Environmental Influences of Quality of Life for Residents of New York City Congregate Site Supportive Housing

A grounded, ethnographic study

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Abstract

The following text explores the question of what environmental influences impact the quality of life of supportive housing residents living in congregate sites in New York City. An extensive review of existing literature was included to provide both the history of supportive housing, which continues to inform the supportive housing model, as well as contemporary studies conducted on supportive housing. The study utilized a grounded, ethnographic method of data collection and analysis. The data used came from eight interviews conducted with both residents and staff of supportive housing programs. The results of the study were subdivided into four sections, based on the four largest influences that were observed as the data was reviewed and prepared for analysis; these four categories were Spatial Relationships, Relationships between Residents and Staff, Community and Resources, and Institutional Factors. These sections were each subdivided down further to provide greater detail about specific influences on residents’ quality of life. The data analysis process revealed that each environmental influence exerted itself independently over residents’ quality of life, and that each influence had a degree of influence on other influences as well, such as the relationship between both Spatial Relationships and Relationships between Residents and Staff. The concluding section of this study discusses the tensions between the positive influences and negative influences of supportive housing on resident quality of life and provides and invites further discussion on the existing congregate model.
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Introduction

Supportive housing is a type of permanent affordable housing that provides a range of supportive services to residents who have experienced homelessness, have a disability, or are otherwise in need of support. Supportive housing can be delivered through two main models: congregate and scatter site. Congregate supportive housing is typically a multi-unit building in which residents have their own private units but share common spaces, while scatter-site supportive housing consists of individual units dispersed throughout a community or city. Both models provide a range of support services to help residents maintain stable housing and improve their overall well-being. The program that I worked at was a congregate site.

Congregate sites in New York City will be the focus of this paper.

Prior to enrolling at Georgia Tech’s School of City and Regional Planning, I lived in New York City for two years where I worked as a case manager at a supportive housing development in Manhattan. That experience was both challenging and rewarding. The challenges of working in the supportive housing realm both confirmed that I would not last a whole career in direct service, and galvanized me to interrogate what made working with and on behalf of supportive housing residents so difficult.

To put things simply, the challenges are all rooted in a lack of resources. Supportive housing residents’ lives often hang in a precarious balance that depends on cash benefits from a handful of underfunded agencies composed of under-paid and overworked staff, and social and health support services from another handful of organizations that are similarly underfunded. That precarity is something that will not change without greater financial commitment from the government towards the mission of supportive housing, which as I understand it, is to offer shelter to those who have experienced chronic homelessness and to assist in the recovery of those individuals so that they might reintegrate into society. This precarity is at odds with the mission of supportive housing, which is intended to provide those who historically have not had much experience with stability with the support they require to live stable and healthy lives.

In order to secure that commitment, those who advocate on behalf of supportive housing residents and staff require a greater body of research that explores the ways in which the resource precarity of supportive housing directly contradicts the mission. My purpose in creating this research paper is to add to that body of research by conducting a grounded ethnographic study that relies on interviews with supportive housing residents and staff to better understand the myriad influences that impact residents’ quality of life. While this paper will be grounded in the experiences of respondents, a number of prior works have guided my research.

As I have had time to reflect on my experience as a supportive housing case manager, there are aspects of the model that have begun to strike me as problematic. Even in a city like New York, which leads the country in terms of social service provision and number of supportive housing sites, those who have experienced homelessness and mental health struggles still live relatively isolated lives. Supportive housing sites can often become islands unto themselves, and allow for little meaningful interaction between residents and the neighborhood around them.

