**, do not have co-occurring substance use and mental health issues and thus can live independently with the assistance of a rent subsidy.

- Determining the number of persons in HIV specific permanent supportive housing placements in December of 2003 (5,191). Based on the results of the key informant interviews conducted as part of this study, it is estimated that 10% of such supportive housing residents, or **519**, are "over-serviced" in the supportive housing system and can live independently with the assistance of a rent subsidy.

- Determining the number of persons using available rent subsidies in December of 2003 (20,603). Based on the results of the consumer survey conducted as part of this study, 3.5% of persons in independent housing, or **721**, have a current unmet need for on-site mental health and/or substance use treatment, and therefore require a supportive housing placement.

The total number of persons currently in need of a rental subsidy was calculated as the sum of those persons in the emergency and transitional systems who can live independently, plus persons currently over-serviced in the HIV supportive housing system **(423 + 713 +519 = 1,655).** The number of persons estimated to be using a rent subsidy but in need of supportive housing was deducted to reach the estimated number of new rental subsidies required **(1,655 – 721 = 934).**

Persons with HIV/AIDS in need of permanent supportive housing

This number was reached by:

- Determining the number of persons in HASA emergency hotel placements in December of 2003 (1,567). Based on the results of the consumer survey conducted as part of this study, it is estimated that 45% of such SRO residents, or **705**, have co-occurring substance use and mental health issues and thus require a permanent supportive housing placement. (The remaining 28% of emergency SRO residents report a substance use issue and are assumed to currently require a supportive transitional setting.)

- Determining the number of persons in HIV specific transitional housing placements in December of 2003 (1,297). Based on the results of the consumer survey conducted as part of this study, it is estimated that 45% of transitional housing residents, or **584**, have co-occurring substance use and mental health issues and thus require a permanent supportive housing placement.

- Determining the number of persons using available rent subsidies in December of 2003 (20,603). Based on the results of the consumer survey conducted as part of this study, 3.5% of persons in independent housing, or **721**, have a current unmet need for on-site mental health and/or substance use treatment, and therefore require a supportive housing placement.

- Determining the number of persons in HIV-specific permanent supportive housing placements in December of 2003 (5,191). Based on the results of the key informant interviews conducted as part of this study, it is estimated that 10% of such supportive housing residents, or **519**, are "over-serviced" in the supportive housing system and can live independently with the assistance of a rent subsidy.

The total number of persons currently in need of permanent supportive housing was calculated as the sum of those persons in the emergency and transitional systems who report co-occurring mental health and substance use problems and are thus assumed to need a permanent supportive housing placement, plus persons currently using a rent subsidy to live independently who require a supportive housing placement **(705 + 584 +721 = 2,010).** The number of persons estimated to be

currently "over-serviced" in supportive housing was deducted to reach the estimated number of additional permanent supportive housing units required **(2,010 – 519 = 1,491).**

Projected Need for HIV-Specific Housing Resources

It is clear that a significant need for HIV-specific housing resources in New York City will exist in the future. The precise size of that need, however, is much less clear. There is no established methodology for projecting housing need, and no comparable population on which to base projections. As the analysis that follows demonstrates, the total need for HIV-specific housing resources can be projected to be between 9,670 and 13,820 in 2010.

Any approach to projecting demand for HIV/AIDS housing resources in New York City is extremely complex, because it relies on multiple and frequently interrelated factors, some of which are known and many of which are unknown. These factors involve external environmental influences as well as methodological decisions.

Environmental factors include:

- *Demographics:* As described in the full needs assessment, the population of persons with HIV and AIDS in New York City is increasingly female, African American and Hispanic/Latino, and living in neighborhoods impacted by poverty. Persons with HIV/AIDS also are impacted disproportionately by substance use, mental illness, and histories of incarceration. The consumer survey described in Part III, indeed, revealed that persons living in HIV-specific housing overwhelmingly are people of color, many of whom have histories of incarceration, substance use, and mental illness. If these demographic trends continue, the population of persons with HIV/AIDS in New York City will increasingly be one that faces significant barriers to the private housing market, regardless of health status.

- *Effectiveness of drug therapies:* All projections of the numbers of persons expected to be living with HIV and AIDS in future years assume that the availability and effectiveness of highly active antiretroviral therapy (HAART) will translate into proportionately fewer people living with AIDS, and more people living with HIV, as the period between seroconversion and

development of AIDS has lengthened. A number of issues relating to HAART's anticipated effectiveness remain, however. It is possible that its effectiveness could suddenly diminish for one or more segments of the population. More optimistically, it is possible that some portion of persons participating in HAART could stabilize their health to the extent that they could be sufficiently employed to not be eligible for or need housing services provided by HASA. Health status is related to the types of housing supports that persons with HIV/AIDS will need: many of those who are healthier presumably will be able to live independently with rental assistance, while those in declining health will need supportive housing.

- *Private housing market:* As emphasized in this report, the vast bulk of the HIV-specific housing resources currently provided in New York City are in the form of rental assistance (72 percent of current capacity) and thus rely on the private housing market. Because rents are so high, enhanced and "above enhanced" rental assistance have been essential to housing persons with HIV/AIDS in New York City. If the rental housing market continues to experience high rents and low vacancy rates, it is unlikely that this situation will change; it is quite likely that the market will become even tighter and difficult for persons with HIV/AIDS to access, even with subsidies, and that more persons with HIV/AIDS will require assistance at the "above enhanced level. If, however, rents come down, more affordable housing is available, and vacancy rates increase, it is possible that some portion of those currently receiving assistance will be able to participate in the private housing market without a public subsidy.

- *Job market:* As mentioned above, if HAART continues to be effective, it could improve the health status of persons living with HIV and AIDS so that they are able to work and thus become independent of HIV-specific housing supports. Another variable, however, is whether these persons will be able to secure adequate employment, given the complex life issues with which they struggle. In a tight job market they will face barriers to employment extending beyond their health status. Additionally, as discussed in the report, the structures of most available HIV-specific housing resources mean that persons returning to work are in immediate jeopardy of losing their housing supports, so that many may decide not to take that risk.

- *Other systems of special needs housing:* As discussed in this report, other systems of special needs housing and residential treatment in New York City, such as housing for people with substance

use issues and mental illness, and public housing, do not serve significant numbers of persons with HIV/AIDS. Results of the consumer survey, however, demonstrate that substantial numbers of persons living in HIV-specific housing currently face or have faced mental health and/or substance use issues. Most persons with HIV/AIDS in New York City are income-eligible for public housing. If these other systems of housing were to absorb and provide appropriate services to significant numbers of persons with HIV/AIDS, the need for HIV-specific housing would decrease accordingly.

- *Eligibility for HIV-specific housing:* In New York City, all persons with AIDS or symptomatic HIV illness (past or current) as defined by the NYS Department of Health AIDS Institute are legally entitled to housing assistance under NYS regulation (Title 18, Section 352.3(k) of the Code, Rules, and Regulations of New York State) and NYC Local Law 49 if they meet income eligibility guidelines. Under existing law, potentially every additional person with AIDS or symptomatic HIV will be eligible for an additional HIV-specific housing support, regardless of whether he or she is currently ill or his or her housing need is HIV-related, assuming he or she is income-eligible. If the laws are changed and eligibility is restricted, need for housing will decrease accordingly. If eligibility is broadened to include persons who are HIV-positive but asymptomatic, need will increase.

Methodological factors in projecting housing need include:

- *Projections of numbers of persons with HIV and AIDS:* Projecting the number of persons expected to be living with AIDS in future years follows a generally accepted methodology, because incidence and deaths are tracked and thus can be projected into the future, although researchers can disagree about the extent and trajectory of incidence and deaths. Projecting the numbers of persons living with HIV is more complex, because identification and tracking of cases is less certain and a large number of persons with HIV are estimated to be undiagnosed. HIV can be assumed to be a constant percentage of AIDS, or can be projected separately. The number of undiagnosed persons can be assumed to be a constant percentage of those who are diagnosed, or can be a constant number.

- *Housing need as a proportion of persons with HIV and AIDS, or persons with AIDS only:* Housing need can be estimated as a proportion of all persons diagnosed with HIV and AIDS currently and in

the future. This proportion could be presumed to be constant, or to increase or decrease. Extrapolating on the basis of the total of AIDS and HIV cases would not include persons who are undiagnosed: the DOHMH estimates that 25% of persons living with HIV have never been tested. Many of the undiagnosed may be quite ill, as 25% of persons diagnosed with HIV in 2002 received their HIV diagnoses at the same time as their AIDS diagnoses. Alternatively, need can be calculated as a proportion of all persons with AIDS only. This method would not account for the anticipated increasing proportion of persons with HIV who do not have AIDS as a result of new drug therapies, but remain legally entitled to housing supports. Still further, one could project need based on the proportion of all persons with HIV and AIDS, both diagnosed and undiagnosed/unreported. This method would include some persons who are HIV-positive but always have been asymptomatic, and thus not entitled to housing assistance under the current law.

- *Allocation of HIV-specific housing among persons with HIV and AIDS:* No information is available currently about how existing housing resources are allocated among persons with HIV and persons with AIDS. In the absence of any such data, a projection might assume that the proportions of persons with HIV and AIDS in HIV-specific housing mirror the proportions in the general population. However, the validity of this assumption is unknown. A merge of HASA and DOHMH AIDS Registry databases that was intended to be undertaken as part of this needs assessment would help to identify the proportion of HASA users with AIDS versus those who are HIV symptomatic. Such information could have helped to assess current trends in the relative demand by subgroup, and supported more reliable extrapolation.

Given these multiple uncertainties, dozens of permutations of projected housing needs are possible, all of which are limited by the shortcomings discussed above. For purposes of this report, however, the Assessment Team has chosen to present six possible models, using three methods:

- The first two models project housing need as a constant percentage of the number of persons diagnosed with HIV and AIDS, where the percentage is derived from the number of persons currently needing housing supports.

- The second two models project housing need as a constant percentage of the number of persons diagnosed and undiagnosed with HIV and AIDS, where the percentage is derived from the number of persons currently needing housing supports.

- The final two models project housing need as a constant percentage of the number of persons with AIDS only, where the percentage is derived from the number of persons currently needing housing supports, and the percentage of persons with HIV and AIDS who have AIDS.

The Assessment Team used epidemiological baseline numbers and projections for persons diagnosed with HIV and AIDS provided by the NYC Department of Health and Mental Hygiene (DOHMH) in all but the second two models. In those models, the Assessment Team used DOHMH's baseline numbers, but, in Projection 2(a), assumed that 25% of persons with HIV/AIDS are undiagnosed, and, in Projection 2(b), applied a slightly different projection methodology that projects HIV and AIDS separately and assumes a constant number of undiagnosed persons.

Projection 1(a): This model projects need as a constant percentage of the existing population of diagnosed HIV-positive and symptomatic and AIDS combined.

Projection 1(b): This model projects need separately for HIV and AIDS, as a constant percentage of the existing population of persons with HIV and AIDS, allocated in future years among persons with HIV and persons with AIDS in accordance with the proportions that are projected to be seen in New York City.

Projection 2(a): This model projects need as a constant percentage of the existing population of diagnosed and undiagnosed HIV and AIDS combined.

Projection 2(b): This model projects need as a constant percentage of the existing population of diagnosed and undiagnosed HIV and AIDS combined, but projects the anticipated increase of HIV and AIDS separately.

Projection 3(a): This model projects need separately for HIV and AIDS, as a constant proportion of the existing population of persons with AIDS only, allocated

in future years among persons with HIV and persons with AIDS in accordance with the proportions that are projected to be seen in New York City in general.

Projection 3(b): This model projects need separately for HIV and AIDS, as a constant proportion of the existing population of persons with AIDS only, allocated in future years among persons with HIV and persons with AIDS in accordance with the current proportions in New York City.

A final table presents the range of estimates for housing need derived from these six models. This table also breaks down need by housing model type, assuming that these types will be needed in the same proportions that they exist currently. Of 28,658 existing HIV-specific housing resources in New York City in December 2003, approximately 72% are in the form of rental assistance, 18% are permanent supportive housing units (both congregate housing and supportive scatter-site units), 5% are emergency hotels, and 5% are transitional supportive housing units. It is not clear if this proportion can and should be maintained in the future.

These projections do not include units of HIV-specific housing that currently are under development, or units that will be funded and developed in upcoming years. The pace and extent of development is contingent on funding availability, as well as numerous other factors. As more units are developed, they will reduce the need for HIV-specific housing resources.

All projections assume an unmet need of 2,425 HIV-specific housing supports as of December 2003, as described above.

For comparative purposes, it is worth noting that the number of persons receiving housing supports from HASA has increased by 65% during the past five years; if this trend continues, the impact on housing need will be daunting – greater than any of the following projections.

Projection 1(a).

- Projects need for HIV-specific housing resources for PLWH and PLWA combined.
- HIV and AIDS projections are based on diagnosed only, numbers provided by DOHMH in letter dated 6/1/04.
- Assumes existing HIV-specific housing resources of 28,658 in 2003, 2,425 unmet need in 2003, and 29,516 units needed in 2003 (1,567 of existing resources are SROs, and scenario assumes that replacement for those units is part of the unmet need).
- Assumes percentage of PLWHA needing housing resources in 2003 (33.9%) will remain constant through 2010.

Table IVA-4.

	PLWHA	Total Need for PLWHA	Unmet Need for PLWHA
2003	87,058	29,516	2,425
2004	91,984	31,183	4,092
2007	106,762	36,192	9,101
2010	120,662	40,904	13,813

Percentage increase in total need between 2003 and 2010: 38.6%

Projection 1(b).

- Projects need for housing for PLWA and PLWH separately.

- HIV and AIDS projections are based on diagnosed only, numbers provided by DOHMH in letter dated 6/1/04.

- Assumes existing HIV-specific housing resources of 28,658 in 2003, 2,425 unmet need in 2003, and 29,516 units needed in 2003 (1,567 of existing resources are SROs, and scenario assumes that replacement for those units is part of the unmet need).

- Assumes percentage of PLWHA needing housing resources in 2003 (33.9%) will remain constant through 2010.

- Assumes existing housing resources in 2003 are allocated in the same proportion that AIDS and HIV are estimated to exist in the current population in NYC (34% HIV and 66% AIDS).

- Assumes that in future years, housing resources needed will be allocated in the same proportion that AIDS and HIV are projected to exist in that year (*i.e.,* in 2004, 35% HIV and 65% AIDS; in 2007, 38% HIV and 62% AIDS; in 2010, 40% HIV and 60% AIDS).

Table IVA-5.

	PLWH	PLWA	Total Need for PLWH	Total Need for PLWA	Unmet Need for PLWH	Unmet Need for PLWA	Total Unmet Need
2003	29,349	57,709	9,950	19,566	825	1,601	2,425
2004	32,251	59,733	10,934	20,252	1,723	2,372	4,095
2007	40,957	65,805	13,886	22,310	4,675	4,430	9,105
2010	48,785	71,877	16,540	24,369	7,329	6,489	13,818

Percentage increase in total need between 2003 and 2010: 66.2% for PLWH; 24.5% for PLWA; 38.6% overall

Projection 2(a).

- Projects need for HIV-specific housing resources for PLWH and PLWA combined.

- HIV and AIDS projections are based on diagnosed and undiagnosed, numbers provided by DOHMH in letter dated 6/1/04, and adjusted to reflect that 25% of HIV is undiagnosed.

- Assumes existing HIV-specific housing resources of 28,658 in 2003, 2,425 unmet need in 2003, and 29,516 units needed in 2003 (1,567 of existing resources are SROs, and scenario assumes that replacement for those units is part of the unmet need).

- Assumes percentage of PLWHA diagnosed and undiagnosed needing housing resources in 2003 (25.4%) will remain constant through 2010.

Table IVA-6.

	PLWHA diagnosed & undiagnosed	Total Need for PLWHA	Unmet Need for PLWHA
2003	116,077	29,516	2,425
2004	122,645	31,152	4,061
2007	142,439	36,157	9,066
2010	160,883	40,864	13,773

Percentage increase in total need between 2003 and 2010: 38.5%

Projection 2(b).

- Projects need for HIV-specific housing resources for PLWH and PLWA combined.

- HIV and AIDS projections are based on diagnosed and undiagnosed. Baseline numbers provided by DOHMH in letter dated 6/1/04. Projections assume an additional 4,200 AIDS cases/year and 2,131 AIDS deaths/year; 4,170 additional HIV cases/year and 317 HIV deaths/year; constant 42,000 non-diagnosed and diagnosed but unreported persons with HIV.*

- Assumes existing HIV-specific housing resources of 28,658 in 2003, 2,425 unmet need in 2003, and 29,516 units needed in 2003 (1,567 of existing resources are SROs, and scenario assumes that replacement for those units is part of the unmet need).

- Assumes percentage of PLWHA diagnosed and undiagnosed needing housing resources in 2003 (22.7%) will remain constant through 2010.

Table IVA-7.

	PLWHA diagnosed & undiagnosed	Total Need for PLWHA	Unmet Need for PLWHA
2003	130,054	29,516	2,425
2004	135,976	30,867	3,776
2007	153,742	34,899	7,808
2010	171,508	38,932	11,841

Percentage increase in total need between 2003 and 2010: 31.9%

* 42,000 represents the midpoint of the sum of the midpoint of the estimated number of persons who are undiagnosed, plus the midpoint of the estimated number of persons who are diagnosed but not reported. The DOHMH estimates that undiagnosed persons range from 11,000 to 43,000 (with a midpoint of 27,000), and that diagnosed but unreported persons range from 11,000 to 19,000 (with a midpoint of 15,000).

Projection 3(a).

- Projects need for housing for PLWA and PLWH separately.

- HIV and AIDS projections are based on diagnosed only, numbers provided by DOHMH in letter dated 6/1/04.

- Assumes existing HIV-specific housing resources of 28,658 in 2003, 2,425 unmet need in 2003, and 29,516 units needed in 2003 (1,567 of existing resources are SROs, and scenario assumes that replacement for those units is part of the unmet need).

- Assumes proportion of PLWA only to total need for housing resources in 2003 (51.15%) will remain constant through 2010.

- Assumes existing housing resources in 2003 are allocated in the same proportion that AIDS and HIV are estimated to exist in the current population in NYC (34% HIV and 66% AIDS).

- Assumes that in future years, housing resources needed will be allocated in the same proportion that AIDS and HIV are projected to exist in that year (*i.e.,* in 2004, 35% HIV and 65% AIDS; in 2007, 38% HIV and 62% AIDS; in 2010, 40% HIV and 60% AIDS).

Table IVA-8.

	PLWH	PLWA	Total Need for PLWH	Total Need for PLWA	Unmet Need for PLWH	Unmet Need for PLWA	Total Unmet Need
2003	29,349	57,709	9,950	19,566	825	1,601	2,425
2004	32,251	59,733	10,712	19,839	1,501	1,959	3,460
2007	40,957	65,805	12,912	20,745	3,701	2,865	6,566
2010	48,785	71,877	14,863	21,899	5,653	4,019	9,671

Percentage increase in total need between 2003 and 2010: 49.4% for PLWH; 11.9% for PLWA; 24.6% overall

Projection 3(b).

- Projects need for housing for PLWA and PLWH separately.

- HIV and AIDS projections are based on diagnosed only, numbers provided by DOHMH in letter dated 6/1/04.

- Assumes existing HIV-specific housing resources of 28,658 in 2003, 2,425 unmet need in 2003, and 29,516 units needed in 2003 (1,567 of existing resources are SROs, and scenario assumes that replacement for those units is part of the unmet need).

- Assumes proportion of PLWA only to total need for housing resources in 2003 (51.15%) will remain constant through 2010.

- Assumes existing housing resources in 2003 are allocated in the same proportion that AIDS and HIV are estimated to exist in the current population in NYC (34% HIV and 66% AIDS).

- Assumes that in future years, housing resources needed will be allocated in the same proportion that AIDS and HIV exist in 2003 (34% HIV and 66% AIDS).

Table IVA-9.

	PLWH	PLWA	Total Need for PLWH	Total Need for PLWA	Unmet Need for PLWH	Unmet Need for PLWA	Total Unmet Need
2003	29,349	57,709	9,950	19,566	825	1,601	2,425
2004	32,251	59,733	10,387	20,164	1,176	2,284	3,460
2007	40,957	65,805	11,443	22,213	2,232	4,333	6,566
2010	48,785	71,877	12,499	24,263	3,288	6,383	9,671

Percentage increase in total need between 2003 and 2010: 25.6% for PLWH; 24.0% for PLWA; 24.6% overall

Table IVA-10. Summary of Total and Unmet Need for HIV/AIDS Housing by Housing Model Type

	2003*		2004		2007		2010	
	Total Need	**Unmet Need**	**Projected Need**	**Unmet Need**	**Projected Need**	**Unmet Need**	**Projected Need**	**Unmet Need**
Rental Assistance Subsidies (73.0% of total)	21,537	934**	22,300 - 22,770	1,700 - 2,170	24,570 - 26,500	3,970 - 5,900	26,840 - 29,860	6,230 - 9,260
Permanent Supportive Units (22.6% of total)	6,682	1,491***	6,900 - 7,050	1,710 - 1,860	7,610 - 8,200	2,420 - 3,010	8,310 - 9,250	3,120 - 4,060
Transitional Supportive Units (4.4% of total)	1,297	0	1,340 - 1,370	50 - 80	1,480 - 1,600	180 - 300	1,620 - 1,800	320 - 500
Total HIV-Specific Housing Resources	**29,516**	**2,425**	**30,550 - 31,190**	**3,460 - 4,100**	**33,660 - 36,300**	**6,570 - 9,110**	**36,760 - 40,910**	**9,670 - 13,820**

* All numbers are as of December 2003.