There was a day in the first two weeks that I worked at my supportive housing site that my coworker explained to me that the way he saw it, the building and more broadly, the entire homelessness service model in New York existed not to service those who were experiencing homelessness but to provide a service to the residents and visitors of the city who could not be
bothered by the presence of these individuals. For some time after this conversation, I fought
this notion. I told myself that even if this were the case, the end result was still the same, wasn’t
it? These individuals, many of whom had spent decades living on the street, now had a secure
place that they could call home; where staff could help connect them with the resources to help
them overcome the weight of the problems that had led them to live on the streets to begin with.
I began to ask questions where I could, to better understand the system that had brought the
six-hundred-and-fifty tenants of the building and the fifty-or-so staff members to that place, and
more importantly, I tried to listen as well as I could to the stories these individuals carried with
them.

When I wasn’t at work, I found myself thinking about the concept of homelessness constantly.
Until I had the chance to encounter people who had been homeless in this way, I had never
really given much thought as to how someone might become homeless. I had never assumed
that those who were homeless were homeless because they wanted to be or for any reason that
was exactly their fault, but I had been operating off of the easy heuristics that our society
provides us with to understand homelessness: these people were on drugs, they were criminals,
they had issues that made them different and they were afflicted by that awful disease of
poverty, which is more like diabetes or heart disease than the flu (that is to say, an affliction
brought on by their actions alone).

The more I got to know people at my site, the less these easy modes of understanding
homelessness seemed to hold up. It was true that many of these people did use drugs, that they
had past run-ins with the law, and that they certainly were different from most of the people you
meet, but encountering them in this way, I started to see people I knew and parts of myself in
everyone I met at the building. I began to think that this whole system rested upon the imagined
barrier between “us” and “them.” What was that barrier made of and what was it doing; both to
the tenants of the building and to our society more broadly?

At the building I worked at, I understood through my conversations with the residents that most
of the residents lived fairly lonely lives. Many of their families and friends lived in the outer
boroughs of the city, if they were still connected with them, many others had not been in contact
with their families and friends at all in many years, perhaps due to their own past behaviors, and
many were hesitant to connect with others who lived in the building for multiple reasons. For
some that hesitancy came from a desire not to be pulled back into patterns that they felt had led
to the negative outcomes in their lives prior to moving into the building, such as using drugs or
alcohol. Others kept their distance, whether they were mentally ill themselves or not, because
they needed to maintain a distance between themselves and people who they perceived as
mentally ill in order to maintain a feeling of autonomy.

The residents who seemed to live the lives that were of the highest quality were those who were
categorized as only “low-income” and did not have a formal mental health diagnosis. These
residents lived their day-to-day lives almost entirely outside of the building. Some of the
individuals who had moved into the building without a diagnosis, however, had actually become
high-need clients. Their stories were often similar: something had gone wrong in their life, they
had lost a job or an important relationship or had experienced a life-changing medical episode
and to cope they had fallen into the patterns of behavior that surrounded them at the building.
The residents who did congregate with other residents of the building often relapsed if they had
been sober, and fell into predatory relationships with other residents. On the day that residents
received their monthly cash assistance payment, drug dealers would line up outside of the
building in anticipation. Older residents who were also users fell into relationships where they
would come to almost completely rely on other tenants to fetch them drugs, food and other household goods and would end up being taken advantage of in the process.

Many of the people I talked to felt trapped. For many who had lived on the streets for years, having a roof over their heads was undoubtedly better than living on the streets, but for some, they actually did begin to question whether they might be better off after all if they could just get out of the building. The three elevators of the building were constantly broken, and even if you could get on one, you might not want to or be able to because of who else was riding it; often people smelled or seemed threatening. Only a few people with a rollator could fit in an elevator at a time; if EMS or police was called, they would require an entire elevator for their gear and their staff. Police and emergency services were almost always present at the building; there were days I would look out of my office window and see two or three ambulances lined up in front of our sidewalk. Police officers were in and out of the building several times a day. I can attest that maintenance staff in the building worked as fast and as effectively as they could be expected to work, but it was an old building that was falling apart in places despite its renovation in the early 1990s that had saved it from complete dilapidation, and many residents felt that their work orders were not being given any attention. Security had the power to ban guests from the buildings, and had keys to every room in the building; both rules made residents feel that their lives were being invaded by building management. For some, working with their case manager was a bright spot amidst the otherwise dark and chaotic conditions of the building, but these relationships could be volatile. For others, the mandatory relationship with a case manager was more evidence of their lack of autonomy, and many were uninterested in and hostile towards this relationship.

I began to feel that the stated goal of supportive housing, social reintegration, was not earnestly being pursued, or if this goal was even one that was realistic for those working and living in supportive housing to strive for. More than this, I found myself considering the structure of society where we have an entire population of people who we do’ not understand, and where that lack of understanding scares us to the point of needing these individuals to be placed out of sight and more importantly out of mind. This place was not a home, but an institution, a warehouse even, for those that society had grouped together out of desperation and out of a willful desire not to understand their complexities. For the sake of convenience, all of these individuals who had formerly experienced homelessness had become “clients.”

The client, or consumer, as more recent social services language has branded them, differs from the individual in that they are a collection of presenting issues and problems that must be approached from a clinical perspective. Goals are set, harm reduction measures are put in place, interventions are made; the individual’s wellbeing becomes a job that workers are paid to do. In reality, the one-dimensional client was actually composed of several groups with different needs; the elderly, those with severe mental health diagnoses, those with substance use disorders, those with physical disabilities and those with some combination of comorbidities. Here I must note that I don no mean to detract from any of the efforts of case workers or social workers who work in supportive housing settings. In my experience, those who work in this capacity are some of the most compassionate, empathetic and genuinely caring people and I have considered it a great privilege and honor to work with many of them; if I critique the “worker” it is only the system by which “clients” and “workers” are created out of a society of individuals.

Most of the residents of the building came from neighborhoods across the five boroughs that had gentrified in recent years, neighborhoods primarily in Brooklyn, Manhattan and the Bronx.
that had been disinvested in for most of the 20th Century. I wondered whether the traumas that they had endured might have been endurable had they not had to deal with the additional trauma of displacement and the loss of one’s community. Gentrification and displacement are closely related phenomena, those displaced experience a wide array of outcomes; some successfully relocate and reintegrate into other neighborhoods, some relocate at the cost of their connection to a specific community, many struggle to find affordable places to live in cities where gentrification is taking place at the citywide level. Within every family and community, there is one person who carries more of the emotional weight of the collective tragedies of that group of people. I felt that the residents of the building, many of whom society had branded as crazy, were serving that role for the communities they had come from, and merely expressing the emotions of a collective trauma that remained unprocessed and ignored by society as a whole.

The access that we have to communicate with one another has never been higher; this combined with the Western tradition of celebrating the individual has resulted in a world where people do seek out people and groups that understand them, but these groups have become increasingly more niche as we are no longer beholden to a common denominator. The niche group becomes an extension of the individual in a way that creates more fragments in our society than unity. The factional nature of our society is only an extension of the atomization we experience on an individual basis. If our selfish natures leave us disinterested in those different from us and our selfish society provides us with no incentive to try to understand those unlike ourselves, how then do we create a home that we all can live in together?

Working as a case manager at the building I worked at, it was clear to me that our society had banished the people who I called clients. In the modern world, and especially in New York City, there is no wilderness to send these people into, no cave located some distance away from town where the banished can be sent. When possible, society makes criminals out of these people that it does not understand, because the position of the criminal, like the client, is one that society understands far better than the position of the person with mental illness who lives on the street. The banishment of my clients was one that depended upon an apparatus that consisted of the police, the hospitals, the bureaucracy of the American welfare system, social service providers like myself, and the professional non-profit organizations that funded the social service providers. The idea of “public/private partnerships” supported this apparatus, as the government provided corporate building management with a formalized philanthropic avenue that they could cruise to improve their public image and claim tax breaks. In the fringeless world, the banishment of my clients involved the constant invasion of their lives by this apparatus, and as a case manager I was frequently the party that was most directly and most regularly performing the function of the invader.