** This number was calculated as follows: 1) Based on the results of the consumer survey, it is assumed that 27% of 1,567 persons in HASA emergency hotel placements (423) have no substance use or mental health issues and thus can live independently with rental assistance subsidies; 2) It is assumed that 55% of 1,297 persons in HIV-specific transitional housing placements (713) do not have co-occurring substance use and mental health issues and thus can live independently with rental assistance subsidies; 3) Based on results of key informant interviews, it is estimated that 10% of 5,191 persons in HIV-specific permanent supportive housing placements (519) are "over-serviced" in the supportive housing system and thus can live independently with rental assistance subsidies; and 4) Based on the results of the consumer survey, it is assumed that 3.5% of 20,603 persons using rental assistance subsidies (721) have an unmet need for on-site mental health and/or substance use treatment, and thus require a permanent supportive housing placement. The calculation is: 423 + 713 + 519 – 721 = 934.

*** This number was calculated as follows: 1) Based on the results of the consumer survey, it is assumed that 45% of 1,567 persons in HASA emergency hotel placements (705) have co-occurring substance use and mental health issues and thus require permanent supportive housing placements; 2) It is assumed that 45% of 1,297 persons in HIV-specific transitional housing placements (584) have co-occurring substance use and mental health issues and thus require permanent supportive housing placements; 3) It is assumed that 3.5% of 20,603 persons using rental assistance subsidies (721) have an unmet need for on-site mental health and/or substance use treatment, and thus require a permanent supportive housing placement; and 4) Based on results of key informant interviews, it is estimated that 10% of 5,191 persons in HIV-specific permanent supportive housing placements (519) are "over-serviced" in the supportive housing system and thus can live independently with rental assistance subsidies. The calculation is: 705 + 584 + 721 – 519 = 1,491.

3. Addressing the Projected Housing Need

As indicated in the above projection of future housing needs, it is expected that the demand for HIV/AIDS housing will expand significantly by the year 2010. The projected increase in necessary housing resources, while large (more than 15,000 units), would actually represent a smaller percentage increase in demand (53% in the next 6 years) than recent experience would indicate. In the five years between 1998 and 2003, the number of New Yorkers receiving HIV-specific housing assistance grew 65%, from 16,400 in December 1998, to 27,000 in December 2003.[16]

Sizeable capital and operating costs will be associated with meeting anticipated need: the basic analysis in the estimate points to projected operating costs of close to $200 million. Moreover, although much of the need can be addressed through rental supports and scatter site programs that use the private market, it is estimated that at least an additional 150-200 units of newly constructed or rehabilitated supportive housing will be necessary to address the projected need, at a total cost of approximately $26 million per year. Existing capital funding streams from the Housing Opportunities for Persons with AIDS (HOPWA) program and the Homeless Housing Assistance Program (HHAP) could provide approximately $10-15 million per year, which would cover a significant portion of this cost. For the remaining funds, the City could leverage these public funds to tap into resources in the private market.

A change in procurement rules allowing for long-term operating contracts, which include a debt service component, would create numerous financing opportunities. One option could be using grant funding as equity to attract commercial lenders. For instance, this funding would cover 25% to 50% of capital costs and the balance could be provided through a commercial mortgage. Alternatively, at an estimated per-unit per-diem debt service cost of $18-$20, tax-exempt bond financing underwritten by the long-term operating contracts could be a cost-efficient source of capital funding. This option is set out in Table IV.A-5 below. These commercial loans and/or tax-exempt bond financing could be combined with Low Income Housing Tax Credits. This bond issuance could be issued by the Housing Development Corporation (HDC) and overseen by the New York City Department of Housing Preservation and Development (HPD).

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[16] New York City Human Resources Administration, HIV/AIDS Service Administration (NYC HRA HASA.) *HASA Facts*. New York, New York: Dec. 1998; Dec. 2003.

The charts set out below outline one possible strategy for meeting anticipated housing needs.

Table IVA-11. One Strategy for Meeting Capital Development Targets		
Estimated Capital Cost		
Estimated Annual Housing Need (Units)		200
Estimated Cost Per Unit		$130,000
Total Capital Cost		**$26,000,000**
Sources of Capital Funds	**Units**	
Housing Opportunities for Persons Living With AIDS (HOPWA)	77	$10,000,000
Homeless Housing Assistance Program (HHAP)	38	$5,000,000
Total Available Capital Funds	**115**	**$15,000,000**
Additional Capital Funds Required	**85**	**$11,000,000**
Financing Sources		
Low Income Housing Tax Credits		$2,200,000
Tax-Exempt Bond Proceeds		$8,800,000
Additional Financing Sources		**$11,000,000**
Tax Exempt Bond Issuance Analysis		
Bond Issuance (Hard and Soft Costs)		$8,800,000
Bond Issuance (Financing Fees)		$880,000
Total Bond Issuance		**$9,680,000**
Interest Rate		3.50%
Term (Years)		25
Annual Cost		$581,524
Annual Cost Per Unit	**85**	$6,873
Per Diem Cost Per Unit		**$18.83**

Table IVA-12. Estimated Capital Costs

ESTIMATED UNMET HOUSING NEED		Immediate	2004	2007	2010
Rental Assistance		934	3,313	7,222	10,282
Permanent Supportive Units		1,491	2,229	3,442	4,391
Transitional Supportive		-	143	379	563
Cumulative Total Unmet Housing Need		**2,425**	**5,685**	**11,043**	**15,236**
ESTIMATED OPERATING COST	**Daily Cost**	**Immediate**	**2004**	**2007**	**2010**
Rental Assistance	24	*	29,021,880	63,264,720	90,070,320
Permanent Supportive Units	60	*	48,815,100	75,379,800	96,162,900
Transitional Supportive	60	*	3,131,700	8,300,100	12,329,700
Cumulative Total Operating Cost		**-**	**80,968,680**	**146,944,620**	**198,562,920**
ESTIMATED CAPITAL COST		**Immediate**	**2004**	**2007**	**2010**
Number of Units (25% of Supportive)**		373	593	955	1,239
Estimated Cost per Unit		130,000	130,000	130,000	130,000
Cumulative Total Capital Cost		**48,457,500**	**77,090,000**	**124,182,500**	**161,005,000**

**This analysis assumes that, of the unmet housing units needed, 25% are congregate housing units that require construction or rehabilitation. The remaining 75% are scattered site units, for which there are no associated capital costs.

*The estimated operating expenses associated with meeting the immediate housing need for Rental Assistance, Permanent Supportive, and Transitional Supportive Units has been calculated as $0 because the calculation of immediate need is based on persons who are already in the housing system, but are placed inappropriately. For the purposes of preparing a simple analysis, it was assumed that the additional costs of placing persons needing additional support into supportive housing would be balanced out by the cost savings associated with moving persons with HIV/AIDS out of the emergency SRO units.

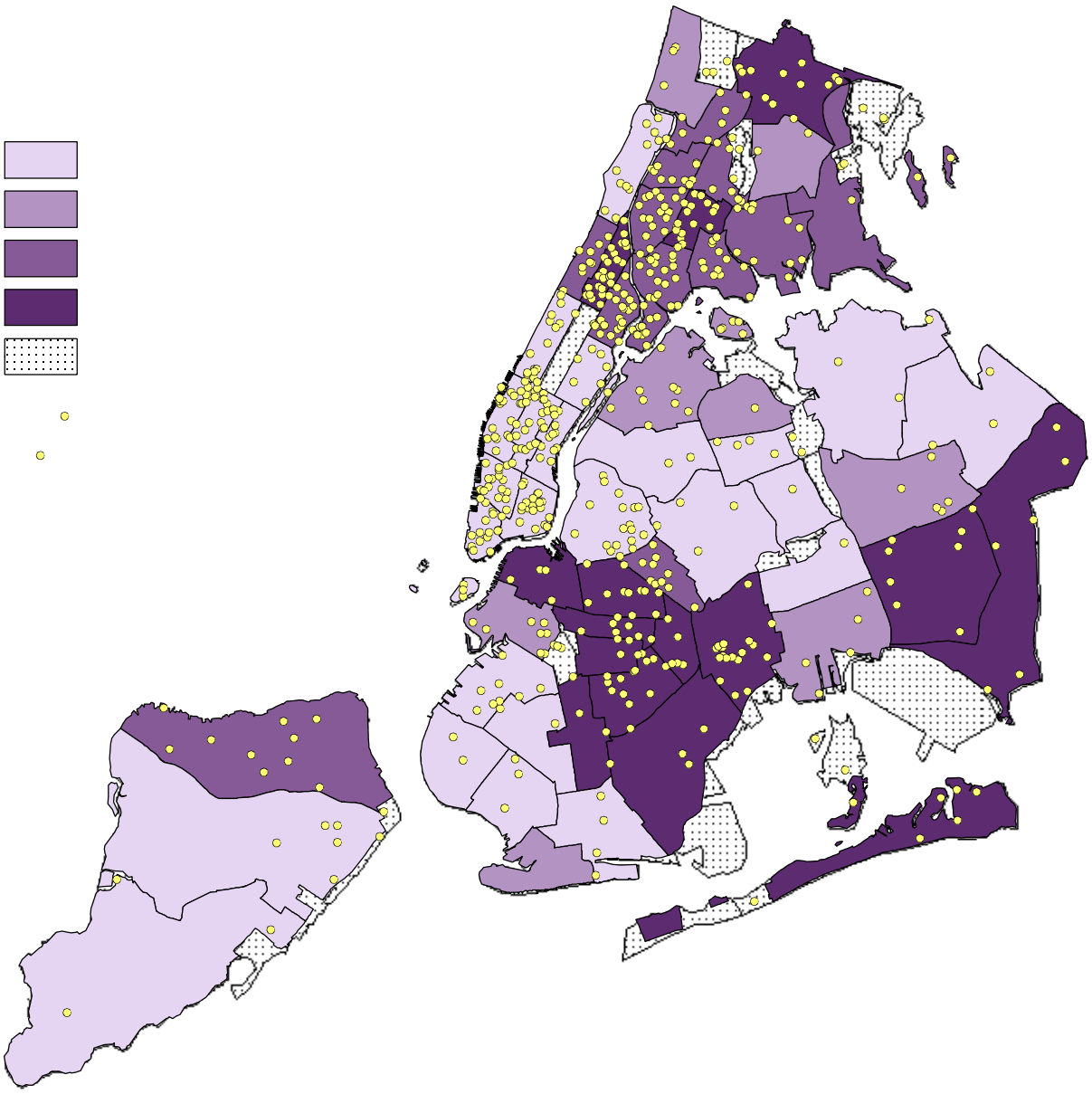
Exhibit IVA-13

City-wide Maps of Living AIDS Cases in New York City

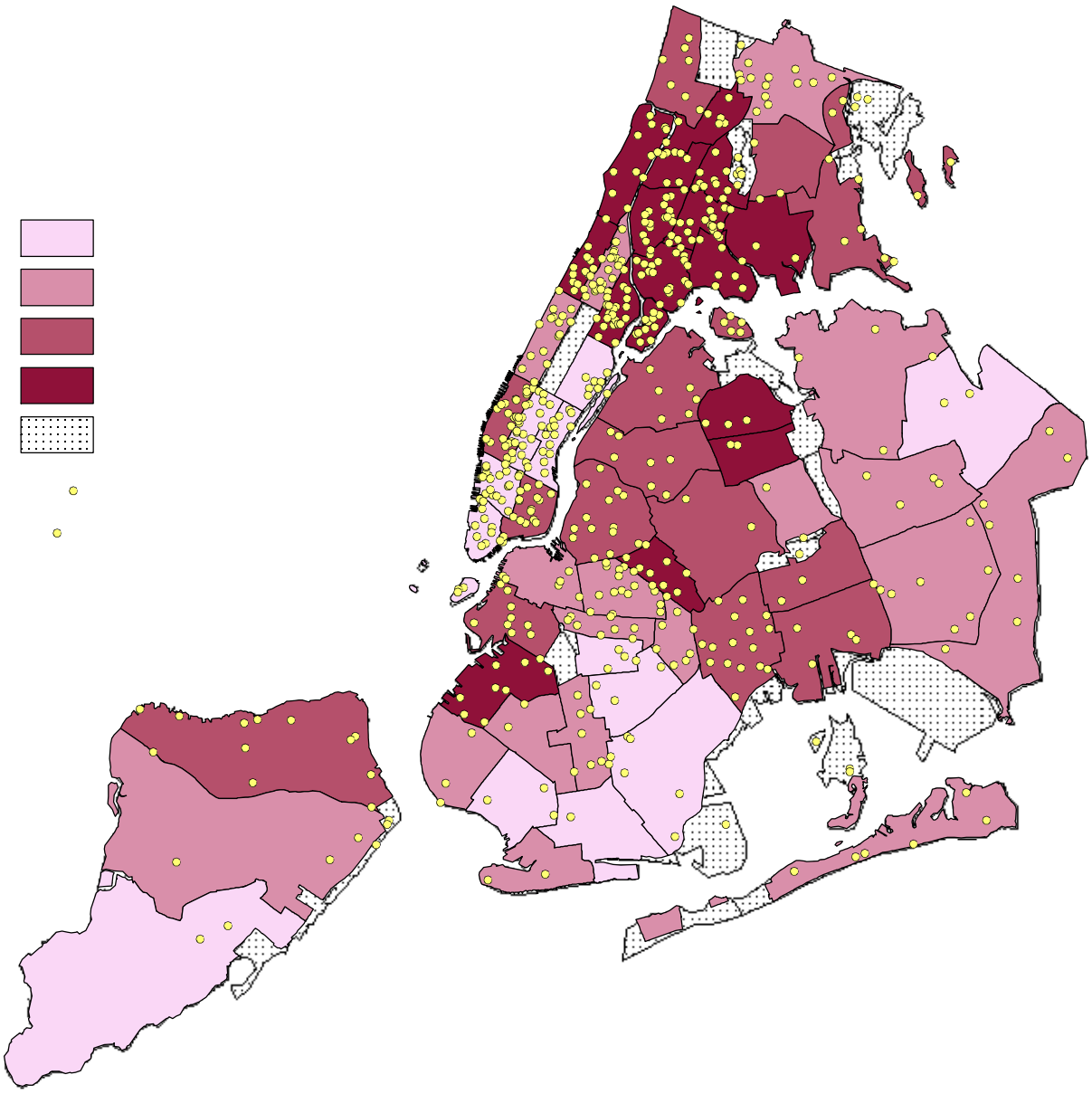
The following three maps depict the distribution of living AIDS cases in New York City, in relationship to Black/African American communities, Hispanic/Latino communities, and poverty rates.

Borough- and county-specific maps are provided in Appendix C. Appendix C also includes a detailed methodology describing mapping procedures, as well as a map showing United Hospital Fund (UHF) Neighborhoods, on which the maps are based.

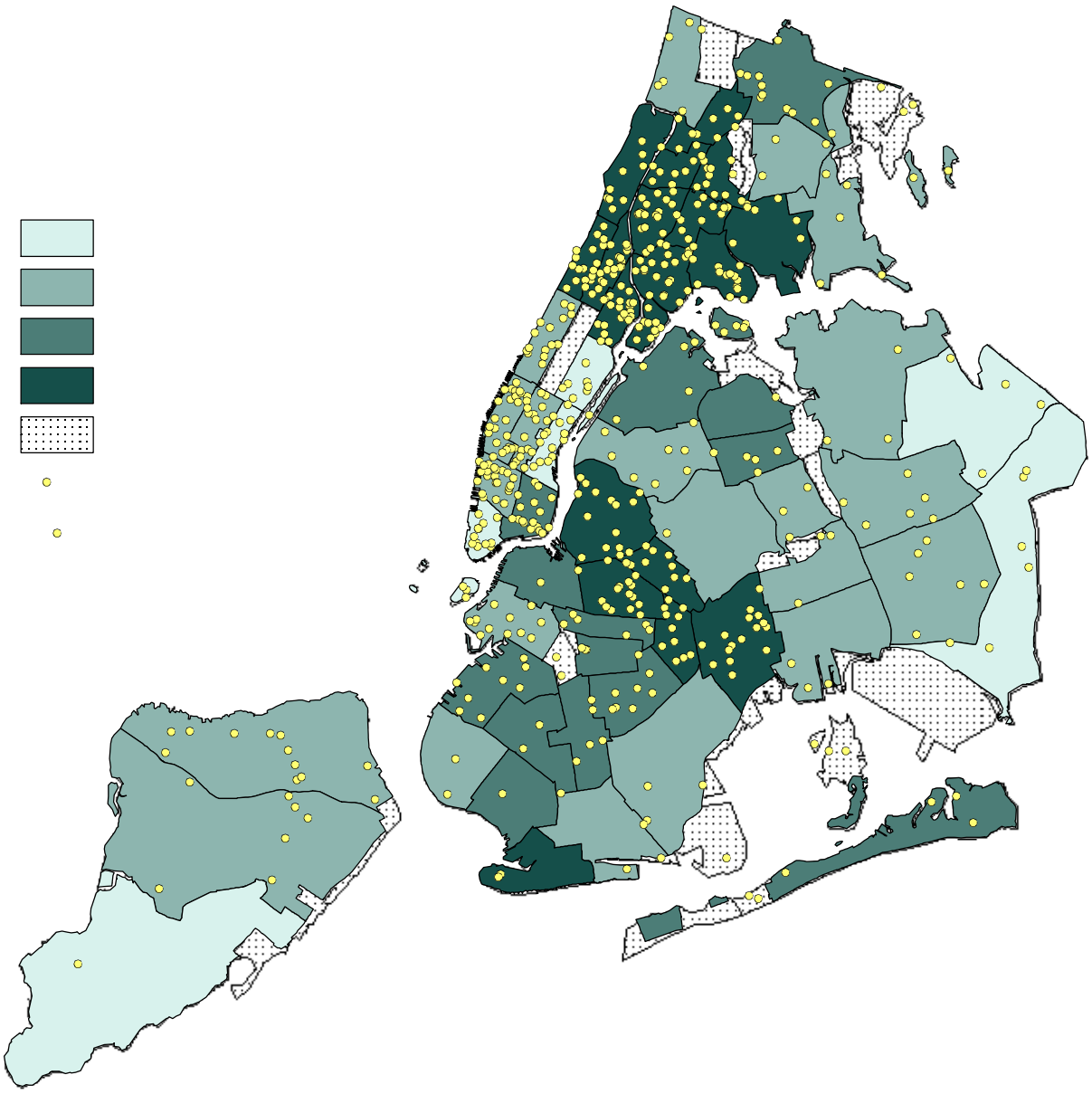
Living AIDS Cases in Black/African-American Communities in New York City



Living AIDS Cases in Hispanic/Latino Communities in New York City



Living AIDS Cases and Poverty Rates in New York City



IV. B. EMERGING NEEDS AND SPECIAL POPULATIONS

There are significant special and emerging housing needs among certain groups of persons living with HIV/AIDS.

This needs assessment identified certain New Yorkers with HIV/AIDS that present special and emerging housing needs. Several subgroups of consumers surveyed for this study were identified as persons who were presumably at special risk for experiencing housing problems. In addition to their diagnosis of HIV or AIDS, these groups are characterized by histories of incarceration, struggles with mental health or substance use issues, or life experiences of homelessness. Analysis of consumer survey results explored these respondents' potential for encountering housing problems by investigating their current satisfaction with their housing, their history of housing instability, and indicators of their current housing stability. These results are set out in Section III above. The discussion below provides additional information on the special challenges faced by these persons, as well as other special populations:

- Undocumented persons;
- Persons with asymptomatic illness that are not eligible for HIV-specific housing services;
- Families with children;
- Persons of transgendered experience;
- Adolescents/young persons;
- Persons over fifty-five; and
- Mobility impaired persons.

Formerly Incarcerated

Almost half of all respondents have a history of incarceration, and 31% have been convicted of a felony.

A substantial percentage (43%) of survey respondents report that they have at some time in their lives been in jail or prison. Of those respondents with histories of incarceration, two-thirds have been convicted of a felony. These respondents are part of the growing number of formerly incarcerated persons who are re-entering their communities: in 2003, 600,000 persons were released from prison nationwide. Each year approximately 26,000 people are released from New York State

prisons; of those persons released, an estimated 20,000 people return to New York City.[1] Approximately 100,000 persons are released from New York City jails each year. While the extent of need for HIV-specific housing and services among those recently released is not known, it is known that the rate of HIV infection among those released is significant, as is their risk for homelessness. The Corporation for Supportive Housing has reported that 8.5% of New York State inmates and 7.1% of New York City inmates are HIV-positive. More than 11% of state prisoners released to NYC enter a Department of Homeless Services (DHS) shelter within two years of release, and 30% of persons leaving NYC correctional facilities enter the DHS shelters, 28% within one week.[2]

Key informants confirmed consumer survey findings that consumers with histories of incarceration experience greater housing instability and homelessness, and face particular barriers to obtaining and maintaining housing. Key informants also described the unique housing and service needs of previously incarcerated persons. Because of a lack of proper discharge planning, consumers recently released from prison often have nowhere to turn and do not have a safe, stable place to live. Consumers recently released explained that they felt that they had to "take whatever housing they can get," which frequently meant living in a dangerous, precarious living situation, even as they were looking for "new beginnings," and sought not to return to the temptations of their old neighborhoods. As key informants reported, persons with felony convictions are excluded from participation in most federally funded housing programs, including public housing and the Section 8 Housing Choice Voucher program.[3]

Mental Health Issues

The widespread occurrence of mental health issues among consumer survey respondents is described above in Section III. Twenty-three percent of respondents indicated that they had been hospitalized for mental health issues. This percentage is consistent with recent research finding that the incidence of mental illness among Medicaid users with HIV infection was significantly higher than among other recipients.[4]

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[1] National H.I.R.E. Network. January 2004. http://www.hirenetwork.org/.
[2] Corporation for Supportive Housing. *Fact Sheet: The Need for Re-Entry Housing*. http://www.csh.org.
[3] New York City Housing Needs Assessment (HNA), Key Informant Interviews (2003).