The perception that I had, and that I believe many of the residents of the building I worked at had, was that their lives were not entirely their own and that the project of the building and buildings like it was not to rehabilitate this population so that they could rejoin society, but to police them and to punish them for deviant behavior. The contempt that society holds for those that it would like to banish but cannot is immeasurable; the words that my coworker had spoken to me in those first few weeks that I worked at the building seemed to have been close to the truth.

My interest in supportive housing comes first from my inability to see the population that lives on the street and in supportive housing as separate from myself, second from my feeling that the exclusion of this group of people from our society is emblematic of a wider inability to commit to
addressing the question of how we all live together and lastly my fascination with the components of place that we associate with the feelings of home.

The issues associated with supportive housing are complicated because at their core is the confrontation between those who have experienced chronic homelessness and often deal with severe mental illness and the rest of the population. The myth that allows us to maintain that boundary between the supportive housing tenant and the rest of the population is a product of the mental process that de-systematizes homelessness and mental illness and assigns individual blame. If we truly realized how close everyone lives to the other side of that boundary, supportive housing may not exist. If we recognized their pathologies as an extension of the wider set of social ills in our society, supportive housing may not exist. Instead, we would recognize these individuals as complicated, sometimes difficult people; as our family, our friends, our neighbors; as people we admire and respect. If we saw this population this way, I would hope we would not be so quick to police them or to make them someone else’s responsibility.

This paper is only a limited exploration of the thoughts and ideas that I have around supportive housing and I have recognized that while my own perspective has become more critical of supportive housing as a model, I do think that it is a net-positive for our society (or at least the best of the politically palatable options we have available). The case managers, social workers, clinical supervisors and program directors who have contributed towards this project are some of the people that I admire the most in this world and whose work with their clients is undoubtedly positive. Although they continue to do the hard work, it is my hope as someone who is now operating in the field of urban planning, that I can use my experience as well as the experiences that they have shared with me in the course of conducting this study to help influence policy and development that makes their jobs easier.

While there are many different avenues that I feel I could explore on the topic of supportive housing, the key question that I am interested in exploring in conducting this research are the influences that impact residents’ quality of life. My hope is that in exploring these influences, both the strengths and weaknesses of the congregate model of supportive housing will be revealed and that the tensions between the most positive and the most negative influences of supportive housing will offer an interesting discussion on the topic of how this model of sheltering and supporting the formerly homeless might be improved.

Literature Review

Historical Perspectives:

To understand supportive housing, it is important to first understand the circumstances which have necessitated the concept. The history of supportive housing has been born out of the American attitude and culture around homelessness. Author Don Mitchell explores the history of homelessness in America by first going further back to England and the end of feudal systems, the bonds of guilds and the enclosure and privatization of the commons as England’s economy and society transitioned to become more industrial in nature. Mitchell identifies these factors as contributing to the creation of “armies of ‘masterless men’: ‘beggars, robbers, vagabonds.’” This population was responded to with violence, enabled through the creation of laws which outlawed “vagabondage” which were aimed at controlling movement, compelling labor and
punishing those who resisted. These laws were carried over into the American colonies, where those who could not sufficiently account for their “wanderings” would be either put to work in workhouses or during the harvest, or if they were unable to work, they would be forced out of town. American vagrancy laws were an essential part of controlling the wandering poor and reinforcing the divide between those that society accepted and deemed deserving of charity and those that it deemed as outsiders who threatened society’s stability.

These vagrancy laws created concentrated geographies of individuals who were either unhoused or poorly housed, sickly and frequently unemployed. These areas were often skid row districts on the outskirts of town or near major transit routes, popping up near railyards or highways and were possible because they were places where law enforcement was less strict about enforcing vagrancy laws. Mitchell points out that many individuals within this population sustained a reserve workforce that was essential for seasonal labor demands. Individuals would often only stay in these places between work in mining, logging and harvesting. Others found themselves in these flop districts because they were the only places that those who could not work due to age, infirmity or addiction could afford to live.