Key informants noted that persons with severe and persistent mental illness are better served in the mental health system. The more pressing demand in the HIV/AIDS housing system is the need for mental health services for persons with less severe mental health issues which are not being addressed by any other system.[5]

Substance Use Issues

People with substance use issues face particular barriers to obtaining and maintaining stable housing. These include housing programs that screen out potential residents with histories of drug use, or that do not permit residents to use substances. Since 1998, it has been federal law that if any public housing tenant, any member of the tenant's household, or any guest engages in drug-related criminal activity on or off the premises, the tenant is subject to eviction. In 2002, the Supreme Court upheld the "one-strike" policy, ruling that public housing tenants could be evicted for another household member's drug use, even if they were unaware of that use. Although fair housing law protects most people with disabilities, it specifies that housing need not be made available to a person actively using illegal drugs.[6]

Undocumented Persons

Key informants discussed the challenges involved in providing housing and services to undocumented immigrants, who are ineligible for most publicly funded benefits, including rental assistance, and many of whom fear deportation if they identify themselves to public institutions that provide housing and healthcare. With legal assistance, many undocumented persons living with HIV/AIDS have been able to secure what is called "PRUCOL" status (permanently residing under color of law), under which they can apply for public benefits, including HASA rental assistance and other housing programs. However, several legal service providers cited increased difficulty in securing "PRUCOL" status following the events of 9/11. Available housing resources are therefore extremely limited, forcing many people to double up with family members or live in substandard illegal housing units. Overcrowding is thus a serious issue among undocumented persons. Housing providers report, moreover, that even eligible immigrants are more resistant than other consumers to living in congregate housing facilities, as a result of the stigma of living with HIV/AIDS. Access

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[4] Blank, M.B., et al. 2002. "Co-occurrence of HIV and Serious Mental Illness among Medicaid Recipients." *Psychiatric Services 53(7)*: pp. 868-873.
[5] HNA, Key Informant Interviews (2003).
[6] AIDS Housing of Washington. 2003. *AHW Fact Sheet: Housing People with Substance Use Issues.* Seattle, Washington. http://www.aidshousing.org.

to long-term rental supports is therefore extremely important, and there is significant unmet need. Key informants reported that the Sustainable Living Fund, which is the primary source of long-term rental assistance for undocumented persons, has no current capacity to offer assistance to new households.[7]

Unmet housing needs among undocumented immigrants are growing steadily, as the number of undocumented immigrants continues to increase. According to one key informant, there are an estimated 450,000 undocumented African immigrants living in NYC, and it is estimated that 20,000 to 25,000 of these persons are living with HIV/AIDS. There are also sizable populations of undocumented immigrants from Central and South America, Asia, and other regions.[8]

HIV Asymptomatic

HIV-positive persons who do not have diagnoses of HIV-illness are not eligible for HIV-specific housing programs or rental subsidies. While these persons fall within the HUD definition of HOPWA-eligible persons, existing New York City HOPWA-funded programs currently employ the HASA criteria for medical eligibility, since many of these programs must rely on the HASA-administered enhanced rental assistance for operating funding. The "standard" public assistance shelter allowance (rental assistance) that is available for a single person has been $215 for many years. As discussed elsewhere in this report, persons using the standard rental assistance are extremely unlikely to be able to gain access to the private rental market.

Homeless persons with asymptomatic HIV infection are referred to the City shelter system, operated by the Department of Homeless Services (DHS). In September, 2003, the New York State Court of Appeals removed legal barriers to enforcement of a 1995 New York State regulation that requires the denial of shelter to homeless people who are said to be in non-compliance with social service plans, assessments or other rules.[9,10] Under the regulation, when a homeless individual fails to comply he or she must be ejected from shelter for thirty days or until the failure to comply ceases, whichever period is longer. The regulation does provide for exceptions for persons with mental or physical impairments. Government and provider key informants called for a clear exemption from

[7] HNA, Key Informant Interviews (2003).
[8] Ibid.
[9] Kaufman, L. "City Cleared to Evict Disruptive from Shelters." *New York Times* September 27, 2003: p. B3.

such sanctions for shelter users who self-identify as HIV-positive but who do not meet the medical eligibility for HASA services and non-shelter HIV-specific housing resources.[11]

More importantly, numerous key informants called for the expansion of HIV-specific housing benefits, particularly the enhanced rental allowance, to persons with as-yet asymptomatic HIV infection, at least as a pilot project. Recent research, discussed in Section IA, has demonstrated the effectiveness of housing as an HIV prevention intervention. As demonstrated by the consumer survey conducted as part of this study, HIV-specific housing resources have engendered stability and connection to health care among persons with AIDS and HIV illness who have histories of homelessness and other complex life issues. There is every reason to expect similar results for persons at earlier stages of HIV infection. The success of the enhanced rental assistance program as a relatively low-cost housing intervention for persons with AIDS and HIV illness would point to the likely effectiveness and significance of extending the program to persons who stand to benefit greatly from early and stable connection to HIV health care.

Families with Children

Key informants identified housing for families with an HIV positive member as a continuing need. In general, persons with HIV/AIDS who were living with their families indicated that they preferred not to live in congregate housing.[12]

Despite improved procedures, lack of appropriate housing remains a factor in the ability of families with a member living with HIV/AIDS to maintain or regain custody of minor children. Housing providers pointed to the need for family housing for persons with HIV/AIDS, indicating that parents lose their children to the foster care system because of their illness, and need supportive living environments in order to get their children back. Despite improvements in coordination between HASA and New York City's Administration for Children's Services (ACS), key informants reported that heads of families are still often caught between the two agencies, with HASA unable to

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[10] Under a legal settlement reached in January, 2003, homeless families are not subject to denial of shelter under the regulation. Kaufman, L. "New York Reaches Deal to End 20-Year Legal Fight on Homelessness." *New York Times* Jan. 18, 2003: p. A1.

[11] HNA, Key Informant Interviews (2003).

[12] HNA, Consumer Focus Group (2003).

approve a larger apartment until children are returned and ACS unwilling to return children until appropriate housing is in place.[13]

Persons of Transgendered Experience

Persons of transgendered experience face particular barriers to securing and maintaining safe and stable housing. First, transgendered individuals face significant discrimination in the housing market, both from landlords that refuse to rent apartments to them, and from neighbors and community members that contribute to a hostile and/or unsafe living environment. Discrimination in the job market limits employment opportunities for transgendered persons, adding to financial insecurity and compounding housing instability. In addition, many transgendered persons have had extremely negative experiences with housing and health care providers who were not informed of, or sensitive to, their needs, so they may be reluctant to seek necessary services. Unconnected to essential health care services and other related social supports, many trangendered persons are at particularly high risk of housing instability. These issues are particularly troubling among this population, where additional high risk behaviors such as hormone and steroid injection, sex work, and sex with multiple partners have led to high rates of HIV/AIDS, particularly among male-to-female transgendered persons.

Adolescents/Young persons

Key informants reported that precariously housed and homeless young persons between the ages of thirteen and twenty-one are a vulnerable population with unmet housing needs. The CDC estimates that half of all new HIV infections in the United States are in people under 25.[14] Many homeless adolescents find that exchanging sex for food, clothing, and shelter is their only chance of survival on the streets.[15] Youth aging out of the foster care system are often released without discharge plans and are forced to survive on their own. Many of these young people have no family ties or social networks. Key informants reported that this population has unique housing and supportive service needs and that there is a lack of housing for these young people.[16] The New York City Coalition on the Continuum of Care, the group of key stakeholders who come together to decide how to

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[13] HNA, Key Informant Interviews (2003).
[14] Centers for Disease Control and Prevention, Division of HIV/AIDS Prevention. "Young People at Risk: HIV/AIDS Among America's Youth." http://www.cdc.gov/hiv/pubs/facts/youth.htm.
[15] AIDS Housing of Washington. 2003. *AHW Fact Sheet: Homelessness & HIV/AIDS.* Seattle, Washington. http://www.aidshousing.org.

prioritize the use of federal McKinney-Vento Homeless Housing Assistance funding, has prioritized creating new units for this population because of the current unmet need, as has the NYC Department of Housing Preservation and Development, through its "Foyer" housing program.

Persons Over Fifty

Thirty-one percent of respondents to the consumer survey conducted as part of this study were over the age of fifty. Focus group findings, key informant results and recent studies indicate that persons with HIV/AIDS over the age of fifty face unique obstacles in obtaining and maintaining housing. Many older people require specialized housing and supportive services to address issues related to aging with HIV/AIDS.[17] Seniors living with HIV/AIDS often find themselves isolated, and living in substandard housing without support networks and access to long term care. Fear of stigmatization keeps some seniors from revealing their HIV status, thus exacerbating their lack of ability to receive care. Key informants suggested that outreach programs must target seniors and need to find a way to connect them to care.

A study conducted by the Columbia University School of Public Health revealed that 27% of older persons with HIV/AIDS are currently or have been in the recent past (past 12 months) in an unstable or inadequate housing situation. This finding is particularly problematic, as seniors are more physically vulnerable to substandard housing conditions. In addition, according to the study, 35% of HIV positive elderly adults are currently experiencing some type of housing problem such as paying rent, or living in sub-standard conditions.[18]

Key informants reported that providers must prepare for an aging population of consumers living with HIV/AIDS. Housing resources must become more flexible, as aging translates directly into more complex and sometimes debilitating health status among clients. Both providers and consumers reported that HIV illness is increasingly complicated by the long term effects of HIV treatments, substance use and other co-occurring medical conditions. High rates of renal failure and diabetes were noted in particular. These conditions often result in fluctuating states of client "independence," underscoring the need not only for "client centered" supports layered on existing

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[16] HNA, Key Informant Interviews (2003).
[17] Ibid.

housing, but also for increased ease of movement between levels of service. One provider noted that designating several "emergency" units within a congregate supportive housing facility would make it possible for residents who had moved on to independent housing to return to the more supportive community environment when illness and increased debilitation made living alone untenable.[19]

Mobility Impaired Persons

Mobility impaired individuals face barriers in obtaining appropriate, handicapped accessible apartments. Despite the recent changes in accessibility to housing stock brought about by the Americans with Disabilities Act of 1990, the majority of housing stock remains unaffected by this law; only 2.56% of the existing housing stock has been built since this law went into effect, although some housing stock has since been renovated into compliance. At this time, only 22% of the housing stock has access all the way from the sidewalk to the apartment without stairs of some sort; the number is somewhat better for vacant apartments, perhaps because of newer housing stock and renovations. However, there are still only 17,877 vacant apartments with complete access.[20]

Congregate supportive housing is an important source of ADA-compliant housing units. Almost all congregate housing for persons living with HIV/AIDS is in compliance with ADA standards and is appropriate for persons in wheelchairs.

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[18] Aidala, A., et. al. 1999. Senior Needs Assessment Project: The Housing and Service Needs of Older New Yorkers Infected and Affected by HIV/AIDS.
[19] HNA, Key Informant Interviews (2003).
[20] New York City Housing and Vacancy Survey 2000. Vacant for Rent by Rent Regulation Status/Series IIA - Table 100 & Renter Occupied Housing Units by Rent Regulation Status/Series IA - Table 100. http://www.housingnyc.com/research/hvs02/.

IV. C. THE AFFORDABLE HOUSING CRISIS

The private rental market will not be sufficient to meet the housing needs of all New Yorkers with HIV/AIDS; the market is too tight and too difficult to use for persons with complex histories of substance use or mental health issues, poor credit, and/or histories of incarceration.

Limits on the stock of affordable private housing may be the most serious threat to the future success of New York City's housing system for persons with HIV/AIDS. Through its rental assistance and scatter site programs, HASA has succeeded in housing thousands of persons, but these programs are tied inextricably to the private market. Approximately 86% of the housing assistance that HASA provides to its clients relies on the private rental housing market, through the use of tenant-based rental assistance or placements in scatter site programs. In order for these programs to serve as viable housing options, HASA clients and housing providers must be able to obtain and retain safe and properly maintained private apartments at rents that fall within HASA's rent guidelines. In addition, people living with HIV/AIDS who are not eligible for HASA's housing assistance because they are asymptomatic, or choose not to use it, find housing either in privately owned apartments at the lower price end of the market, or in other subsidized housing systems, such as public housing and Section 8 rental assistance. The issue of housing for people living with HIV/AIDS, accordingly, must be considered within the larger context of the current and longstanding affordable housing crisis in New York City, and the tremendous significance of both the private housing market and other systems of subsidized housing to the City's current response to the housing needs of persons with HIV/AIDS.

Given the rising costs and shrinking supply of affordable housing units on the private market, moreover, it is clear that an increase in rental subsidies, while necessary, will not alone be sufficient to meet the current and future housing needs of people with HIV/AIDS in New York City. More permanently affordable units must be created. Key informants cited a "responsibility" on the part of government and non-profits to use available targeted HIV/AIDS resources to increase the number of low-income units available, and to ensure their long-term availability and affordability for persons with HIV/AIDS.[1]

[1] New York City Housing Needs Assessment (HNA), Key Informant Interviews (2003).

In recent years, the City has taken a number of important steps to encourage development of more affordable housing. Most notably, Mayor Bloomberg's *The New Marketplace: Creating Housing for the Next Generation*, released in 2002, proposes investment of new funds and redirection of existing allocations to support housing production. The plan represents a positive and innovative move towards meeting New York City's housing needs. Key informants interviewed by the Assessment Team noted the importance of the mayor's determination to make housing a top priority in the City, and to publicize that priority. As will be discussed in more detail, however, the plan does not purport to be an adequate solution to the housing needs of the City's lowest income residents, particularly the need for supportive and other special needs housing. If the City is committed to increasing the mix and volume of housing for people with HIV/AIDS, sufficient funding must be targeted to the programs that produce this housing.

A picture of the "affordable" New York City housing market in recent years reflects an increase in costs and a simultaneous decrease in supply. This situation has not been impacted by the nationwide recession: New York is one of two or three cities in the United States in which rental prices have not decreased significantly over the past two years, and the pressures on rents at the lower end of the scale have been particularly intense. Rental prices have risen while real wages have remained stagnant. Although overall, the City has gained housing units, it is true that the City has lost and continues to lose hundreds of thousands of affordable units at the lowest rent levels, and the overall rental vacancy rate in New York City is only three percent. These factors, along with others, make the task of finding a safe, affordable apartment in New York City a difficult challenge for any New Yorker, particularly those who are more vulnerable and may have particular housing needs as a result of HIV/AIDS. As Mayor Bloomberg's 2002 housing plan states, "[w]hile New York City's housing stock is in better condition than it has been in decades, nearly half of all New Yorkers pay more than 30% of their income in rent and hundreds of thousands live in overcrowded conditions."[2,3,4]

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[2] City of New York. 2002. *The New Housing Marketplace: Creating Housing for the Next Generation.* New York, New York.
[3] This picture of New York City's housing market is echoed in a recent report on family homelessness issued by the Special Master Panel charged with evaluating the City's family shelter system. New York City Family Homelessness Special Master Panel. 2003. *Family Homelessness Prevention Report*. pp. 31-33.
[4] While there are many definitions of "affordable" housing, the one used most commonly by housing analysts assumes that households can afford to pay thirty percent of their monthly incomes towards their shelter expenses. For persons with HIV/AIDS who receive SSI or public assistance, this number is quite low.

Housing Supply

The supply of affordable private market and subsidized housing in New York City is severely limited in terms of costs, vacancy rates, and conditions, and the number of available affordable units is shrinking dramatically. The housing crunch that impacts middle- and upper-income New Yorkers has had an even more disastrous effect on people who can afford only the units at the lowest end of the scale on the private market. Rental prices are inelastic, renters pay enormous percentages of their income towards housing expenses, vacancy rates are low, and housing conditions, while greatly improved in recent years, reflect the realities of a housing stock that is old and not always properly maintained. As a result, people with HIV/AIDS who are seeking to rent apartments on the private market, either with or without a rental subsidy, are competing within a small and shrinking pool of affordable apartments.

Consumers reported a number of types of perceived discrimination that made it difficult to get or retain housing.

Key informant housing providers and consumers repeatedly confirmed the pressures exerted by these circumstances, reporting that they found it increasingly difficult and expensive to secure and maintain units on the private market. As the market tightens, moreover, persons with HIV/AIDS may be more likely to face discrimination from landlords who can afford to be selective: housing placement assistance providers reported that consumers with criminal histories have particular difficulties renting apartments on the private market, and that consumers also face discrimination in the private housing market due to their income sources, their HIV/AIDS status, bad credit, and/or a lack of rental history or references. These reports are supported by the consumer survey results, in which respondents reported perceived discrimination making it difficult for them to secure or retain housing, including discrimination based on their race or ethnicity (26% of respondents), their HIV/AIDS status (23% of respondents), their income source (25% of respondents), and bad credit (20% of respondents).[5,6]

Housing Costs

While real median household incomes for renters have essentially stayed the same for the past twenty years, the cost of renting an apartment in New York City has grown at twice the rate of

[5] HNA, Key Informant Interviews (2003).
[6] HNA, Consumer Survey (2003).

inflation. Renters in New York City pay a greater portion of their income to rent than in any other place in the country. As emphasized in Mayor Bloomberg's *New Housing Marketplace,* "[a]lthough America today is plagued with problems of affordability in the housing market, New York's problems are extreme, with median gross rents substantially above national averages."[7]

New York City renters' incomes demonstrate reduced purchasing power over the last several decades. From the late 1970s to the late 1990s, real median income for all renters, adjusted for inflation, remained essentially unchanged. The average real income of the poorest fifth of households, however, declined by sixteen percent.[8]

At the same time, rents have increased substantially. Between 1987 and 1999, real median contract rent increased by 22%, after adjusting for inflation.[9]

The most obvious result of unchanged or decreased incomes combined with increasing rents has been a rise in rent burdens, or the percentage of their incomes that people must obligate to their rents. Not surprisingly, low income renters shoulder particularly onerous rent burdens. In 2002, half of all New York City renters paid 29% or more of their income in rent and 26% paid more than half their incomes in rent. Fifty-four percent of households with annual incomes of less than $25,000 have rent burdens of 50% or higher. High rent burdens are much more prevalent in low income communities: 32% of households in low income neighborhoods, for example, have rent burdens of more than 50%, which is considered a severe rent burden, in contrast to only 24% of households in high-income communities.[10,11]

Consumer survey results demonstrate the importance of rental subsidies in reducing rent burdens for persons with HIV/AIDS. The average ratio of *total* rent to income among survey respondents in independent housing was 124%, meaning that, on average, respondents' unsubsidized rents are greater than their incomes. The average ratio of *out-of-pocket* rent to income, however, was 48%, illustrating starkly that persons with HIV/AIDS who receive rental assistance would not have access

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[7] *New Housing Marketplace,* p. 4.
[8] NYC Department of Housing Preservation and Development. Housing Vacancy and Survey Report (NYC HPD HVS). 1978, 1991, 1999.
[9] NYC HPD HVS (1999): p. 336.
[10] NYC HPD HVS (2002).
[11] Citizens Housing and Planning Council. 2003. "Heavy Burdens." *The Urban Prospect.*

to the private market without this subsidy. Their average rent burden, nonetheless, rises close to the level of a severe rent burden.[12]

As discussed in Section IIC, describing HASA's rental assistance program, New York State regulations authorize an enhanced rental assistance amount to $480 for people who are HIV positive and symptomatic, and each additional family member entitles the household to an additional $330 in assistance.[13] HASA's case-by-case financial assessment process, however, provides an "above enhanced rental assistance" that is capped informally at the payment standard for Section 8 Housing Choice Voucher programs in New York City. HASA reviews each case individually to determine if higher rents can be approved.[14] As of December 2003, 66% of HASA's caseload was receiving some form of rental subsidy: 19% of HASA's clients were receiving standard rental assistance (TANF, Safety Net, or Temporary Disability Assistance), 13% were receiving enhanced rental assistance, and 34% were receiving "above enhanced rental assistance."[15] Almost two and a half as many HASA clients received the higher level of assistance, accordingly, because HASA itself recognized that these standards, set by New York State regulations, were unrealistic within the New York City housing market, but nonetheless required case-by-case justification for the more realistic rent subsidy level, placing a burden both on an overworked agency and often fragile clients.

Vacancy Rates

New York City's low vacancy rates persist at all rent levels, but are particularly extreme at lower rent levels, making it nearly impossible for low income renters to secure apartments in certain neighborhoods. The current overall vacancy rate in New York City is less than 3%; housing experts declare a housing crisis when the vacancy rate reaches 5%. In NYC, vacant apartments are renting at 164.3% the cost of the occupied apartments. Between 1996 and 1999, the number of vacant units available for rent in New York City decreased by 21%; the number of vacant and occupied rental units declined by 10,000 during this period. Most notably, the number of low rent units declined during the period 1996 to 1999, and the number of high rent units increased; the resulting vacancy rate for units with rents of less than $500 was 1.54% in 2002, and 1.42% for units with rents

[12] HNA, Consumer Survey (2003).
[13] Codes, Rules and Regulations of New York State, Title 18, Section 352.3(k).
[14] HASA letter: September 2001. (Copy on file with the Hudson Planning Group).
[15] NYC HRA HASA. *HASA Facts.* December 2003. New York, New York.

between $500 and $699. By contrast, the vacancy rate for units with rents between $1,000 and $1,749 was 4.36% in 2002, and 9.25% for units with rents of $1,750 or more.[16]

The average unsubsidized rent burden of survey respondents in independent housing is 124%, while the average subsidized rent burden for the same respondents is 48%; without a market rate subsidy, persons with HIV/AIDS who rely on public supports will not be able to continue to access private market housing.

These low vacancy rates are particularly significant for persons accessing New York City's housing system for persons with HIV/AIDS. Of the consumers surveyed through this Housing Needs Assessment, 40% reported a total monthly rent of $600 or less and 66% pay less than $800 per month. The vacancy rate for units renting for less than $500, and thus affordable to consumers receiving the enhanced rental assistance rate of $480, was 1.54% in 2002.[17,18]

Contrary to what many observers might expect, vacancy rates are lower in low income communities, reflecting a tighter housing market given renters' economic confines. Manhattan, for example, has the highest borough vacancy rate, 3.86% in 2002.[19]

Housing Conditions

Because New York City has some of the oldest housing stock in the United States, proper maintenance of that housing presents a significant challenge. Housing conditions are one indicator that has demonstrated improvement over the past several years. Many buildings have been rehabilitated, and the overall condition of New York City housing has improved in recent years so that it is now the best that it has been in decades. The Mayor's housing plan proposes to preserve housing stock in low income communities, where the need is greatest, and also recognizes the

[16] NYC HPD HVS (1999, 2002). As HPD has indicated, it is not entirely accurate to compare the results of the 2002 Housing and Vacancy Survey with results from prior years. A new sample was drawn for the 2002 HVS, using the 2000 Census and including an address list containing 370,000 additional addresses that were unknown in 1990. According to HPD, the Census Bureau is working on a reconciliation of the data sets to allow comparability between the 2002 HVS and earlier surveys. The comparisons made in this section, however, are presented solely for the purpose of identifying trends in New York City's housing stock.
[17] HNA, Consumer Survey (2003).
[18] NYC HPD HVS (2002).
[19] Ibid.

importance of addressing the risks posed by aging housing stock and the impacts of abandonment in the 1970s and 1980s in communities where nearly 28% of New Yorkers now live.[20,21]

The physical condition of New York City housing, nonetheless, remains related closely to its age and rent level. Sixty percent of the housing stock was built before 1947. Low-income neighborhoods tend to have the highest percentages of housing units built before 1930 (75% of units in Morningside Heights/Hamilton Heights in Manhattan, 71% of units in Highbridge/South Concourse in the Bronx, and 65% in Bedford-Stuyvesant in Brooklyn, for example). While overall maintenance conditions in New York City have improved, conditions of rent-controlled units, rent-stabilized units in buildings built before 1947, and public housing units remained relatively poor in 1999.[22,23,24] The New York City Council Speaker's Housing Task Force estimates that there may be as many as 100,000 illegal rental units in New York, an estimate confirmed by the Citizens Housing and Planning Council. The Mayor's housing plan insists that "preservation of the existing housing stock must be a priority, particularly given the constraints on new construction." On the other hand, because the plan is committed to development of new housing, HPD has had to shift $160 million in funding, primarily away from housing preservation, in order to cover the expenses of new construction. As the NYC Independent Budget Office has observed, while the majority of HPD's capital budget will continue to be dedicated to rehabilitation of existing housing units, "a clear shift in priorities has occurred, with a declining share of the overall capital budget going to preservation programs." HPD asserts that this shift is the result of "operational realities" rather than priority changes.[25,26,27,28]

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[20] Ibid.
[21] *The New Housing Marketplace,* pp. 5, 8, 14.
[22] *The New Housing Marketplace,* pp. 8, 14.
[23] NYC HPD HVS (1999).
[24] Furman Center for Real Estate and Urban Policy, New York University. 2003. *State of New York City's Housing and Neighborhoods 2003.* New York, New York. Table 8-1, p. 190.
[25] NYC Speaker's Housing Task Force. 2001. The Housing Crisis in New York: Recommendations to Address the Shortage of Affordable Housing in New York City.
[26] Citizens Housing and Planning Council. 2003. "New York's Underground Housing." The Urban Prospect.
[27] New York City Independent Budget Office (NYC IBO). 2003. "Priorities Shift in City's Plans for Spending on Housing." *Inside the Budget.* New York, New York.
[28] Letter from HPD to Hudson Planning Group, October 21, 2004.

Pressures on Existing Affordable Housing Stock

A number of factors are exerting pressures on the existing stock of affordable market and subsidized housing that serves as an alternative to the private market. Non-HIV-specific housing resources that have complemented or substituted for the housing assistance provided by HASA to people with HIV/AIDS are becoming scarce or nonexistent.

Rent Stabilized Housing

Rent regulation has been critical in preserving affordable rents in New York City since its adoption, in a different form from the current system, as an emergency measure during World War II. In 2002, 51% of New York City's rental housing stock was rent-stabilized, and 3% was rent-controlled. In addition to providing tenants with important tenancy rights, rent regulations limit rent increases available to owners, thus keeping many apartments within the reach of lower income households. In recent years, however, the supply of rent-regulated housing has dwindled. The number of rent controlled units has been shrinking for some time, because as a matter of definition rent control status is available only to tenants who have occupied their units since 1974 or earlier, with some exceptions. Though there are now 59,324 rent-controlled apartments with traditionally low rents, unless an eligible family retains the rent-controlled status the apartments are decontrolled as tenants vacate. The number of rent stabilized units, however, has eroded significantly in recent years, after state legislation and City Council adoption gave owners the ability to deregulate automatically apartments renting for more than $2,000. The data collected in the most recent HVS reveal that the number of units is shrinking, with a loss of at least 32,000 units between 1999 and 2002, particularly from Manhattan where rent levels are higher, and that in areas outside of Manhattan, rent stabilized rents often are no longer lower than market rents. In the 1990s, New York City lost 22% of all apartments in the City renting for $500 or less in constant 1999 dollars, after adjusting for inflation.[29,30]

Section 8 Project-Based and Other Private Subsidized Housing

The City's supply of private subsidized housing is under significant pressures. Between the 1960s and early 1980s, HUD entered into contracts with developers to create privately owned and federally

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[29] NYC HPD HVS (2002). See the caution in footnote 15 concerning comparisons between the 2002 HVS and prior years.

[30] Barbanel, J. 2003. "As Rents Rise, So Does Deregulation." *The New York Times.* November 16, 2003. Section 11: p. 1.

subsidized affordable rental housing, with HUD providing project-based subsidies to ensure affordability of the housing. More than 500 properties with 92,000 units were created through this method, most of them with twenty-year contract terms. Many of these units are occupied by households with very low incomes. To make these programs attractive to developers, federal funders allowed them to opt out of the programs at the end of their contract terms: as these terms expire, owners can choose to discontinue the subsidies that make the units affordable, or pre-pay their assisted mortgages. Rents then can be raised to market levels. As of May 2003, more than one of every ten private HUD-subsidized housing units in New York City had been removed from the subsidized stock or was in the process of being removed. A significant number of additional units are due to expire in 2004.[31]

Low Income Housing Tax Credit Housing

Since 1987, much private affordable housing has been financed using the resources of the Low Income Housing Tax Credit (LIHTC). In exchange for realizing the benefits of the tax credits, investors are required to maintain the project's rents at affordable levels for fifteen years. Beginning in 2002, therefore, LIHTC projects began to reach the end of their tax credit compliance periods, and were no longer required to maintain units as affordable. Unless the City acts to preserve these units as affordable, they also will begin to deplete the affordable housing stock at an increasingly rapid pace.[32]

New York City Housing Authority (NYCHA) Public Housing

Changes in federal housing policy have translated into reduced funding for construction and maintenance of public housing units. For the last decade, indeed, the bulk of funding for public housing development has been channeled to the HOPE VI program, which renovates existing public housing projects and often results in an overall loss of units. Levels of capital and operating funds received by the New York City Housing Authority from the federal government have dropped significantly in recent years. As a result, public housing, for which the wait in New York

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[31] Community Service Society. 2003. Keeping the Doors Open: HUD-Subsidized Housing in New York City. New York, New York. http://www.cssny.org.

[32] Collignon, K. 1999. "Expiring Affordability of Low-Income Housing Tax Credit Properties: The Next Era in Preservation." Neighborhood Reinvestment Corporation.

City is already substantial, as discussed below, is becoming a severely limited resource for low income New Yorkers.[33]

Reduced Government Investment

In addition to the loss of affordable housing units, public investment in and subsidy of affordable housing has been shrinking. This limits housing options even more. Mayor Bloomberg's *New Housing Marketplace* captures the vital role played by public subsidies: "[w]hile an overall increase in construction will help to provide units, without government subsidies a range of income levels from the poorest to the middle class will continue to seek housing and be unable to obtain it."[34]

Declining Federal Funding

In 1980, the U.S. Department of Housing and Urban Development's (HUD) budget was $50 billion, or $104 billion in today's dollars, compared to $21 billion in 2000. The passage of the federal Quality Housing and Work Responsibility Act in 1998, followed by President Bush's reduction in federal housing budgets, has meant that federal housing funds flowing into New York City have shrunk significantly. According to the New York City Independent Budget Office, the New York City Housing Authority (NYCHA) anticipated a 3.2% decline in revenue between calendar years 2002 and 2003, representing cuts to public housing operating funds and rent payments, as well as to Section 8 payments.[35]

The federal government's reduction in funding for Section 8 Housing Choice Vouchers also has had a significant impact on affordable housing in New York City. As a tenant-based resource, Section 8 is a housing subsidy that allows tenants to exercise choice over the housing and neighborhoods in which they live. A recent study demonstrated that Section 8 produces the best overall housing outcomes for low income renters in New York City.[36] HUD has not authorized more than small allocations of Section 8 vouchers over the past several years, and as a result NYCHA and HPD, like housing authorities throughout the country, have been forced to rely on voucher turnover to subsidize new households. In the 1970s, the federal government provided 200,000 new Section 8

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[33] NYC IBO. 2003. "Federal Changes May Mean Less Housing Aid for the City." Fiscal Brief. New York, New York.
[34] *The New Marketplace*, p. 6.
[35] NYC IBO. 2003. "Federal Changes May Mean Less Housing Aid for the City." Fiscal Brief. New York, New York.
[36] Van Ryzin, G. & T. Kamber. 2002. Subtenures and Housing Outcomes for Low Income Renters in New York City. *Journal of Urban Affairs* 24, pp. 197-218.

vouchers each year. In the 1990s, the number of new vouchers provided was reduced by 40%. In recent budgets, moreover, the federal budget has reduced the funds available to support full renewal of existing vouchers. In addition, a proposal has been proposed and supported by the Bush Administration to block grant Section 8 funding to states. The proposal has not been authorized by Congress, but remains a threat to the level of funding for this important housing subsidy program.[37,38,39,40]

Declining City Funding

Until the release of Mayor Bloomberg's New Housing Marketplace Plan, New York City's investment in affordable housing had been shrinking. To some extent this reduction reflected the reality of the City's budget deficit and the resulting need to cut budgets, but housing suffered from more significant reductions than other funding areas. In 1989, New York City's capital expenditure on housing was $739 million; in 2000, it was $294 million. Under the Giuliani administration, real capital investment in housing was reduced by 38% compared to the previous administration. In 2001, the City cut 18% to the four-year capital housing budget, more than cuts to other capital budgets. The City's Ten-Year Capital Strategy for fiscal years 2004 to 2013 projects decreasing capital housing funds by 27%, from $4.4 billion to $3.2 billion. Most recently, for the 2004 capital budget plan, the City has reduced its three-year capital budget from $1.3 billion to $1.2 billion. Although the capital plan anticipates that some new housing needs will be met with investment from the Housing Development Corporation (HDC) and allocations of federal Low Income Housing Tax Credits, the end result is still a funding reduction.[41,42,43,44]

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[37] Markee, P. 2002. *Housing a Growing City: New York's Bust in Boom Times.* Coalition for the Homeless. New York, New York. http://www.coalitionforthehomeless.org.
[38] NYC IBO. 2003. "Federal Changes May Mean Less Housing Aid for the City." Fiscal Brief New York, New York.
[39] Center on Budget and Policy Priorities. 2003. President's Budget Requests Insufficient Funding for Housing Vouchers in 2004. Washington, D.C. http://www.cbpp.org.
[40] Community Service Society. 2003. Section 8 Housing Vouchers: Block Grants to the State? http://www.cssny.org>.
[41] Markee, P. 2002. *Housing a Growing City: New York's Bust in Boom Times.* Coalition for the Homeless. New York, New York. http://www.coalitionforthehomeless.org.
[42] Housing First! 2003. *Affordable Housing for All New Yorkers: A Review of Mayor Bloomberg's New Housing Marketplace Plan.* New York, New York. http://www.housingfirst.net.
[43] City of New York. 2003. Ten-Year Capital Strategy: Fiscal Years 2004-2013.
[44] NYC IBO. 2003. "Priorities Shift in City's Plans for Spending on Housing." *Inside the Budget.* New York, New York.

Mayor Bloomberg's New Housing Marketplace

Mayor Bloomberg's new housing plan, released in December 2002, represents a positive step towards comprehensive and long-range planning for development to meet the affordable housing needs of New Yorkers, the first such plan since Mayor Koch's $5 billion 1985 Ten-Year Plan. The Bloomberg plan looks strategically at leveraging limited resources in order to maximize production of affordable housing through investment of more than $3 billion. The Mayor's plan allocates $100 million to create more than 2,000 units of low-income housing, as well as additional funding to develop and preserve housing for moderate and middle-income New Yorkers. The program also proposes development of several new housing programs.[45]

The *New Housing Marketplace* proposes to address the short supply of affordable housing in New York City, and thus should be commended for confronting the need for bricks-and-mortar development. It must be expanded, however, if it is to have a measurable impact on the complex and major housing needs of people with HIV/AIDS. The plan reflects more reallocation of existing funds than dedication of new funding. Funds that had been targeted to housing preservation are being reallocated to new construction. Many of the new and rehabilitated units that it proposes are targeted to moderate and middle income households: sixteen percent of units are to be affordable to middle income households, 38% to moderate income, and 46% to low income. The Housing First! coalition deems the plan "a vital down payment on the long-term commitment required" to make a meaningful dent in the City's housing need. Most notably, the plan reaches only 10% of Housing First!'s proposed ten-year funding goal of 16,000 supportive housing units. Through HPD's existing Supportive Housing Program, the plan proposes an additional 582 units to the program's baseline number of units. It is unclear, however, how many of these units are committed to persons with HIV/AIDS: a January 2004 progress report on the Mayor's Housing Plan states that funding for supportive housing was increased "in order to expand this program's reach to new populations including youth aging out of foster care and homeless families with special needs."[46,47,48]

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[45] *The New Housing Marketplace*, 2002.

[46] NYC IBO. 2003. "Mayor Bloomberg's Housing Plan: Down Payment on the Future." *Fiscal Brief.* New York, New York.

[47] Housing First! 2003. *Affordable Housing for All New Yorkers: A Review of Mayor Bloomberg's New Housing Marketplace Plan.* New York, New York. http://www.housingfirst.net.

[48] *The New Housing Marketplace: Progress Report 2003.* January 2004, p. 11. In a letter to Hudson Planning Group in October 2004, HPD stated that "the Mayor's Plan presents a commitment to develop 2021 units of supportive housing between FYs 04-08."

The *New Housing Marketplace* proposes creation of several new financing programs. The New Ventures Incentive Program (NewVIP) makes capital available for predevelopment loans for projects with potential environmental hazards primarily located in manufacturing zones that have been or are going to be rezoned for residential use. The New Housing Opportunities Program (NewHOP) provides permanent financing and additional subsidies for rental projects affordable to middle-income families. The Low-Income Affordable Marketplace Program (LAMP) provides subordinate loans that can be used in conjunction with subsidies provided by other agencies. The NewHOP Mod Program provides tax-exempt financing and subsidies for low and middle-income units in projects in which certain percentages of units are set aside for low-income and middle-income households, and remaining units are set at market rate. While these are valuable and important initiatives, none of these new programs is targeted to persons with HIV/AIDS, and few will create many new units affordable to very low- or low-income households. Key informants called for an increase in the set-aside of resources under the plan dedicated to extremely low income and disabled persons, and some called for a set-aside specifically designated for persons with HIV/AIDS.[49,50]

Liberty Bonds are another potential source of funding for housing for people with HIV/AIDS that have not been made available. The $1.6 billion in federal tax-free Liberty Bonds set aside to encourage the reconstruction of Lower Manhattan through private residential development has not been allocated to support affordable housing, but instead has been directed to market-rate development, with a limited set-aside for middle income housing. Typically, projects financed with tax-exempt bonds must set aside 20% of the units for low income households, but this requirement was waived for Liberty Bonds. HDC stated only that it would prefer projects with affordable housing components.[51]

The *New Housing Marketplace* plan is a valuable base on which to build a housing program that will make a measurable impact on housing need in New York City. The City should look to Mayor Koch's Ten-Year Plan as a model in order to expand the vision and reach of Mayor Bloomberg's

[49] HPD. New Ventures Incentive Program ("NewVIP"), New Housing Opportunities Program (NewHOP), Low-Income Affordable Marketplace Program (LAMP formerly known as 100% Lite), NewHOP Mod Program.
[50] HNA, Key Informant Interviews (2003).
[51] Community Service Society. 2003. Testimony at Hearings on Proposed Developments at 95 Maiden Lane and 90 Washington Street to Be Financed with Liberty Bonds.

plan. In the Koch plan, almost 90% of the housing units financed went to households earning below 80% of median income; in the Bloomberg plan, 81% of new units financed will go to households with incomes *above* 80% of median.[52]

Housing Demand

Demand for affordable housing in New York City continues to grow, pressured by population growth, and evidenced by housing crowding, long housing lists for public housing and Section 8 rental subsidies, and growing homelessness. Demand for housing has increased on all fronts. As New York City's population has increased, in large part as a result of immigration, existing housing stock has been insufficient to meet the need. The result has been overcrowded housing, long waits and closed waiting lists for available subsidized housing, and a steady increase in the number of homeless households in the City. All of these pressures on private market and other subsidized housing systems serve to impact the HIV/AIDS housing system as well, as people with HIV/AIDS are increasingly shut out of opportunities to access housing that is not specific to their health status.

Population Growth

New York City has experienced a surge in population and an influx of new residents over the last decade. As the population grows, competition for quality, affordable housing grows as well. New York City's population has grown by 9% in the last decade; according to the 2000 Census, the city is now home to 8,008,278 people – compared to 7,322,564 in 1990. This population growth was driven substantially by immigration: between 1980 and 1996, close to 1.7 million immigrants moved legally to New York City. In the 1980s, more than 40% of immigrants were from the Caribbean, and more than 25% were from Asia. These numbers do not include immigration by undocumented immigrants, who contribute to a more severe level of housing need, because they are not eligible for most publicly-subsidized housing programs. Population growth is projected to continue.[53]

Crowding

Today more than ever, renters are living doubled-up in apartments. New Yorkers always have experienced overcrowding, but, as Mayor Bloomberg's 2002 housing plan notes, the 1999 Housing and Vacancy Survey revealed that the crowding rate for renter households was the highest since

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[52] Pacenza, M. April 2003. Housing: The Next Generation/Housing Next. *City Limits.*
[53] *Housing a Growing City,* 2002.