The Great Depression and World War II and the resulting post-war economic boom both had a profound effect on homelessness and the way that Americans thought of those who experienced it. With the Great Depression, far more Americans than ever before found themselves in situations in which they could not afford shelter of any kind. A number of interventions, including the creation of public housing, the construction of large urban renewal housing projects, and the heavy subsidization of suburbanization were introduced in order to address the crisis. This resulted in the destruction of and decline in the availability of the single-room occupancy hotels and rooming houses that had provided housing to those previously most precariously housed.

Several factors contributed to a change in the demographic character and attitude towards those experiencing homelessness. In response to the Great Depression, the government significantly expanded the social welfare system. Work programs such as the Civilian Conservation Corps, the Works Progress Administration, and guest worker programs that allowed migrant workers to work seasonally in the United States provided expanded employment opportunities. The “Great Compromise” between labor and capital resulted in the creation of social security, support for labor unions, health insurance, and state and corporate pensions. With the creation of these programs and the perception that economic opportunity was plentiful and open to everyone, those who remained homeless (primarily single, often black or brown, men) were viewed as responsible for their own situations. The reasons for why black and brown men persisted to represent the segment of this population that they did are numerous and are rooted in systemic racism, the legacy of slavery and sharecropping to name only a few.

While affordable housing availability continued to decline in each successive decade due to urban renewal, neighborhood demolitions for highway projects, and later urban gentrification efforts, the laws around homelessness swung like a pendulum. In the 1960s and 1970s, that pendulum swung in favor of individuals who were experiencing homelessness, as the Supreme Court struck down anti-vagrancy laws and laws that permitted individuals to be jailed solely on the grounds that they were addicts as overly vague and as violations of human rights respectively.
In the 1980s and 1990s however, the pendulum swung back in the other direction, with the introduction of federal and state legislation aimed at restricting the freedom of homeless individuals. In the 1980s and 1990s, the welfare protections that had been put in place under the New Deal were dismantled, further contributing to a more visible state of homelessness in American cities. Individuals suffering from severe and persistent mental illness and who often had substance abuse disorders showed up in seemingly ever-greater numbers in American cities. The laws created to regulate this population outlawed many of the activities that were inherent to the conditions of homelessness, such as sleeping in public, sitting on sidewalks, begging for change and collecting recyclables. Solutions proposed during this period, defined by anti-homelessness laws and a collapse of public housing and welfare programs, followed the logic that viewed homelessness as a personal choice and responsibility. Many of the efforts to house these individuals included stipulations about sobriety and work, which made them less desirable to homeless individuals.

Parallel to this story of American homelessness, defined by the gradual loss of affordable housing, the collapse of welfare programs, the outlawing of homelessness and the societal perspective that homelessness was a personal choice, runs the story of the asylum system in America, and its gradual “deinstitutionalization” after World War II. In the West and in America specifically, the asylum system was viewed widely during the 19th Century as the peak of humane mental health treatment. These institutions had a different character during that original period than they would take on in the century to follow, offering long-term services to relatively few chronic cases. The state asylums were also viewed as the care facility of last resort, typically reserved for more violent or troublesome patients. Community facilities were more commonly used between 1830 and 1870, as the legislation of the time required that localities pay for patient care and state asylums were more expensive than local hospitals and almshouses.

This legislative environment meant that relatively few individuals were sent to state asylums, and few stayed in the community facilities for very long as localities were eager to discharge these individuals regardless of their level of recovery. While the efficacy of this system could certainly be contested, there is some evidence based on readmission data that these shorter visits to community facilities actually resulted in about a 58% rate of successful reintegration without any readmission.