1965, and reflected an increase of 9.1% since 1996. Low-income renters are unable to afford their own apartments and are forced to sleep on floors and couches of families and friends. Vacancy rates shrink steadily as the size of the apartment grows. While the vacancy rates for studio or one-bedroom apartments is 3.33%, the vacancy rates for apartments with two or more bedrooms is 2.54%, bottoming out at 1.46% for apartments with four or more bedrooms. Living in an overcrowded apartment is often the last step before becoming homeless. This situation places particular stress on individuals and families with HIV/AIDS, whose health often is precarious and who must adhere to medication regimes. The 1999 Housing and Vacancy Survey reported that there were 221,000 doubled-up households in New York City in 1999, an increase of 9% in the three years since 1996; and that these doubled-up situations contained 355,000 hidden households, many of whom may have needed their own housing units. Between 1978 and 1999, the number of "seriously crowded" apartments, housing more than 1.5 persons per room, increased by 161%. Among rental sub-tenures, rent-stabilized units have the highest level of crowding: 5.3% of units house 1.5 persons or more.[54,55,56,57]

Waiting Lists for Publicly-Subsidized Housing

Given the increase in rents in the private market and the low vacancy rate, many low income New Yorkers must turn to subsidized housing. Due to the decrease in production and the growing unmet demand for affordable housing, however, hundreds of thousands of low income residents are waiting for affordable subsidized apartments. Existing tenants are not moving out: as the New York City housing market has tightened, public housing residents' average tenure has risen in recent years, particularly among people of color and those with the lowest incomes. There are currently 146,000 people on waiting lists for public housing operated by the New York City Housing Authority (NYCHA). NYCHA's public housing program provides 181,000 units in 345 housing developments. These units represent 8.3% of the City's rental housing; when combined with more than 85,000 housing units subsidized by Section 8 rental vouchers administered by NYCHA, these residents occupy 12.2% of New York City rental units. There are currently 149,000 households on the waiting list for NYCHA's Section 8 rental vouchers. The average waiting period for a public

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[54] NYC HPD HVS (1999).
[55] *The New Housing Marketplace,* 2002.
[56] *Housing a Growing City*, 2002.
[57] Furman Center for Real Estate and Urban Policy, New York University. 2003. *State of New York City's Housing and Neighborhoods 2003.* New York, New York. Table 8-6, p. 189.

housing unit is eight years, and the waiting list for a housing voucher has been closed in NYC since 1994 (with the exception of limited program for homeless families in shelters). Because the waiting lists are so long, only a few of New York City's neediest households have access to these valuable resources. In addition, because public housing denies eligibility to many applicants with felony convictions, it is simply not an option for many households that otherwise would be eligible.[58,59]

Rising Homelessness

Homelessness is, of course, the most serious outcome of the housing crisis in New York City and demonstration of the increased demand for housing, and has a particularly severe impact on people living with HIV/AIDS. As reported by the New York City Department of Homeless Services (DHS): more than 38,000 adults and children sleep in a New York City shelter on any given night; since 1998, the New York City homeless shelter population has increased by more than 80%; an estimated 240,000 people in New York City have experienced homelessness during the past 5 years; and in the 1990s, the number of homeless families placed into permanent housing declined by 42%, from 7,000 to 4,200 families per year. According to the New York City Independent Budget Office, in 2001 the City spent $880 million in expense budget funds and $76 million in capital funds on emergency shelter, housing, and services for the homeless. In December 2003 DHS reported an average daily census of 38,400 homeless individuals, including 16,600 children, 13,300 adult family members, and 8,500 single adults. A concerted effort to address the problems in the housing market that have contributed to these rising numbers will, as the Mayor's housing plan promises, "address the homeless problem and help families with critical needs."[60,61,62]

The Housing Market in the Tri-County Region

Persons with HIV/AIDS receiving housing assistance in the Tri-County Region of the EMSA (Putnam, Rockland and Westchester counties) receive rental assistance that requires them to secure decent and affordable apartments on the private housing market. The Tri-County Region, however, is experiencing its own crisis of affordable, available housing, which serves as a barrier to utilization

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[58] Bahchieva, R. & Hosier, A. 2001. Determinants of Tenure Duration in Public Housing: The Case of New York City. *Journal of Housing Research 12:* pp. 307-348.
[59] NYCHA Fact Sheet, December 2, 2003.
[60] *Housing a Growing City.*
[61] NYC IBO. 2002. "Give 'Em Shelter: Various City Agencies Spend Over $900 Million on Homeless Services." New York, New York.
[62] New York City Department of Homeless Services. Critical Activities Report: Total DHS Services – Fiscal Year 2004.

of this rental assistance. While rental units in larger buildings are most typical of larger cities, owner-occupied single family homes predominate in smaller cities and suburbs. The division between owner-occupied and renter-occupied housing in the two components of the EMSA, accordingly, is stark. Except for Staten Island, the majority of the housing in New York City is renter-occupied; in the Tri-County region, the majority of housing units are owner-occupied. Without even considering affordability, rental units are that much less available.

As one of the larger counties, Westchester has a great deal of variation in the availability of rental housing in different areas. Overall, the county has 39.6% renter-occupied households with a vacancy rate of 2.8%, but that rate varies from 2.5% in Northern Westchester, which is 24.3% renter-occupied, to 3.4% in Yonkers, which is 56.8% renter-occupied.[63] HUD anticipates a demand for approximately 1,760 units of market-rate rental housing and 2,420 units of sales housing in the next two years in Westchester. While both the sales market and rental market in Westchester County are tight, most of the new housing units recently developed have been higher-priced sales and rental units, with approximately 90% of the new units for sale, relieving some of the stress on the sales market but none on the rental market. Only 16% of housing units constructed in Westchester in the 1990s were multi-family, and conversion of rental apartments to cooperatives has further diminished the rental market in the last decade. Westchester County sought to create 5,000 additional affordable housing units by the year 2000 but was only able to build 2,300 units by mid-2000. According to the Westchester County Youth Bureau, "the high cost of housing, low level of new rental unit construction and low number of rental units available . . . have created a housing crisis for both low and middle-income families and senior citizens on fixed incomes."[64] The county's rental housing vacancy rate has been declining significantly: in 1990, it was 3.9%; in 2000, it was 3.0%; it is currently 2.8%.[65]

This lack of available rental units has caused rents to significantly increase. Average residential rents in Westchester County in 2000 were $850 for a studio, $1,082 for a one bedroom apartment, $1,550 for a two-bedroom apartment and $1898 for a four bedroom apartment.[66] Yonkers rents are

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[63] HUD Economic and Market Analysis Division. 2002. Analysis of the Westchester County Housing Market, table 4, p. 14.
[64] Westchester County Youth Bureau. 2002. Needs Assessment, pp. 16-18.
[65] HUD Economic and Market Analysis Division. 2002. Analysis of the Westchester County Housing Market, p. 8.
[66] Westchester Department of Planning. 2001. Westchester County Databook, p. 51.

significantly lower than the county averages but still out of reach for most recipients of rent subsidies.

Rent levels for occupied housing units, based on the 2000 Census, are significantly higher in the Tri-County Region than in New York City. According to the 2000 Census, Putnam County's median rent for occupied units is $813, Rockland County's median rent is $811, and Westchester County's is $782.[67]

[67] U.S. Census Bureau. 2000. Census 2000. Summary File 3.

IV. D. BARRIERS TO HOUSING DEVELOPMENT

Given the pressures on the private housing market, stepped-up development of new units of HIV-dedicated housing is essential in order to ensure the long-term availability of affordable housing to meet the needs of New Yorkers with HIV/AIDS.

Significant barriers prevent development of adequate housing for people with HIV/AIDS, in terms of both the volume and the quality of the housing.

Factors that impede access to and use of funding can be described as both structural and practical: structural barriers are inherent in the manner in which funding is made available; practical barriers reflect pressures that are external to the funding process. Structural barriers to housing development for people with HIV/AIDS include insufficient access to funding and lack of coordination among funding streams; inadequate funding for predevelopment expenses; inadequate subsidies to support the operating costs associated with HIV/AIDS housing; and regulatory red tape. Practical barriers include site availability and securing site control, particularly for not-for-profit developers; community opposition; and organizational capacity.

Structural Barriers

Lack of Funding Coordination

Successful development requires the combination and coordination of various capital and operating funding streams; unified or coordinated interagency funding applications save time and money.

Developing a supportive housing project for people with HIV/AIDS almost always requires packaging several sources of financing, including capital, operating and support services funding. While all of these funding streams are critical to successful development, they typically must be secured through separate processes that often are not designed to achieve complementary goals. Each funding source is administered by a different agency and has its own requirements to commit funding. In addition, each funding source has its own funding cycles and priorities, and even with successful proposals the entire process can take years. Often it can be difficult to get the first funding commitment without having any other commitments in place. Too frequently, the result is that not-for-profit housing providers must cover interim expenses through their own limited financial resources. This practice strains organizational capacities and limits development

opportunities to large, well-funded organizations. In key informant interviews, many providers noted that they look to private sources, such as the Corporation for Supportive Housing, for this important first commitment. They also noted that it requires significant knowledge and expertise to put together a capital funding package.[1]

The coordination process for securing capital funding, generally awarded by the New York City Department of Housing Preservation and Development (HPD) or New York State's Homeless Housing Assistance Program (HHAP), and operating funding, generally awarded by the New York City HIV/AIDS Services Administration (HASA), is particularly unwieldy. HASA's contracting process is long and frequently difficult to navigate, and although HASA has an established list of providers to be notified when an RFP is to be issued, providers often do not know when an RFP will be issued and when subsequent funding determinations will be made. Several key informants discussed the need for more coordination among government agencies, to develop and implement a unified vision to create a range of housing resources that address consumer needs and preferences. Key informants called for specific strategies to decrease competition among City agencies for scarce resources.[2]

New York's mental health housing system has addressed the issue of funding coordination through its highly successful New York/New York (NY/NY) agreements, signed in 1990 and 1999. Under these agreements, New York City and State each contribute to development of a specified number of housing units with support services for homeless mentally ill adults. Both the City and the State fund capital development and operating subsidies, and the State Office of Mental Health funds clinical and social services provided to residents of all NY/NY units. Because funding is available and coordinated for all aspects of a project, through a single application process, the NY/NY agreement ensures through its "one stop shop" approach that development of mental health units are completely funded in a timely manner.[3,4]

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[1] HNA, Key Informant Interviews (2003).
[2] Ibid.
[3] Houghton, T. 2001. *A Description and History of the New York/New York Agreement to House Homeless Mentally Ill Individuals.* Corporation for Supportive Housing. New York, New York. http://www.csh.org/.
[4] New York City Independent Budget Office (NYC IBO). 2002. "Can Another NY/NY Deal Deliver Housing for the Mentally Ill Homeless and City Savings?" *Inside the Budget.* New York, New York.

Building on the experience and success of the NY/NY agreements, HPD, HASA, and other relevant government entities should together design and implement a unified funding application and process that will allow providers of housing for persons with HIV/AIDS to seek support from a one-stop shop. HPD and HASA should enter into a collaborative process for funding of supportive units for people with HIV/AIDS, thus addressing the barrier to housing development posed by the lack of coordination between existing funding sources. HPD and HASA should develop a process in which they assess available capital, operating and service dollars twice in each fiscal year, and then project how many housing units, with associated services and operating expenses, can be developed for people with HIV/AIDS with those dollars. The two agencies should then issue a joint RFP seeking applications from qualified developers and providers, or institute a rolling applications process, and jointly evaluate each application's strengths. Such a joint application would not use all of HPD and HASA's funding available for HIV/AIDS housing: each agency would need to reserve a certain amount of funding to support projects that need only one type of targeted funding. Over the longer term, HPD and HASA should explore coordinating application processes with HHAP as well.

In recent years, moreover, availability of federal rental subsidies has shrunk substantially. More than ever, this situation calls for strategic and targeted use of the limited subsidies that are available, to ensure that they are directed to projects that already are receiving government funding for development. Strategies are needed to promote funding partnerships and collaborations among government entities, particularly agencies that fund HIV/AIDS services and agencies that fund mental health services.

Insufficient Predevelopment Funding

Agencies developing housing can incur substantial expenses in the predevelopment phase, which can be prohibitive and hard to fund.

In order to responsibly conceptualize and assess project viability, housing providers must have access to flexible predevelopment funding that allows them to plan and structure housing for people with HIV/AIDS. However, available predevelopment funding is extremely limited and can be difficult to identify and secure.

An agency developing housing can incur substantial expenses in the predevelopment phase, which can be prohibitive, particularly for smaller agencies. During the predevelopment phase, agencies incur architect's fees, consultant fees, acquisition or option costs, environmental/engineering costs, and a range of other costs, as well as significant staff time and resources. In order to ensure organizational viability during predevelopment, housing providers must have access to flexible predevelopment funding that allows them to fund some of these costs. Such funding is not readily available (A description of available funding sources for development of housing for persons with HIV/AIDS is provided in Appendix E.).

While many public funders express concern that not enough providers are available and willing to develop housing for people with HIV/AIDS, the lack of flexible funding to cover predevelopment expenses means that providers must self-select, and only those that have the financial and organizational infrastructure necessary to meet predevelopment expenses themselves are able to take on projects.

Although limited sources for such funding do exist, most require applicants to demonstrate extensive experience and capacity. As a result, newer, less-established agencies are barred from accessing funding, although those may be the agencies that need the funding most. Flexible funding for site acquisition and other legitimate pre-development expenses should be provided to groups developing housing for persons with HIV/AIDS.

Insufficient Operating Subsidies

Operating subsidies ensure that a housing development, once completed, will remain financially viable over the long term. Without significant long-term rental subsidies committed to a project, often for the period of time for which a funding source requires housing to remain affordable, lenders are reluctant to provide financing, and the project's long-term success becomes uncertain. This situation can result not only in significant delays, if the lack of sufficient operating monies holds up construction, but also in the inability to develop housing at all, if the lack of operating funding leaves capital money unspent. Some special needs housing providers have been able to leverage long-term funding commitments to secure permanent financing for development, but few governmental agencies that support HIV/AIDS housing offer operating funding commitments for terms longer than one to four years.

Funds used currently for emergency housing and rental assistance, moreover, are provided at a "room and board" rate and cannot be capitalized. This restriction places a structural limit on the ability to attract private mortgage funds.

City procurement rules limit HIV/AIDS operating contracts to an initial term of four years, with two two-year renewals. A nine year operating contract simply is not adequate to attract private financing, such as a bond issue.

Because, as discussed above, availability of federal rental subsidies has been sharply curtailed, there is a pressing need to identify or create sources of long-term and/or sustainable operating funding streams, which could be leveraged to finance housing development. As a possible model, development of shelter facilities for families is supported through the Tier II model, which has a long-term operating subsidy that supports bond financing.

Funding Restrictions

While some of the greatest need for housing assistance among people living with HIV/AIDS is found among undocumented immigrant populations and people leaving the criminal justice system, many federal funding sources prohibit assistance to undocumented households and people convicted of certain felonies. These restrictions operate as a barrier to meeting the housing needs of these populations.

Regulatory Barriers

New York City's existing zoning resolution and its process for disposal of City-owned land serve as barriers to development of housing for people with HIV/AIDS, by restricting where and how the housing can be developed. As a recent study by the Brookings Institution notes, regulatory changes to encourage private housing production are too often overlooked as tools for development, and should be reassessed by local governments.[5]

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[5] Center on Urban and Metropolitan Policy. 2003. *Rethinking Local Affordable Housing Strategies: Lessons from 70 Years of Policy and Practice*. The Brookings Institution and The Urban Institute. p. 67-84.

New York City has the highest percentage of single-person households in the United States,[6] but existing zoning prohibits private construction or reconfiguration of existing building as single room occupancy units, and limits the number of SRO units that can be included in a residential development with units of various sizes. The existing zoning resolution, enacted in 1961, is more than forty years old and in many cases does not reflect today's development and housing climate. Many elements of the resolution have been amended, but the resolution still bans creation of new SRO/studio units by for-profit developers.[7] This section was reasonable at the time of enactment, when for-profit SROs provided unsafe, inadequate housing that destabilized neighborhoods. Since then, however, not-for-profit housing providers and government funders have worked collaboratively to develop sophisticated and successful models of multi-unit supportive housing. These housing developments have made positive contributions to the neighborhoods where they are located. This model can and should be adapted for use by for-profit developers. In addition, the zoning resolution restricts the number of efficiency housing units that can be created in multifamily buildings.

Recommended changes to the zoning resolution, allowing for-profit construction of SRO units and increasing the number of efficiency units that can be developed, have been suggested for years, by a wide range of analysts both within and outside government. They were included as part of the Department of City Planning's 1996 report on "Zoning to Facilitate Housing Production," and within Mayor Bloomberg's 2002 *New Housing Marketplace.* The Housing First! Campaign, and the Furman Center for Real Estate and Urban Policy at NYU also all have called for changes to the zoning resolution to enable more development of SRO and studio housing units. Key informants interviewed by the Assessment Team applauded the inclusion of these proposed changes in the Mayor's housing plan.[8,9,10,11,12]

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[6] In 2000, almost 32% of New York City households were comprised of one person living alone, substantially more than the nationwide figure of just under 26% of all households. New York City Department of City Planning. 2002. *NYC2000: Results from the 2000 Census: Population Growth and Race/Hispanic Composition*, p. 10.

[7] New York City Zoning Resolution, Article II, Chapter 3, Section 23-20.

[8] NYC Department of City Planning. 1996-7. *Zoning to Facilitate Housing Production.*

[9] City of New York. 2002. *The New Housing Marketplace: Creating Housing for the Next Generation*, p. 13. New York, New York

[10] Housing First! 2002. *An Action Plan for Reducing Costs and Stimulating Construction of Affordable Housing in New York City*, p. 4. http://www.housingfirst.net.

[11] NYU Center for Real Estate and Urban Policy. 1999. *Reducing the Cost of New Housing Construction in New York City*, p. iii-iv.

In addition, the Department of City Planning could consider incorporating mandatory inclusionary zoning provisions within the zoning resolution, such as that recently proposed by Brooklyn Community Board 1, which would create "Affordable Housing Zoning Districts," particularly in gentrifying neighborhoods. New developments or conversions would be required to set aside a percentage of units as affordable.[13]

The City's processes for disposing of its own land also hinder effective housing development. When a project involves acquisition of City-owned property, under the city's Uniform Land Use Review Process (ULURP) the appropriate Community Board must hold a public hearing and adopt and submit a written recommendation to the City Planning Commission, the applicant, and the Borough President. Although private property is not governed by ULURP, any project funded by the City's Department of Housing Preservation and Development, whether using City-owned or private property, requires Community Board approval, as well as support from elected officials and other community organizations.[14] Expedited review, by only the City Planning Commission and City Council, is available under the Urban Development Action Area Project (UDAAP) process, for property that is at least 80% owned by the city and of four units or less, but is not used sufficiently and often is slower than it should be as a result of the City Council's inability to act on applications in a timely manner.[15,16,17] These processes too frequently lead to community opposition, which is discussed below; they also dramatically slow down the development process and may cause housing providers to incur unnecessary costs associated with financing and other pre-development expenses.

ULURP is mandated by the City Charter, which should be amended so that HPD can be delegated to certify completeness of applications for residential projects that do not present substantial issues, rather than only the Department of City Planning, and so that community boards are entitled only to notification, rather than a full review process.

The New York State UDAAP statute should be amended via legislative action, to apply to larger projects as well, when certified by HPD and not presenting substantial issues. UDAAP also should

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[12] HNA, Key Informant Interviews (2003).
[13] Stabile, T. November 24, 2003. "In the Zone," *City Limits Weekly*.
[14] NYC HPD, Division of Special Needs Housing. 2003. Supportive Housing Program: Questions and Answers.
[15] NYC Charter. Section 197-c, subsection a.
[16] NYC Planning Commission. June 27, 1990. Uniform Land Use Review Procedure Rules.
[17] New York State Consolidated Laws. General Municipal, Article 16. Urban Development Action Area Act.

be amended to provide that when the City Council fails to make decisions on projects within sixty days of their submission, the submissions are deemed approved.[18]

Mayor Bloomberg's *New Housing Marketplace* proposes that disposition of City-owned property be centralized under Deputy Mayor Daniel Doctoroff. This plan is a welcome recognition that centralization will be more efficient and productive.[19]

Practical Barriers

Site Availability and Control

The most significant barrier to the development of new units of affordable and supportive housing for persons with HIV/AIDS is the inability of non-profits to locate and secure appropriate sites.

Securing legal control of a particular property through a purchase, lease agreement, or purchase option can be the most challenging aspect of developing housing. Historically, not-for-profit New York City housing developers had access to an extensive inventory of tax foreclosed City-owned properties that could be acquired at nominal cost. Through license agreements with the City, furthermore, they were able to maintain site control throughout the lengthy pre-development process with only minimal carrying costs. Because of the burden of maintaining and then disposing of a huge inventory of housing, the City abandoned the policy of acquiring tax delinquent properties while it continued to pursue policies and programs to dispose of its inventory, more frequently through the private sector. As a result, very few City-owned properties remain.[20,21,22] Additionally, the communities in which these remaining properties are located are understandably eager to see alternative kinds of development, particularly homeownership and other moderate income housing.

As available City-owned sites have dwindled in number, not-for-profit developers have been forced to compete for sites in the overheated private real estate market, which requires significant up-front capital. As discussed above, acquisition funds are difficult to obtain and few not-for-profits have

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[18] NYU Center for Real Estate and Urban Policy. 1999. *Reducing the Cost of New Housing Construction in New York City,* Chapter 8: Land Use Review Processes.
[19] *The New Housing Marketplace,* p. 12.
[20] Chen, D. 2003. "One Housing Woe Gives Way to Another." *New York Times.* December 21, 2003: p. B1.
[21] HPD projects that by the end of FY 2004, the City's inventory of *in rem* housing will be reduced to 3,868 units, down from 95,414 units in 1986. NYC HPD. 2003. *The New Housing Marketplace: Progress Report 2003,* p. 19.
[22] *The New Housing Marketplace*, p. 20.

enough capital to fund a project themselves. In most cases, site control is a threshold requirement in order to apply for additional project funding. This requires up-front cash, a significant barrier to non-profits, the ability to act quickly to secure a site, and access to funds to carry the site during the lengthy pre-development period, which can last as long as two to three years.

The City should explore creation of a land trust or other mechanism that could secure privately held sites for a defined period of time, while appropriate providers sought the necessary financing. Such a concept also could be used to prevent private developers from speculating with sites: they could be required to begin development in three years, or else the City's land trust would realize an option to acquire the site. This recommendation would require capitalization of a fund to support such purchases. This strategy has been explored in other cities, including Oakland, California, and Burlington, Vermont. In conjunction, the City should consider exercising its condemnation authority under Urban Renewal Law to acquire blighted vacant properties to be used for affordable housing development. Because the City no longer initiates tax foreclosure proceedings on properties with tax delinquencies, these properties too often remain in limbo for years.

Not-for-profits must have flexible funding and boards of directors willing to take risks in order to move quickly to secure sites. Many housing providers have reported that when they are seeking privately-owned sites, they too frequently are out-bid and out-maneuvered by private developers; when seeking City-owned sites, as discussed above, the City's required Uniform Land Use Review Process is complicated and slow.[23] As a result, not-for-profit developers have no option but to seek sites that are undesirable to private developers. Often they have difficulty even finding out about availability of these sites: while sites in boroughs outside of Manhattan are more affordable, and are located in neighborhood with high unmet need for HIV/AIDS housing, there is no centralized listing system for available sites in the outer boroughs. A secure website could serve as such a centralized listing, and could be made available only to developers and providers screened and approved by the City, who would then be required to use the sites for development of housing for people with HIV/AIDS, or to meet other critical housing needs. The City should partner with one or more private real estate brokers to support such a website. This strategy would help to address the problem of information flow, in which many non-profit providers simply do not hear about available sites until it is too late.

[23] HNA, Key Informant Interviews (2003).

The City should establish a revolving loan fund to be used for site acquisition and other legitimate pre-development expenses associated with housing for people with HIV/AIDS. The fund should be housed at HPD, and could be capitalized through a bond issue and/or investments from banks, in exchange for Community Reinvestment Act (CRA) credit, or other private resources, including foundations and intermediaries such as the Local Initiatives Support Corporation (LISC) and the Enterprise Foundation. Loans could be approved within thirty days, and could be used to allow non-profits to secure sites for a limited period of time, from one to three years, while they seek permanent funding from other sources. Loan applications would be evaluated by HPD staff in the context of the likelihood of the project succeeding. Principal and interest payments would be deferred until the time period expires or construction begins, whichever is earlier, and would be forgiven if the project ultimately did not move forward. This strategy of establishing a loan fund for acquisition has been adopted by other municipalities with similarly overheated real estate markets. In its New Ventures Incentive Program (NewVIP), proposed by Mayor Bloomberg as part of the *New Housing Marketplace* initiative, facilitating development of projects in manufacturing zones that are being rezoned for residential use, HPD has incorporated a mechanism for pre-development funding that could serve as a model for this mechanism. These NewVIP loans would use funds made available by financial institutions and the City.

Community Opposition

Developers of housing for people with HIV/AIDS using sites owned by the City face opposition from communities that argue that they are "saturated" with such facilities, as well as those that prefer market-rate projects. The first congregate AIDS housing facility in New York City, Bailey House, encountered community opposition, as have many subsequent projects. This opposition is a significant barrier to housing development: if community members oppose a project, elected officials and City and State agencies will be reluctant to support it, and public funding will be nearly impossible to secure. Housing providers identify community opposition as the most formidable barrier to development of new units, especially in certain communities that oppose any type of special needs programs. Non-profit developers of special needs housing and treatment/services facilities have been addressing community opposition for many years. The qualitative aspects of community opposition have changed, however, further complicating the development process:

communities that had been supportive of special needs housing now perceive themselves to be "saturated" with this type of development; and other communities that are now beginning to see strong revitalization trends fear that the presence of special needs projects will drive away market-based projects.

Since Community Board approval is required only for the sale of City-owned property under the City's ULURP process, the purchase of private property for HIV/AIDS housing mitigates somewhat these trends in community opposition. Any project funded by the City's Department of Housing Preservation and Development, however, requires Community Board approval, as well as support from elected officials and other community organizations.[24] At best, the land use review process delays construction of critically needed housing; at worst, the developer is forced to withdraw the project altogether. The State's Homeless Housing and Assistance Corporation does not require community approval, and there have been many instances when HHAP has continued to fund projects despite lack of community support. Applicants to HHAP are nonetheless required to demonstrate community notification, and this requirement alone has stopped some development projects, by prompting early opposition to projects that then proved hard to overcome. Key informants interviewed by the Assessment Team suggested the creation of economic incentives designed to address "fair share" inequities among neighborhoods and boroughs in accepting the development of housing for persons with HIV/AIDS.[25]

The requirement of community board approval should be changed, so that developers using City property or funding need only notify community boards of their intention to develop housing. The City's review and approval process also should be streamlined for most projects. ULURP is mandated by the City Charter, which should be amended so that HPD can be delegated to certify completeness of applications for residential projects that do not present substantial issues, and so that community boards are entitled only to notification, rather than a full review process. HPD should change its policies to require that developers of housing for people with HIV/AIDS merely notify the appropriate Community Board, rather than secure approval. HPD's process would then be parallel to what the State requires for HHAP applicants.

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[24] NYC HPD, Division of Special Needs Housing. 2003. Supportive Housing Program: Questions and Answers.
[25] HNA, Key Informant Interviews (2003).

Organizational Capacity

Development of HIV/AIDS housing units is a complicated, expensive and time-consuming endeavor that even established providers of HIV/AIDS services may not have the organizational capacity to undertake.

The complex nature of the various funding streams for development of housing for people with HIV/AIDS requires that applicants for funding be sophisticated, entrepreneurial, aware of all funding opportunities, and able to use funding sources within appropriate time frames. A capital project also places significant strain on a not-for-profit agency's resources, including people, time, and money. Even some larger, established providers of HIV/AIDS housing and services reported that they do not have the internal staff and financial capacity to undertake development of new units. The perception of some government funders, moreover, is that few non-profit agencies are willing and able to undertake the development of HIV/AIDS-specific units:[26] HIV/AIDS service providers often do not have the capacity to take on a long and difficult development project, while housing development organizations prefer to develop other types of units that are easier to operate and may be more palatable to communities.

One way that providers increase their capacity is by collaborating in development and operation of supportive housing programs for people with HIV/AIDS. This strategy results in both successes and challenges. Support service providers, for example, whose job is to assist residents to retain housing, have found themselves at odds with housing operators, whose job is to ensure building safety and security and timely payment of rent.

Other providers have sought guidance from technical assistance providers, who can guide an organization through the process of developing housing. Key informants stressed a particular need for practical, hands-on, grant-funded technical assistance, which can be accessed by organizations with few resources.[27]

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[26] Ibid.
[27] Ibid.

IV. E. INEFFICIENT USE OF EXISTING HOUSING RESOURCES

Lack of a uniform assessment and a centralized placement system results in inefficient use of the existing supportive housing system, marked by inappropriate referrals and placements and both "under-serviced" and "over-serviced" consumers.

The effectiveness of existing housing resources for people with HIV/AIDS in the New York City EMSA is impeded by systemic barriers that are costly to government and harmful to consumers. A number of structural inefficiencies have become incorporated into the system over time, both formally and informally, that leave some consumers either under- or over-serviced in existing housing. This section includes a discussion of inefficiencies in the existing referral and placement system, and changes needed in the continuum of housing resources to accommodate consumers' changing service needs with a more flexible and supportive approach. Other systemic barriers discourage or prevent some persons with HIV/AIDS from moving to more independent housing or even returning to work. Those are discussed in Section IVF below.

Inefficiencies in the Housing Referral and Placement System

Key informant interviews and focus groups revealed serious inefficiencies in the housing referral and placement system that make it difficult to target vacancies in the existing supportive housing system to consumers with the greatest service needs, or impede the use of the rental assistance program in the private rental market. A Referral and Placement Working Group composed of members of the Housing Needs Assessment's Advisory Group met several times to consider existing obstacles to effective independent, supportive and emergency housing referral and placement.[1] The group, which included representatives of the City's HIV/AIDS Services Administration (HASA) and other government agencies, housing and service providers, and consumers of HIV/AIDS housing services, worked closely with the Assessment Team to develop detailed principles and recommendations for improving existing systems. The findings and strategies developed by the Referral and Placement Working Group are summarized in this section and reflected in the

[1] HASA key informants reported during the course of the study that adjustments were being made in the referral and placement system to address concerns of consumers and providers. For example, the system is being changed to offer greater movement among supportive housing programs within the housing continuum; to improve communication and technology within HASA; to conduct staff trainings; and to update the HASA housing desk guide.

Recommendations set out in Section V below. Appendix B to this report sets out in greater detail the Guiding Principles, Strategies and Implementation Timeline developed by the Working Group.[2]

There is currently no assessment conducted of HASA clients' housing and service needs, and housing placements are based not on assessed need but are rather largely "the luck of the draw" or the result of "squeaky wheel" advocacy by persistent consumers and their community-based providers.

No Assessment of Consumer Needs to Guide Placement

More than 90% of the HIV-specific supportive housing programs surveyed as part of this study take referrals solely or primarily from HASA. Contractual requirements tied to operating funding require most New York City supportive housing programs to take referrals exclusively from HASA. Moreover, most persons with HIV/AIDS in New York City with housing needs apply directly to HASA for a rent subsidy or direct housing assistance; even those who seek housing with a particular provider must make the application through their HASA case managers.

Yet, despite its central role in HIV/AIDS housing placement, HASA currently conducts no formal assessment of housing applicants' housing and service needs and preferences. Key informant government representatives, housing providers and consumers all identified the lack of a uniform assessment tool and process to determine housing and service needs for people entering the HIV/AIDS housing system as the most significant barrier to effective use of existing resources and appropriate housing placements. Housing providers described HASA's assessment of referred consumers as "scanty" and often lacking in information regarding consumers' housing histories, substance use and mental health issues. While most housing providers themselves conduct some assessment of consumers referred for placement, many lack the professional staff and tools necessary to properly assess mental health and substance use needs, and all have a very limited time (typically ten days from referral) to decide whether the supports they offer are appropriate and necessary for a particular consumer. Moreover, different housing providers employ different standards and eligibility requirements. Without an assessment, both HASA and the providers lack the information necessary to match applicants to appropriate programs. The most serious outcome

[2] A detailed review of existing referral and placement processes were the subject of a prior needs assessment deliverable and informed the findings and recommendations of the Referral and Placement Working Group. This section summarizes inefficiencies in the existing systems with a view to recommended strategies for improvement.

of this lack of information is that consumers end up under- or over-serviced in their housing placements, resulting in wasted resources and/or, more seriously, continued housing instability.

Both HASA and housing provider key informants called for the use of a standardized, client-centered assessment tool to be employed system-wide for all publicly funded supportive housing resources for persons with HIV/AIDS in the EMSA. Such a tool would be administered by appropriate professional staff and would be used to determine whether an applicant met objective thresholds or criteria for housing with varying levels of service intensity. It was suggested that trained professionals provide consumers with multiple points of entry into the system, with assessments conducted in a variety of settings including: HASA; the NYC Department of Homeless Services; community-based case management programs; hospitals; and nursing homes.

No Means of Matching Consumers with Appropriate Supportive Housing Vacancies

There is no system-wide triage process for targeting allocating limited supportive housing resources to persons with the greatest support service needs.

The system for referring housing applicants to vacancies in the existing supportive housing system was described by government, providers and consumers as largely "arbitrary," since there is no system-wide process for assessing housing and service needs and for using that assessment to "triage" applicants for new vacancies. Providers of HIV/AIDS supportive housing report that inefficiencies in the placement system can make it difficult to fill vacant units in a timely manner, and both providers and consumers report inappropriate referrals and under- and over-serviced consumers in the existing supportive system. More seriously, many of the most vulnerable consumers end up at risk of housing loss in an unsupported independent living arrangement, or worse, relegated to a series of placements in substandard commercial SROs with no services.

The existing supportive housing placement process is initiated by completion of a HASA housing application. One issue is that some consumers do not immediately complete housing applications upon intake into the HASA system, particularly those living in SROs. Key informants called for improved HASA systems to ensure that housing applications are completed and followed up on, and to prioritize housing applications according to consumers' length of time in the system or the status of their illness. Housing providers have criticized the housing application that HASA uses as

too shallow, with no ability to capture the information needed by the provider, and completed applications were described as often incomplete, inaccurate, illegible, and out-of-date.[3]

Moreover, the lack of an appropriate assessment of housing and service means that housing providers receive inappropriate referrals of consumers whose service needs are not matched with the housing and services the provider offers. Too frequently, consumers then fail in the placement and recycle through the system. Like most of the inefficiencies in the referral and placement system, inappropriate referrals tax all of the stakeholders: the consumer suffers from the failed placement and often has no option but to return to an inappropriate SRO; the provider must find another consumer to fill the unit; and HASA has to expend resources to re-house the consumer repeatedly.

Even referrals that are only somewhat inappropriate are inefficient. Consumers report that they have little information about available supportive options, and so desperately need housing that they can not or do not exercise choice based on the nature or requirements of particular programs. When there is not a good match between a consumer and a housing placement, the result is inefficiencies across the system: the consumer may not participate in the services offered by the program and the program staff wastes time trying to engage consumers who do not want services.

Providers have trouble receiving referrals consistently from HASA, and have reported particular difficulty receiving family placements from HASA. Many housing providers with established relationships with HASA personnel report that they prefer to employ a "squeaky wheel" approach to referrals. These programs identify a specific applicant for each available vacancy, then attempt to move that consumer through the HASA system as a targeted referral. Yet, even providers who use this approach report that it is not always successful, and express frustration with the difficulty and length of time involved in moving a specific consumer through the HASA referral process.[4]

Some key informants noted this practice of self-referral also poses the danger of "creaming" of housing applicants by providers; this practice remains a problem, acknowledged by both providers and government administrators. Housing program managers face unavoidable pressure to select those applicants with the least service needs and the greatest likelihood of success. Pressure is greatest in programs where consumers are required to manage their own leases.

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[3] HNA, Key Informant Interviews (2003).
[4] Ibid.

Although HASA does not permit consumers' substance use issues and history to be used as criteria for admission to housing programs, key informants report that some providers screen consumers and refuse to house persons with serious past or present substance use issues. HASA key informants report that they know this occurs, but do not have a process for monitoring this issue and thus do not penalize providers for refusing to house active drug users.[5]

The Referral and Placement Working Group recommended the use of a centralized database to track all HIV/AIDS supportive housing vacancies, and to match each eligible applicant to vacant units with the appropriate levels of supports. The details of this recommendation are set out in Appendix B. The centralized system would include a database to track vacancies and applications, uniform triage methodology criteria to match applicants with appropriate units, and measures to require use of the system for all HIV-specific supportive housing programs.

Centralized referral and placement systems – such as the successful Single Point of Access (SPOA) program for New Yorkers with mental illness – have been demonstrated to be effective means for making appropriate housing and service referrals and allocating limited supportive housing resources.

Such a system would not be unprecedented. As described in Appendix B, the New York State Office of Mental Health (OMH) and the New York City Department of Health and Mental Hygiene (DOHMH) have developed a joint statewide demonstration project, the Single Point of Access (SPOA) Housing Pilot, which serves as a central element of the New York State OMH Best Practices Initiative. The SPOA Housing Pilot focuses on housing services for eligible adults with severe and persistent mental illness in New York City. The main goals of the initiative are to improve the coordination of housing placement, and assure access to, and use of, appropriate services. OMH created the SPOA initiative to reduce the time from referral to receipt of services, ensure the appropriateness of the match between individuals' needs and the level of services they receive, and increase community tenure and integration. The programs implementing the initiative

[5] Ibid.

in New York State are charged with becoming accountable for assessment and successful referral to services that adhere to best practice guidelines.[6]

Not-for-profit organizations in Portland, Oregon, and Alameda County, California, moreover, have created searchable housing databases that improve consumers' access to both private market housing units and supportive housing programs. Housing Connections, in Portland, developed a web-based system containing regional information on affordable and special needs units. Property managers and landlords can list their available units in the system, including information on rental units that accept Section 8 or other rental subsidies, as well as information about neighborhoods and services. Consumers and providers can search the system for units based on a number of criteria. Consumers complete housing applications on-line on their own or with a service provider's assistance. Eden I&R, in Alameda County, provides information about 43,000 available, affordable housing units through an on-line database. Consumers and providers access the housing information via a paper subscription, on-line, or by phone, and can search by rent, city, building type, number of bedrooms, and subsidies accepted. Information is available on neighborhood amenities such as public transportation and other services.

[6] The success of a centralized placement system for mental health housing is discussed in: Houghton, T. 2001. *A Description and History of the New York/New York Agreement to House Homeless Mentally Ill Individual.* Corporation for Supportive Housing, pp. 41-43.

Systemic Bottlenecks That Impede Access to Private Market Rentals

Key informants suggested a number of ways to streamline the current rental assistance application process, in which lack of information, communication difficulties and multiple steps provide many opportunities for failure by consumers and for landlords to withdraw available apartments.[7] HOPWA- and Ryan White-funded housing placement providers report that there can be significant delays in establishing individual eligibility for the rental assistance, in getting apartments inspected, and in the approval of necessary case-by-case financial assessments authorizing rents in excess of regulatory amounts. HASA reviews each case individually to determine if higher rents can be approved. They also describe barriers to necessary communication with HASA staff, including lack of voicemail for case managers and the inability of some HASA staff to receive faxes.[8]

Housing placement providers report that it is very difficult to locate appropriate apartments that landlords are willing to rent to persons who often have no little or no rental history, bad credit, and must rely on public rent supports. They stressed the importance of ensuring that rental assistance applications are handled efficiently and rent payments issued in a timely manner. Landlords confirmed that when HASA approval of a rental assistance application is delayed, the lease is withdrawn and the apartment rented to someone else. They also cited delays or interruption of ongoing rental payments as a common problem. Housing placement providers pointed out that in addition to the loss of individual apartments, repeated problems damage relationships with landlords.[9]

Housing placement providers suggested that in order to move along the rental assistance application, HASA pre-certify individual financial eligibility for the benefit. Providers also suggested that where possible HASA pre-certify landlords, brokers and properties, so that consumers do not need to wait for this process to occur each time an application is made. Such a process would not mean that private market apartments would be "held" for HASA clients, but simply that the approval process

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[7] A detailed discussion of problems encountered by consumers seeking access to the enhanced rental assistance for persons with HIV/AIDS in New York City were the subject of a report from the City Comptroller issued during the course of this study. City of New York, Office of the Comptroller. (June 30, 2003). Audit Report on the Processing of Clients' Permanent Housing Applications by the HIV/AIDS Services Administration of the Human Resources Administration.

[8] HNA, Key Informant Interviews (2003).

[9] Ibid.

would be streamlined for buildings and brokers with which HASA works regularly. There is precedent for such a streamlined process in programs operated by the Department of Homeless Services and the Department of Housing Preservation and Development. To expedite apartment inspections, providers suggested designating HASA apartment inspection staff, and that community based providers be trained and authorized to inspect apartments with HASA oversight. Providers also suggested a centralized HASA system for monitoring consumers' application status, so that it is not necessary in every instance to contact the HASA case manager for information.[10]

The Referral and Placement Working Group made a number of concrete suggestions for streamlining the rental assistance application process and supporting consumers' success in independent housing, set out in detail in Appendix B. In addition to the suggestions noted above, recommendations include improved communication of rent guidelines and application processes to consumers and widespread availability of financial management assistance for consumers, including the option of direct deposit of SSI or SSDI income with an automatic draw to pay rent.

Emergency Housing Placements That Are Destabilizing and Often Long-Term

Providers, consumers and HASA representatives expressed concern not only about the continued necessity to use commercial single room occupancy housing to meet emergency housing needs, but also about the length of many consumers' stays in the emergency system and the instability and chaos experienced by consumers in those placements. As described more fully in Section IIIC above, results of the consumer survey conducted as part of this study show that residents of single-room-occupancy (SRO) housing experience the highest level of housing instability (3 times that of persons in independent housing), report high rates of mental health and substance use issues, and have the lowest rate of connection to a primary health care provider (10% need but do not receive primary health care) and participation in HAART (71% compared to 82% among persons in independent housing).

Consumers in emergency SRO housing expressed frustration that some placements are still limited to twenty-eight days in order to prevent the accrual of tenants' rights.[11] When an emergency housing placement is limited, consumers are required to again become "literally" homeless, gathering

[10] Ibid.
[11] HASA reports that as of April 2004, the 28-day stay policy for placements in commercial SROs is no longer in effect.

their belongings and returning physically to HASA to receive a new placement. Health care and support service providers noted that such movement is extremely destabilizing, often resulting in consumers becoming lost to follow up. HASA representatives indicated the intention to eliminate such time-limited placements. Providers and consumers suggested that consumers be permitted to stay until a permanent placement could be made. If this was not possible, the suggestion was made that consumers be permitted to arrange their next stay before the end of a current placement, and receive assistance with the transfer of belongings.[12]

More importantly, all key informants stressed the importance of intensive housing placement support for consumers placed in emergency housing. Although SRO placements are "emergency" in nature, some consumers reported being in that system for months or even years. The high rate of housing instability among consumer survey respondents would indicate that some persons with HIV/AIDS are "cycling" through the system, with repeated short-term stays. Some consumers and providers reported the need for more targeted housing placement assistance for persons in emergency placements. Recommendations by the Referral and Placement Working Group, set out in more detail in Appendix B, include mandating that HASA provide clear written information on permanent housing options, assist consumers to complete housing applications at the time of each emergency placement, and schedule appointments for housing assessments within the first week of each emergency stay.[13]

Poor Discharge Planning That Results in Precarious Housing or Homelessness

> **Poor discharge planning for persons with HIV/AIDS leaving institutional settings (hospitals, nursing homes, prisons and City jails) leaves vulnerable New Yorkers in precarious housing situations or homeless, and in some cases prevents consumers from leaving prison or expensive medical settings.**

As described in Section IVB above, both the growing number of persons with HIV/AIDS leaving jails and prison and the demonstrated relationship between incarceration and homelessness underscore the need for timely and careful discharge planning for New Yorkers with HIV/AIDS

[12] HNA, Key Informant Interviews (2003).
[13] HASA reports that as of the spring of 2004 it has begun to engage commercial SROs in new memoranda of understanding that require linkage agreements with supportive service providers, and that it expects to complete this process by the end of calendar year 2004.

being released from incarceration. An overriding concern is that the lack of vacancies in the supportive housing system means that persons with special needs being released from institutions cannot secure appropriate placements. However, improved discharge planning makes it possible to target existing supportive housing vacancies, to assist persons to secure private market housing, and to arrange community-based services to support persons living independently. Key informants called for increased resources for prison in-reach by community-based organizations that provide housing and supports, as well as improved institutional discharge planning, including proper documentation and communication of consumers' medical and support service histories. Low-threshold, easily accessible services are needed to meet the immediate needs of persons with HIV/AIDS leaving City jails, and to connect them to ongoing housing, health care and other supports.[14]

Key informants also cited the need for improved discharge planning by hospitals and nursing homes. HASA representatives described what they call "hospital drive-bys," where persons with HIV/AIDS are literally dropped off by hospitals in front of the HASA emergency housing office without a housing placement or discharge plan. Consumer focus group participants currently living in nursing homes described being "stuck" in these settings despite improved health due to their inability to find housing. Many of these nursing home residents described being newly in recovery and in need of housing in neighborhoods and/or with supports that would support sobriety and good health. Consumers expressed frustration over lack of information about available permanent housing options, and a lack of cash assistance and other resources needed to search for private market housing.[15]

Key informants reported that there is a growing cottage industry of outer-borough boarding homes housing persons with HIV being released from upstate prisons. Key informants described a group of at least 25 boarding houses that are housing formerly incarcerated persons living with HIV/AIDS; they receive referrals primarily from non-profit providers of discharge planning, although HASA knowingly pays for its clients housed in these facilities. Most report that their sole source of operating funding is the $480 in enhanced rental assistance received by residents. Some key informants expressed concern that the boarding houses are in substandard physical condition

[14] HNA, Key Informant Interviews (2003).
[15] Ibid.

and do not provide the support services that consumers require. However, others noted that the boarding houses fill an unmet need and that without the housing they offer many persons would be unable to leave prison. Operators of boarding houses cited the need for technical assistance and enhanced funding to bring buildings up to code and to make support services available to residents.[16]

Barriers to Movement within the Housing Continuum

Consumers are experiencing growing fluctuation in their physical and psychosocial health status related to aging, prolonged HIV treatments, and co-occurring substance use and mental health issues.