In the 1870s, the number of chronic patients had increased, and localities, which had previously been required to pay for the treatment of individuals, successfully lobbied their states (led by Massachusetts and New York) to be absolved of financial responsibility for patient treatment. The argument that led to this centralization of services within the state was that while local facilities were cheaper, they were not as effective and that lack of efficacy generated a greater rate of chronic mental illnesses. State facilities, it was believed, had greater capacity to treat the mentally ill.

While the intent of this shift was to increase the chance of recovery for those who would benefit from a short, high-quality visit to a state mental health facility and to provide more humane care for those with chronic conditions, the actual effect of this shift from local facilities to state facilities was that state facilities became responsible for a much larger population than they had intended to take responsibility for. Localities saw the opportunity to empty their local almshouses of not just mentally ill individuals, but also of the elderly who suffered from senility and who had no family and no resources. From 1880 to 1920, the number of elderly individuals and the number of elderly individuals with mental illnesses admitted to almshouses declined
This change in financial responsibility and the funding structure for mental health care created a situation in which state mental health facilities became home to individuals with both chronic mental health problems, and senile, elderly individuals without resources. Both of these populations constituted groups that would likely never leave the state asylum once they were admitted. By 1946, half of new admissions to asylums were aged persons with varying degrees of senility or paresis. It became clear that a change was necessary in this system, and in the 1950s a number of critical pieces were published attacking the asylum system. While some of these publications offered criticisms that were slightly inaccurate, and did not consider the two decades of neglect due to the Great Depression and World War II, consensus grew that conditions in the asylums had worsened significantly.

After the war, the attitudes towards asylums and opinions on the proper way to deliver treatment to the mentally ill began to favor a community treatment model. The change in approach to treating those with severe mental illnesses led to a dispersion of mental health staff, long concentrated in asylums and mental hospitals, towards local clinics. The idea that the clinic model would service mental health patients in their communities in an effort to help preserve and restore them to a “normal life,” rested on assumptions that were shaky at best. The clinical model assumes that patients have a home and a sympathetic family or supportive entity in their life who is willing and able to assume responsibility for their care, that households themselves would not impede the treatment of an individual, and that a patient’s presence in a household would not cause undue burden on its members.

The dispersion of mental health services towards a clinical model diverted both resources and staff from the asylum system. At the same time, psychology and psychiatry was becoming of greater interest to a larger segment of the population. The rate of treatment declined at state asylums and mental hospitals and treatment rates increased at clinics; however, this change did not reflect an equivalent replacement of treatment for individuals who had been institutionalized as new groups began to utilize mental health services, namely the middle class and those who were not characterized as severely mentally ill. Despite these changes, the mean rate of stay at state asylums actually increased, as less severe cases were released and asylums became the facility of last resort for the severely mentally ill. These individuals were most commonly those diagnosed with some form of schizophrenia.

The shift to the community-care clinical model that we recognize as deinstitutionalization was born out of two conflicting sets of interest that make it difficult to easily categorize the impact of this movement. The first interest was in providing more effective care, something that community-care advocates believed would be easier to provide through out-patient treatment centers. The second and perhaps most motivating reason for deinstitutionalization was the desire by states to reduce the cost of providing care by shifting fiscal responsibility to the federal government through funding opportunities provided under Medicaid, Medicare and Supplemental Security Income. On the one hand, many hail the end of the asylum system as a victory, as the overcrowding and neglect that characterized many of those institutions was viewed as inhumane and, from a psychiatric standpoint, ineffective. Many also advocated on behalf of mental health facility patients, who in many cases had been deprived of their civil rights through their involuntary commitments to state asylums. On the other hand, those who attacked the asylum system and championed the community-based clinical model did not fully
consider the needs of many for whom the asylum had provided a much needed sanctuary, particularly those who required the highest degree of support.

John Talbott succinctly describes the disasters that resulted from the movement to the community-care model, namely the overuse of hospital emergency departments and jails by deinstitutionalized patients, both a result of the discharge of institutionalized individuals into environments that lacked all the services available in the state hospital, such as medical and psychiatric care, social services, housing and nutriment, income maintenance or appropriate employment, and vocational and social rehabilitation.