Disincentives and inefficiencies prevent the use of New York City's housing system for people with HIV/AIDS as a true continuum of care: housing providers and consumers encounter significant barriers when attempting to adjust housing and services as consumers' circumstances change. Current HASA policies prohibit most movement of consumers from one supportive housing program to another, allowing consumers to move within the system in one direction only – to a placement in what is considered a more "independent" model of housing.

HIV illness is increasingly complicated by the long term effects of HIV treatments, substance use and other co-occurring medical conditions, such as renal failure and diabetes. These conditions often result in fluctuating states of consumer "independence," underscoring the need not only for "client centered" supports layered on existing housing, but also for increased ease of movement between levels of service.

Changing service needs can threaten housing stability and connection to care, since discrete housing programs can only respond within the limits of existing funding and a shift to a higher service intensity often requires that a consumer leave one housing situation for another.

The "continuum" remains a largely linear one, with the articulated goal of moving consumers towards ever-greater degrees of financial and social independence. Such expectations not only

[16] Ibid.

encourage "creaming" by housing providers understandably concerned with the perceived success of programs, but also set up some consumers for failure. Key informants expressed a need to reexamine the uniform assumption of continuous movement from the use of supports to greater independence in housing situation. Because consumers' needs are not linear, by making housing permanent, layering services, and moving to a model of consumer-driven planning, a change in service needs would not require a change in housing situation.

IV. F. BARRIERS TO CONSUMER INDEPENDENCE

Systemic disincentives discourage or prevent some New Yorkers with HIV/AIDS from moving to more independent housing or even returning to work.

Efficient use of existing housing resources for people with HIV/AIDS in the New York City EMSA also is impeded by structural barriers to greater consumer independence that operate to threaten the housing stability of some consumers who want to return to work, and discourage other consumers from moving out of supportive housing programs to live on their own with the use of rent supports.

Improved health status among New Yorkers living with HIV/AIDS has created the need for a housing "bridge" to work.

Treatment advances have dramatically improved health outcomes for many persons with HIV/AIDS, stimulating increasing demand for systems and services that will allow individuals to re-enter the workforce or secure employment for the first time. This situation presents complications with all benefit programs that base eligibility on continuing disability and extreme poverty.

Results of the consumer survey conducted as part of this study demonstrate that concern over the loss of housing supports operates as a disincentive to consumers who are able and willing to work. Only 8% of consumer survey respondents reported receipt of a paycheck from work. While a third of survey respondents (33%) reported that they would like to return to work within the next six months, the same percentage (33%) reported that they were reluctant to work more because they might lose their housing.

Income support programs such as SSI/SSDI have programs in place to "bridge" the gap between disability and employment through a "disregard" of earned income during a trial return-to-work period.[1] In 2000, the New York City Human Resources Administration's HIV/AIDS Services Administration (HASA) initiated its Work Opportunity Program, which is a voluntary program that offers a variety of incentives for persons with HIV/AIDS who would like to participate in

[1] Proposed revisions to the regulations governing the HUD HOPWA program include an income disregard for twelve months for program participants, to allow disabled persons residing in HUD funded housing to return to work. For information see www.hud.gov/offices/cpd/aidshousing.

vocational rehabilitation activities and prepare for entry into the work force.[2] There is a modest disregard as part of the program, and on a case-by-case basis HASA may apply more generous disregards which may allow public assistance recipients to keep part of their benefits. However, there is not a clear disregard of income to ensure the continuance of the primary rent subsidy program for New Yorkers with HIV/AIDS – the State and City-funded enhanced rental assistance program. Without a disregard, each dollar of income earned while receiving this independent living benefit directly reduces the subsidy. Key informants noted that, ironically, the only HIV/AIDS housing programs in New York City that do allow participants to return to work are certain *supportive* housing programs where residents pay 30% of any income earned as rent. Thus, of the 28,000 persons currently receiving housing supports in New York City, only the 5,000 in permanent supportive housing programs may work full or part time (with earnings of up to $34,000 annually) without jeopardizing their housing.[3] Both consumers and providers stated that the potential loss of housing supports functioned as a serious barrier to persons with HIV/AIDS interested in returning to work, and suggested the enhancement of the existing HASA Work Opportunity Program to establish a housing bridge to continue a consumer's housing subsidy, in whole or part, during a period of transition to work.[4]

Rent burden in independent housing threatens stability and discourages movement to more independent housing.

Systemic disincentives affecting both consumers and providers may prevent some consumers of HIV/AIDS housing resources from moving to more independent housing. Housing providers acknowledge that they have little incentive to encourage clients ready for independent living to move out of supportive housing programs, particularly because providers perceive these clients to be stabilizing and low-maintenance to the housing community, and to require limited support services. When consumers in supportive housing do not have exit opportunities, the system becomes backed up, and new consumers face additional barriers to entry. The process is further slowed by delays in the process for approving rental subsidies.

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[2] NYC HRA HASA Work Opportunity Program (HASA brochure). See also: www.gmhc.org/policy/benefits/work.html.
[3] HNA, Key Informant Interviews (2003).
[4] Ibid.

However, the most serious disincentive to more independent living for residents of supportive housing programs who receive income, typically SSI or SSDI disability benefits, is the large rent disparity between persons receiving rent supports and those in supportive programs.[5] HUD considers paying more than 30% of income towards housing costs to be a hardship and NYC EMSA supportive scatter site and congregate housing programs follow that guideline and charge program residents with income from work or disability benefits rent equal to 30% of income received. For HASA clients who live in independent housing, the picture is very different. Because of the structure of subsidies and personal allowances, clients receiving rental assistance to live independently are required to put any monies received towards their rent, leaving a personal allowance of only $330 for food and other personal needs. As the budgets set out below reflect, this means that persons with income who use the rental assistance program to live independently in the private rental market pay 48% or more of income towards rent.[6]

The results of the consumer survey conducted as part of this study confirm that rent burden varies considerably for New Yorkers with HIV/AIDS, depending upon the type of housing assistance received. As set out in Section III above, survey respondents in supportive scatter site and congregate programs report average rent burdens of 34% and 35%, while residents of independent housing report an average rent burden of 49%. These findings are consistent with the three examples set out below of monthly Public Assistance (PA) budgets for individuals receiving rental assistance administered by HASA or by a local social service district. (Family allowances are higher.)[7]

The following examples are for single adults and assume receipt of a monthly SSI benefit of $639 and eligibility for the nutritional and transportation allowances provided through HASA, which raise the amount of monthly cash assistance for food and other needs from $137 (received by persons on regular public assistance) to $330 per month.

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[5] Of course this issue affects only those HASA clients who receive Supplemental Security Income (SSI) or Social Security Disability (SSDI). As of December 2003, HASA reported that 5,200 clients received SSI (17% of HASA's caseload) and 2,600 clients receive SSDI (8% of HASA's caseload). HASA Facts December 2003.

[6] Since persons on SSDI receive more disability income than persons on SSI, allowing them to retain only $330 in income would mean that they would pay an even higher portion of income towards rent.

[7] Additional examples of budgets for persons with HIV/AIDS with varying benefits and housing supports are set out in Appendix D. Thanks to the Gay Men's Health Crisis web site, www.gmhc.org, for these examples.

Example 1: Recipient of Enhanced Rental Assistance

Maximum food and other allowance (higher than PA pays to non-HASA clients)	$330
Maximum rent allowance	$480*
Total monthly allowance	$810
Less standard SSI benefit	($639)
Amount of rent assistance received	$171
Total assistance available for needs other than housing	$330

*If the rent is higher than $480, this person could request that the HASA caseworker ask for a special approval (an "exception to policy") for the full amount of the rent.

Out of pocket rent represents 48% of total monthly income ($309/$639). This rent burden would remain constant regardless of the amount of the approved rent.

Example 2: SSI Recipient Living in a Scatter-Site I Program

SSI Benefit	$639
Utility allowance provided by non-profit scatter-site program	$60
Total Benefits	$699
Less Program Fee equal to 30% of income	$192
Total Assistance available for needs other than housing	$507

Out of pocket rent represents 30% of total income ($192/$639). This consumer would be left with $177 more in monthly assistance than a person receiving rental assistance.

Example 3: SSI Recipient Living in a Congregate Program

SSI Benefit	$639
Total Benefits	$639
Less Program Fee equal to 30% of income	$192
Total Assistance available for needs other than housing	$447

Out of pocket rent represents 30% of total income ($192/$639). This consumer would be left with $117 more in monthly assistance than a person receiving rental assistance.

As rents soar, the amount of assistance provided may increase but the quality of life does not. Clients living in scatter site and congregate housing and receiving SSI/SSD/VA benefits may keep up to 70% of those benefits for personal expenses, significantly improving their quality of life; clients living in independent housing may only keep $330 a month for all personal expenses.

Many key informants – including both consumers and providers of housing, as well as government administrators of rental subsidies – identified financial management as one of the most significant issues facing clients. The inability of residents of both independent and supportive housing to pay rent and utilities on a consistent and timely basis was cited as the most persistent reason for housing instability and loss. Client advocates and legal service providers also reported that they see an increasing number of new clients in intake each week who are seeking assistance with debt management resulting from credit card debt, student loans, and other types of personal debt. The need for financial management training and strategies was repeatedly raised by key informants, though it was also noted that improved financial management skills could only go so far in addressing the problem, since clients who use the enhanced rental assistance program only receive (or are allowed to keep) $330 per month in cash assistance.[8]

Key informants described two types of financial management that are currently available to persons with HIV/AIDS, but noted that these services are available on only a very limited basis. A few service organizations in the City offer to act as a client's "representative payee" for disability

[8] HNA, Key Informant Interviews (2003).

benefits; and/or have negotiated the availability of cooperative financial management through commercial banks. Under a "rep payee" arrangement, an individual (typically a family member) or a service organization (a housing or health care provider) is appointed through the Social Security Administration to receive and manage the disability benefits of a person who has been determined to be unable to manage or direct the management of his/her own resources. Organizations that have provided this service noted that it is a significant administrative and clinical responsibility. The rep payee is responsible for paying the consumer's bills (rent, utilities, etc.) and then making the remainder of the person's benefits available as necessary to pay for food, clothing etc. It was noted that HASA has mandated the establishment of a representative payee relationship in some instances where consumers have fallen into rent arrears. One organization has been funded to provide representative payee arrangements in such cases, which it did through a consultant who charged a $25 monthly fee. The organization is now working to establish a system to provide the service directly.

Key informants stated that there is a need for wider availability of less formal financial management services. Under these arrangements, the consumer's disability benefits are directly deposited into a bank account, and rent is paid automatically in accordance with a pre-arranged draft on the account. At least two banks offer bank accounts with only a $4 monthly fee – the only cost to the client. It was noted, however, that since this arrangement is voluntary, it is easy for the consumer to undo. It is also impractical for clients who have outstanding debts or liens, or other financial obligations such as child care obligations.

Consumers expressed a need for services like financial skills classes, and believed that these skills would help them once they obtained their own apartments. Some key informants suggested that providers should be held accountable when supportive housing clients accrued serious arrears, because it reflects a failure of the supportive housing program to work with clients on financial management.[9]

A recent initiative developed by the Corporation for Supportive Housing (CSH), in coordination with the NYC Department of Housing Preservation and Development (HPD), the NYC Department of Homeless Services (DHS), the NYC Department of Health and Mental Hygiene

[9] Ibid.

(DHMH) and the NYS Office of Mental Health (OMH), seeks to address the inflexibility of the housing continuum. Through this initiative, titled "Moving On," a comprehensive set of resources will facilitate the placement of homeless individuals in supportive housing, and provide opportunities for current supportive housing tenants who are interested in other permanent housing options. Funding and resources have been made available to assist supportive housing providers to move current supportive housing tenants who are ready for more independent living into private market apartments using Section 8 rental assistance (which requires residents to pay no more than 30% of income from benefits or work towards rent). Providers can then move long-term shelter stayers from either the DHS or the HPD shelter systems into the vacated supportive housing units.

V. Key Findings and Recommendations

V. A. KEY FINDINGS

HIV/AIDS Housing as a Public Health Intervention

1. New York City's policy since the mid-1980s of providing non-shelter housing for homeless persons with HIV/AIDS is unprecedented in its scope and effectiveness.

2. HIV/AIDS housing resources in NYC have expanded rapidly in response to the growing epidemic, from 3,600 enhanced rental subsidies and 186 supportive units in 1990, to 20,000 rent subsidies and 6,500 supportive units at the end of 2003.

3. HIV/AIDS-specific housing resources are used currently by 23% of all New Yorkers with HIV/AIDS.

4. Recent research demonstrates a strong association between housing status and risk for HIV transmission, with the homeless and unstably housed at much greater risk of engaging in high risk behaviors.

5. New York City's unprecedented investment in housing for persons with HIV/AIDS has had a significant impact not only to improve the health status of New Yorkers with HIV/AIDS, but simultaneously to reduce homelessness overall, to care for the homeless mentally ill, and to provide housing to persons with chronic substance use problems that would otherwise be on the streets or in City shelters.

Housing is Healthcare

6. Housing status and stability are key determining factors in an individual's ability to access ongoing health care, and to benefit from Highly Active Anti-Retroviral Treatment (HAART) and other life-sustaining HIV treatments.

7. The overwhelming majority of consumers surveyed for this study are stably housed, despite a very high prevalence of histories of behavioral health problems, criminal justice system involvement and homelessness.

8. Ninety-five percent of consumers surveyed have a relationship with a primary care provider, and 77% report participation in HAART.

9. One-quarter of all respondents (25%) reported that a lack of appropriate housing had at some point interfered with their ability to adhere to HAART or other HIV medication

The Development of HIV/AIDS Housing Resources

10. Almost 6,500 units of supportive housing have been developed in the NYC EMSA since 1990; however, the rate of growth in the supportive housing system has slowed in recent years while the number of persons living with HIV/AIDS continues to rise rapidly.

11. The enhanced tenant-based rent subsidy for New Yorkers with HIV illness and AIDS enables more than 20,000 persons with HIV/AIDS to remain housed in the private rental market.

Current Costs and Funding for HIV-Specific Housing Resources

12. Available supportive housing programs for New Yorkers with HIV/AIDS are funded at rates of $75 per day or less; compared to daily costs of $112 for a City jail, $79 for a State prison cell, $350 for a State psychiatric hospital, $600 - $1,600 for a City acute care hospital bed, and $68 for a cot in a City congregate shelter.

13. In City fiscal year 2003, New York City's expense budget spending on housing and related services for persons with HIV/AIDS totaled more than $189.6 million.

The HIV/AIDS Supportive Housing Inventory

14. Thirty-seven percent of the transitional and permanent supportive housing inventory is located in Manhattan; 27% is located in the Bronx; 22% is located in Brooklyn; 11% is located in Queens; 2% is located in Staten Island; and 1% is located in Staten Island.

15. Fifteen percent of the transitional and permanent supportive housing inventory houses families, and 85% houses single persons.

16. Services most commonly provided to residents of the transitional and permanent supportive housing inventory are case management (94% of programs), substance use support groups (74%), and recreation (83%).

17. There is a limited and inadequate array of housing options for persons with HIV/AIDS in the Tri-County Lower Hudson Region of the EMSA.

Housing-Related Services

18. Medicaid and grant funded support services – such as case management, medical and social day programs, harm reduction programs for active substance users, and mental health care – are providing essential "wrap around" services necessary to keep many persons in independent housing stable and connected to health care.

Other Systems of Special Needs Housing

19. Neither mental health housing, public housing, nor any other supportive/subsidized housing system is a significant source of housing assistance for New Yorkers living with HIV/AIDS.

The Continued Use of the Commercial SROs

20. Despite the size and scope of the currently available HIV/AIDS housing resources, more than 1,500 persons with HIV and serious co-occurring substance use and mental health issues remain relegated to substandard commercial SRO housing that is short-term, provides no supportive services for residents, and costs, on average, from $50 to $80 per night.

Persons Served by the HIV/AIDS Housing System

21. Forty-five percent of survey respondents have a history of "literal" homelessness, sleeping in a shelter or on the streets.

22. Four out of five survey respondents (80%) report a substance use problem or mental health issue in the past or present.

23. Almost half (43%) of all respondents have a history of incarceration, and 31% have been convicted of a felony.

24. Younger males are at particular risk of housing instability.

25. Complex life issues reported by survey respondents substantially increase their risk of homelessness and housing instability.

26. Presence of a steady income is important for maintenance of stable housing.

27. SRO housing is most associated with instability and dissatisfaction. The transitional nature of much of this housing, the multiple problems that are often presented by the tenants of this housing, and at times the substandard conditions of this housing all contribute to instability.

28. Supportive scatter site and congregate housing are effective means of facilitating housing stability among persons who are at risk for housing instability or homelessness.

29. Living in a larger household with family members has a positive impact on housing stability.

30. African-American respondents reported the lowest participation in HAART among ethnic groups, and non-white respondents were almost twice as likely as white respondents to not be on HAART.

31. High rates of former homelessness, substance use, mental health issues and criminal history demonstrate that there is a substantial amount of adversity concentrated in direct housing programs, especially SROs.

32. Residents of independent housing report the highest level of HAART participation (82%) and SRO residents the lowest (71%).

33. The rent burden of survey respondents varied significantly by housing type, with residents of permanent supportive housing reporting an average out-of-pocket rent burden of only 34%, while residents of independent housing pay, on average, 49% of income towards rent.

34. The average ratio of *total* rent to income among survey respondents in independent housing was 124%, meaning that on average unsubsidized rents are greater than income; with available rental subsidies the average *out-of-pocket* rent burden is reduced to 49%.

35. 71% of survey respondents reported satisfaction with their housing.

36. Users of supportive scatter site and congregate housing express the highest levels of housing satisfaction.

37. Consumers expressed strong preferences for living "in their own place," for integration into the community, and for enhanced safety.

38. HIV/AIDS status and history of incarceration are serious impediments to getting housing in the private market.

Anticipated Housing Needs for Persons with HIV/AIDS

39. Best estimates based on consumers' service needs indicate a current unmet need for 900 additional rent subsidized independent rental units and 1,500 additional supportive units to appropriately house persons currently placed in HIV emergency and transitional housing, or whose independent housing is unstable due to unmet service needs.

40. Even the most conservative projections of HIV/AIDS and related housing needs indicate that 10,000 to 14,000 additional units of housing will be needed to meet the housing needs of New Yorkers with HIV/AIDS in 2010 (6,200 to 9,300 additional tenant-based rent subsidies; 3,100 to 4,100 permanent supportive housing units; and 300 to 500 new transitional units). Such an investment could cost in excess of $200 million.

Emerging Needs and Special Populations

41. There are significant unmet and emerging housing needs among certain groups of persons living with HIV/AIDS, including those being released from prison or jail, undocumented persons, persons of transgendered experience, families with children, people over 50 years

old, adolescents and youth aging out of foster care, persons in need of harm reduction services, and persons with mobility impairments, among others.

The Affordable Housing Crisis

42. The private rental market will not be sufficient to meet the housing needs of all New Yorkers with HIV/AIDS; the market is too tight and too difficult to use for persons with complex histories of substance use or mental health issues, poor credit, and/or histories of incarceration.

Barriers to Housing Development

43. Given the pressures on the private market, stepped-up development of new units of HIV-dedicated housing is essential in order to ensure the long-term availability of affordable housing to meet the needs of New Yorkers with HIV/AIDS.

44. Successful development requires the combination and coordination of various capital and operating funding streams; unified or coordinated interagency funding applications save time and money.

45. Agencies developing housing can incur substantial expenses in the predevelopment phase, which can be prohibitive and hard to fund.

46. The most significant barrier to the development of new units of affordable and supportive housing for persons with HIV/AIDS is the inability of non-profits to locate and secure appropriate sites.

47. Development of HIV/AIDS housing units is a complicated, expensive and time-consuming endeavor that even established providers of HIV/AIDS services may not have the organizational capacity to undertake.

Inefficient Use of Housing Resources

48. Lack of a uniform assessment and a centralized placement system results in inefficient use of the existing supportive housing system, marked by inappropriate referrals and placements and both "under-serviced" and "over-serviced" consumers.

49. There is currently no assessment conducted of HASA clients' housing and service needs, and housing placements are based not on assessed need but are rather largely "the luck of the draw" or the result of "squeaky wheel" advocacy by persistent consumers and their community-based providers.

50. There is no system-wide triage system for targeting allocating limited supportive housing resources to persons with the greatest support service needs.

51. Centralized referral and placement systems – such as the successful Single Point of Access (SPOA) program for New Yorkers with mental illness – have been demonstrated to be effective means for making appropriate housing and service referrals and allocating limited supportive housing resources.

52. Poor discharge planning for persons with HIV/AIDS leaving institutional settings (hospitals, nursing homes, prisons and City jails) leaves vulnerable New Yorkers in precarious housing situations or homeless, and in some cases prevents consumers from leaving prison or expensive medical settings.

53. Consumers are experiencing growing fluctuation in their physical and psychosocial health status related to aging, prolonged HIV treatments, and co-occurring substance use and mental health issues.

54. Changing service needs can threaten housing stability and connection to care, since discrete housing programs can only respond within the limits of existing funding and a shift to a higher service intensity often requires that a consumer leave one housing situation for another.

Barriers to Consumer Independence

55. Systemic disincentives discourage or prevent some New Yorkers with HIV/AIDS from moving to more independent housing or even returning to work.

56. Improved health status among New Yorkers living with HIV/AIDS has increased demand for a housing "bridge" to work; ironically, of the 28,000 persons currently receiving housing supports in New York City, only the 5,000 residents of *supportive* housing programs (who pay 30% of income towards rent) may work full or part time without jeopardizing their housing.

57. Only 8% of respondents report receipt of a paycheck from work, and while a third of survey respondents (33%) report that they would like to return to work within the next six months, the same percentage (33%) state that they are reluctant to work more because they might lose their housing.

V. B. RECOMMENDATIONS, NEEDS, AND STRATEGIES

The Assessment Team's research, analyses, and findings resulted in a series of concrete recommendations that, while acknowledging the unique effectiveness of New York's response to the housing needs of persons living with HIV/AIDS, identify particular actions to be taken to improve and build on that effectiveness, eliminate inefficiencies in the system, and anticipate and meet the need of increasing numbers of persons living with HIV/AIDS in the New York City EMSA. Seven broad goals emerged from the study:

1. Promote Housing Retention and Stability as a Baseline for HIV Treatment;
2. Realize Efficiencies in the Current HIV/AIDS Housing System through Improved Housing Referral and Placement;
3. Support the Greatest Possible Level of Consumer Independence;
4. Create New Units of Affordable and Supportive Permanent Housing to Meet Current and Future Housing Needs;
5. Coordinate Public and Private Advocacy in Support of Increased Funding for Low-Income Housing Available to New Yorkers with HIV/AIDS;
6. Engage in Ongoing Research on the Need for and Effectiveness of HIV/AIDS Housing Assistance; and
7. Develop an Action Plan to Ensure Results by Empowering an Interagency Commission to Implement Recommendations.

GOAL I. Promote Housing Retention and Stability as a Baseline for HIV Treatment

1. To ensure ongoing access to the private rental housing market, **peg the level of enhanced rental assistance available under New York State regulations to 110% of HUD established fair market rents (FMRs)**, the standard used by NYCHA and HPD for their Housing Choice Voucher Section 8 programs; 110% of FMR for a studio in New York City is currently $933. This rental rate should be available both to individuals and to Scatter Site I providers.

2. **Improve initial supportive housing placements** through use of a central assessment and referral system, described in Goal II below.

3. **Track the outcomes of housing referrals and placements**, including length of stay in supportive housing programs and for consumers with tenant-based rental assistance, in order to assess the stability of supportive and independent housing placements and identify consumers in need of greater housing supports.

4. **Continue to develop and employ supportive housing models and strategies that promote stability and prevent housing loss**, such as:

    a. Scatter site units in which the primary lease is held by a social service provider;

    b. Programs that link housing and intensive support services for the growing numbers of consumers with co-occurring mental health and substance use issues;

    c. A uniform contractual requirement that consumers in all permanent housing programs be offered lease or sub-lease agreements;

    d. Imposition, monitoring, and enforcement of requirements by program funders that supportive housing providers ensure and track consumers' connection to health care;

    e. Contractual requirements imposed by program funders that providers take progressive actions to prevent eviction; and

    f. Contractual incentives that reward providers and consumers for client stability and/or movement to a more appropriate level of care.

5. Ensure that when consumers are discharged from time-limited or long-term supportive housing, HASA and other program funders require the provision of **on-going support services** for as long as necessary, as well as the option of participation in **on-going housing-related case management to preserve housing stability,** through COBRA or grant-funded case management.

6. Move to a **"client-centered" continuum of housing options** that provides for both flexibility and stability as clients' health and support service needs change, through reimbursement of layered support services of varying intensity on permanent housing placements. This strategy would mean that the consumer would not move, but instead that services would adjust while the consumer remained in his or her housing.

7. Ensure the **ongoing availability of COBRA case management and Ryan White case management, living skills training, harm reduction supports,** and other wrap-around services for clients in independent housing (including Scatter Site II), to address isolation and lack of independent living skills.

8. Offer **low threshold services including medical and social adult day care programs** and other services that are not necessarily connected to clients' living situations, by exploring increased funding from the Medical and Health Research Association (MHRA) and Medicaid.

9. Ensure the availability of **mental health services provided by the appropriate level of professional clinical staff using low threshold strategies, including in-home and in-shelter services,** to address the behavioral health problems of persons with HIV/AIDS who have mental health issues that threaten housing stability and connection to care, but do not meet the criteria for the mental health housing system and are not being addressed by any other system of care.

10. Ensure **adequate code enforcement services** to ensure that consumers in independent housing with rental assistance are living in apartments that are safe and adequately maintained.

11. To prevent the loss or abandonment of independent housing, ensure the availability of **emergency utility assistance** and other emergency supports where they are needed.

GOAL II. Realize Efficiencies in the Current HIV/AIDS Housing System through Improved Housing Referral and Placement[1]

Overall system

12. Implement a **client-centered standardized assessment tool**, administered by HASA, by community-based service providers, and at other appropriate points of entry to the system, to determine housing and related service needs, based on objective eligibility thresholds/criteria, and administered by persons with appropriate qualifications and training.

13. Use a **centralized referral and placement** system administered by HASA or by a contracted provider, to allocate limited HIV/AIDS supportive housing resources according to a clear triage methodology based on the standardized assessment.

14. Institute improved, written **communication of permanent housing options by the HIV/AIDS Services Administration (HASA)** to consumers in emergency/transitional placements and others with unmet housing needs, to provide information including individual program descriptions, application processes and requirements.

15. Expand **in-reach** through community-based providers as part of discharge planning for people leaving prison or jail, and ensure that discharge plans for persons leaving nursing homes, hospitals and other treatment settings include appropriate housing that will prevent homelessness and/or re-institutionalization.

16. **Explore the introduction of adjustable service reimbursement for supportive housing programs, with appropriate services "layered" on permanent housing units and both services and reimbursement adjusted as appropriate to address residents' changing needs**; this could be achieved by structuring housing programs to include a mix of service reimbursement among the residents of a contracted housing provider, and/or through the use of an "assisted living" model of experience-based service reimbursement layered on to a stable living situation.

17. ***Supportive housing*** – match applicants to vacancies through a **centralized database manager**.

    a. Target existing supportive housing resources to applicants with the greatest need.

    b. Establish accepted thresholds for a tiered system of housing models, from the least service intensive (independent housing with rent subsidy) to the most service

[1] See Appendix B for a detailed description of principles and recommendations developed by the needs assessment Advisory Group's Referral and Placement Working Group.

intensive (24 hour on-site clinical staff). The system would include five to eight levels of housing need.

c. Determine consumer eligibility for placement only at the assessed level or lower (market availability will determine a consumer's ability to choose).

d. Establish an agreement among HASA, HUD, HOPWA, Ryan White & NYCCoC to make participation in the system a contractual requirement under operating contracts (with programs required to fill vacancies only with those applicants that have assessed needs at or above the program's service level).

18. ***Independent housing*** – **streamline the rental assistance application process** through:

a. Pre-certification of individual eligibility.

b. Pre-certification and periodic recertification of landlords, brokers, and properties.

c. Designated apartment inspection staff within HASA, and expansion of non-profit inspection with HASA oversight.

d. Improved communication of rent guidelines and application processes.

e. Central system for monitoring application status at HASA.

19. ***Emergency housing*** – **eliminate the use of the commercial SROs as emergency housing placements** and provide instead supported transitional housing.

a. Limit the use of "emergency" short-term housing placements to homeless persons first entering the HIV housing system and persons who have left or been terminated from one permanent housing placement and must secure another.

b. Place persons in need of "emergency" housing in harm reduction transitional settings where supportive services and housing placement assistance are available on-site.

c. Initiate the HASA permanent housing placement process at time of the emergency/transitional placement (schedule an initial housing assessment interview within one week of the emergency placement).

d. At the time of placement, require that HASA provide each emergency/transitional housing resident with written information on permanent housing options and placement processes.

e. Continue emergency/transitional placements until permanent housing is secured (do not impose 28-day stay limits).

f. Where continuous placement is not possible, arrange for a resident's next emergency/transitional stay before the end of the current placement, and provide assistance with moving possessions.

20. ***Commercial SROs/boarding houses*** – Return these units to the housing stock, as described in Section IV below, but improve them so that they can serve as permanent housing for consumers who choose a lower level of service intensity.

GOAL III. <u>Support the Greatest Possible Level of Consumer Independence</u>

21. Create a **bridge-to-work program** so that the loss of housing supports is not a barrier to consumers who are able and ready to return to work.

22. Provide **financial planning** as part of placement assistance, including providing housing applicants with written information on the financial impact/affordability of housing options.

23. Ensure **clear and uniform communication by HASA of consumers' obligations** for rent and utilities (both amounts and payment mechanisms).

24. Ensure **widespread availability of financial management services**, including the option of direct deposit of SSI/SSDI benefits into low-cost bank accounts, with a pre-arranged automatic draw to pay rent.

25. Ensure **consumer access to legal services** to prevent housing loss, to establish eligibility to entitlements, to manage parole and probation, and to address other legal matters that may become a barrier to stable housing, employment or other goals.

26. **Remove structural barriers** to increased consumer independence**:**

    a. **Limit the housing cost burden to a uniform 30%** to eliminate the disparate housing cost burden of consumers on fixed incomes (SSI/SSDI) that live in supportive housing (30% of income) versus those who use the enhanced rental assistance program to live independently (50% or more of income).

    b. **Create incentives** to encourage clients to move out of supportive housing when ready, and into independent housing, such as the Corporation for Supportive Housing's "Moving On" program, which provides consumers with Section 8 Housing Choice Vouchers to subsidize housing in the private market.

GOAL IV: <u>Create New Units of Affordable and Supportive Permanent Housing to Meet Current and Future Housing Needs</u>

Current and Projected Need for HIV/AIDS Housing Resources

	IMMEDIATE UNMET NEED	2004	2007	2010
Rental Assistance Subsidies	934	1,700 – 2,170	3,970 – 5,900	6,230 – 9,260
Permanent Supportive Units	1,491	1,710 – 1,860	2,420 – 3,010	3,120 – 4,060
Transitional Supportive Units	0	50 - 80	180 - 300	320 - 500
Cumulative Total Need	**2,425**	**3,460 – 4,100**	**6,570 – 9,110**	**9,670 – 13,820**

27. **Satisfy current unmet need** among the estimated 116,000 to 130,000 New Yorkers living with HIV/AIDS through additional housing resources directed to persons living with HIV illness and AIDS:

    a. **930 additional rental assistance subsidies** to secure private market rental housing for persons currently in the HIV emergency and transitional housing systems, or over-serviced in the permanent supportive housing system (estimated at 10%).

    b. **1,490 additional permanent supportive housing placements**, to meet the needs of persons currently in the HIV emergency and transitional housing systems, and persons currently living independently who require a greater level of housing related supports to maintain stability and connection to care.

    c. These figures for unmet need include 1,500 persons living with HIV/AIDS who are currently housed in commercial SRO units, and, although they would be most appropriately served in the permanent supportive housing described above, have an immediate need for **appropriate transitional housing**, particularly housing that meets the needs of special populations such as undocumented persons, transgendered persons, and persons recently released from incarceration.

28. **Meet the projected housing needs** of New Yorkers living with HIV illness and AIDS, which will require:

    a. **3,460 to 4,100 total additional units by the end of 2004**, including 1,700 to 2,170 new rental assistance subsidies, 1,710 to 1,860 new permanent supportive housing units, and 50 to 80 new transitional supportive housing units.

b. **6,570 to 9,110 total additional units by the end of 2007**, including 3,970 to 5,900 new rental assistance subsidies, 2,420 to 3,010 new permanent supportive housing units, and 180 to 300 new transitional supportive housing units.

c. **9,670 to 13,820 total additional units by the end of 2010**, including 6,230 to 9,260 new rental assistance subsidies, 3,120 to 4,060 new permanent supportive housing units, and 320 to 500 new transitional supportive housing units.

29. In recognition of the tremendous costs involved in meeting this projected need, **create new financing models that leverage existing and new funding sources.**

30. Develop **housing types** that respond directly to identified needs.

    a. Address housing needs of **special and underserved populations**. These populations include both those who currently have no access or insufficient access to the housing system, and those who have access, but have special needs:

        - Those being released from prison/jail, and those with past felony convictions
        - Undocumented persons
        - Persons with asymptomatic illness that are not eligible for HIV-specific housing services
        - Families with children;
        - Persons of transgendered experience
        - Adolescents/young persons
        - Persons over fifty-five
        - Mobility impaired persons

    b. Develop **less service intensive**, and hence less expensive, models of subsidized HIV/AIDS housing than existing supportive programs for those who do not need intensive on-site supports.

    c. Promote development of **HIV-specific units within mixed use** special needs/low income housing projects.

    d. Explore the use of **capital funding for purchase of apartments** by non-profit housing providers, especially in neighborhoods of low density and/or where community opposition to congregate housing is very strong.

31. Address the **housing and service needs of homeless New Yorkers with asymptomatic HIV infection** who are not currently eligible for HIV-specific housing resources.

    a. Provide education and in-reach in homeless shelters and low-threshold outreach/drop in programs to **encourage persons to seek HIV testing and counseling**, and to assist homeless persons with HIV/AIDS (conservatively

estimated at 800 to 1,000 persons on a given night) to access available housing and services.

b. Through a pilot project, provide **non-shelter housing options, including rental assistance at a rate equal to the enhanced rental assistance offered by HASA, for persons who are HIV-asymptomatic** and therefore are not eligible for HASA services or HIV-specific rent supports and supportive housing. This approach is suggested by the demonstrated importance of housing to secondary prevention and entry into health care.

c. **Exempt HIV positive single adult shelter users from sanctions** under New York State regulations that result in denial of shelter based on failure to comply with an individual treatment plan.

32. **Target and streamline** available funding:

a. Target **HOPWA funding** to uses for which there are limited alternative funding sources, and to serve persons with HIV/AIDS who are not eligible for City/State public assistance housing supports (such as undocumented persons).

b. Enhance **unified or coordinated funding applications** allowing providers to apply simultaneously for targeted capital funding, operating support and supportive services funding, along the lines of the highly successful HPD Supportive Housing Loan Program and the NY/NY mental health housing agreements.

c. Improve the use of **funding partnerships and collaborations among government entities**, particularly the New York City Department of Housing Preservation and Development (HPD), the New York State Homeless Housing Assistance Program (HHAP), the New York City Human Resources Administration's HIV/AIDS Services Administration (HASA), the New York State Office of Mental Health (OMH), and the NYC Department of Health and Mental Hygiene (DOHMH).

d. Explore the adjustment of procurement rules that limit the terms of operating contracts to a total of nine years, as well as other barriers that impede the creation of **new models of capital financing**, such as leveraging sustainable or long-term operating subsidies to finance housing development.

e. Utilize programs that create **special needs units that are cross-subsidized by market-rate units or through public tax benefits** in the same projects.

33. Overcome **barriers to development**:

a. **Create a "land trust" supported by public and private funds** to secure appropriate sites on the private market for future development of HIV/AIDS housing.

b. Provide **pre-development funding and technical assistance** to help organizations build infrastructure and overcome initial barriers to housing development.

c. Improve the ability of non-profit providers to compete for sites in the private housing market, through **access to acquisition funding** and information about site availability.

d. Promote **public/private partnerships** for investment in new housing, such as a **web-based brokers' listing** for potential development sites, and a **revolving loan fund** for site acquisition and pre-development funding.

e. Require **community board notification only** as a condition of HPD capital funding, rather than community board approval, and continue to implement a public relations campaign to promote supportive housing more generically.

f. Establish a **legal mandate requiring each borough to host its "fair share"** of housing for people with HIV/AIDS, in accordance with demonstrated need based on prevalence of HIV/AIDS in each borough.

g. **Remove barriers to non-profit and private development of new SRO/studio housing** by changing zoning resolutions to increase allowable densities of small units.

h. As mentioned above as part of new units to be developed, explore using capital funding to enable non-profit housing providers to **purchase scatter-site apartments**.

34. **Preserve the existing single room housing stock** and make it available as permanent low-income housing**:**

a. Immediately require that **each commercial SRO that receives HASA placements enter into a contract with HASA** that imposes uniform housing and safety standards as well as clear house rules and procedures, that allows access by providers of on-site outreach and support services based on a harm reduction model, and that provides for regular oversight and enforcement by HASA.

b. Increase enforcement of code requirements by the NYC Department of Housing Preservation and Development (HPD)'s SRO Code Enforcement Unit to **compel owners of existing SRO units and boarding houses to bring units into compliance with building and safety codes**; and consider the imposition of penalties on non-compliant owners that would prohibit development or other uses for a period of time (similar to existing "certificate of no harassment" requirements).

c. Where existing owners fail to comply, **take control of units** through the use of a 7A Administrator or the exercise of eminent domain.

d. **Create a governmental "SRO Housing Authority"** with the charge of acquiring and improving the remaining SRO housing stock, to be owned and/or operated by non-profit providers of low income housing for vulnerable New Yorkers, including persons with HIV/AIDS.

e. **Make SRO housing available as a permanent housing option** for single persons with HIV/AIDS. When appropriate, provide separate bathrooms for all persons, and provide owners with incentives to improve housing.

35. Ensure the availability of and access to **grant funded, hands-on and practical technical assistance** to assist existing and potential housing providers with:

    a. Capacity building and organizational infrastructure development;

    b. Program conceptualization and design;

    c. Development of capital and operating funding packages;

    d. Preparation of complicated and coordinated funding applications;

    e. "Bricks and mortar" project development and management;

    f. Services program development and staff training; and

    g. Facility and program maintenance.

GOAL V. <u>Coordinate Public and Private Advocacy in Support of Increased Funding for Low-Income Housing Available to New Yorkers with HIV/AIDS</u>

36. Maintain and increase Federal, State and local **funding for the development and operation of HIV-specific affordable housing** available to meet the needs of extremely low income persons with HIV/AIDS.

37. Coordinate with other providers of homeless housing assistance and low income housing to advocate for increased **federal funding to the New York City EMSA under the McKinney-Vento Act** Homeless Housing Assistance program.

38. Maintain the **set aside of Homeless Housing Assistance Program (HHAP) capital funding for HIV-specific housing units** at existing or increased levels.

39. **Redirect the New York City Housing Opportunities for People With AIDS (HOPWA) formula grant from supportive services to the provision of direct housing assistance, including housing-related assistance,** in a manner that ensures the ongoing provision of essential HASA case management services.

GOAL VI. Engage In Ongoing Research on the Need for and Effectiveness of HIV/AIDS Housing Assistance

40. **Examine the overlapping issues of homelessness and HIV/AIDS** though the merger of administrative data bases maintained by the AIDS Surveillance Unit of the New York City Department of Health and Mental Hygiene, the New York City Department of Homeless Services and the HIV/AIDS Services Administration.

41. Engage in **research and analysis to assess stability and length of stay in various housing models**, including the various scatter site housing models, in order to inform planning and funding decisions.

42. Conduct further **research to support the connection between appropriate housing, better health access, and improved outcomes, including lower mortality**, through an examination of client level Medicaid utilization and mortality rates for persons with HIV/AIDS with different housing histories and/or in different models.

GOAL VII. Develop an Action Plan to Ensure Results by Empowering an Interagency Commission to Implement Recommendations

43. Present these needs assessment findings and recommendations to the New York City and Tri-County Housing Committees of the Ryan White Planning Council, which also act as HOPWA Advisory Committees, to inform the **development of detailed five and ten year plans** to meet the housing and related service needs of persons living with HIV/AIDS in the NYC EMSA.

44. Empower an **Interagency Commission of New York local and State agencies** to work together, and in collaboration with the community and the private sector, to implement HIV/AIDS housing plans and recommendations that require coordinated initiatives, such as:

    a. A bridge-to-work program for persons with HIV/AIDS;

    b. A land trust to secure housing units and development sites;

    c. Preservation of the remaining SRO housing stock; and

    d. Unified or coordinated applications for capital and operating funding for new housing units.

45. Ensure the effectiveness of the commission by funding **dedicated staff members at each participating agency**, and requiring regular participation from staff at the level of Deputy Commissioner or its equivalent.

46. **Address interagency competition for limited low income housing resources** through unified planning and priority-setting.

47. To meet the projected need for housing for persons with HIV/AIDS, **conduct in-depth financial analysis and develop financing models** that rely on tax-exempt financing and/or commercial loans, and ensure incentives for development.