Around the 1980s, the parallel histories of homelessness and mental health treatment in America reached a convergence point. By this time, most states have fully deinstitutionalized their state-run mental health facilities due to changing attitudes about treatment and the opportunity to shift financial responsibility for the mentally ill onto the federal government. Simultaneously, the legacy of urban renewal has resulted in the absence of low-entry housing such as single occupancy rooms and rooming houses, which had provided the less securely housed members of American society to keep a roof over their heads. The construction of public housing also ceased even before the 1980s with a shift towards the voucher program, and a conscious neglect of existing public housing necessitated much of its demolition and replacement with “mixed-income” housing under HOPE VI in the late 1980s and 1990s.

The 1980s were a moment of great transition that many treated as unanticipated despite being the result of decades of policy decisions that stripped away support and resources from America’s most vulnerable populations. Many American cities found themselves with the issue of visible homelessness in their downtowns during the 1980s, and as cities began attempting to bring tourism and eventually permanent residents back to their city centers, it became increasingly politically necessary to address this issue.

New York City was one of the first cities to recognize and respond to the contribution of deinstitutionalization and the destruction of SROs to the worsening state of homelessness. In 1973, Mayor John Lindsay established a unit to investigate the needs of SRO tenants. In 1981, Mayor Ed Koch’s Office took greater responsibility for development in response to the New York State Supreme Court decision *Callahan v. Carey* which mandated that New York localities provide emergency shelter to those without housing. The Mayor’s Office recognized that SROs could play a major role in helping to meet the now mandated need to house New York City’s homeless population. In the early 1980s, innovative non-profit organizations such as Project Find and St. Francis Friends of the Poor pioneered early rehabilitation and development of SROs to house individuals experiencing homelessness, many of whom had recently been discharged from state mental asylums.

The Mayor’s Office took notice of these efforts and created an early development finance structure to help aid these nonprofits called the SRO Loan Program, which helped make the preservation of SROs financially feasible. This program, along with a 1985 citywide moratorium on the demolition or conversion of SROs, was responsible for the preservation of thousands of SRO units in New York City throughout the 1980s. Organizations such as Project Find, St. Francis Friends of the Poor, the Committee for The Heights Inwood Homeless (now Broadway Community Services), Columbia University Community Services (now the Center for Urban Community Services or CUCS), as well as Catholic Charities of Brooklyn and Queens were all early service providers that created the vision for what housing with supportive services could look like. In the 1990s, additional funding streams, such as the federal McKinney-Vento
Homeless Assistance Act and the Low Income Housing Tax Credit Program both made the development of supportive housing more attractive to larger development groups.

The preservation of SROs and the growing presence and capacity of social service providers resulted in the creation of what we now know as the congregate supportive housing model, which combines the affordability of SROs with the wrap-around services of community-based social service providers, who came to offer case management services to residents where they were living. The development of supportive housing development proved itself in a certain sense with Common Ground’s (now Breaking Ground) acquisition and renovation of the 650 unit Times Square Hotel for the purposes of housing and providing services to 455 formerly homeless individuals. Since that time Breaking Ground and other developers (both private and public) have created thousands of units of supportive housing across New York City, with many more in the development pipeline today.

Connecting individuals experiencing homelessness with housing was another challenge entirely. Programs that attempted to house homeless individuals while requiring sobriety and enrollment in employment programs were largely ineffective, and so a different approach had to be invented. Around the same time that the financing of supportive housing was becoming more stable, in 1992, an appealing concept called “Housing First” was developed by Dr. Sam Tsemberis. While Housing First is not itself supportive housing, the ideas at the core of both are deeply intertwined. These ideas are namely that housing is a human right and that through the stability that housing provides, along with supportive services, those who have experienced chronic homelessness who also experience severe and persistent mental illnesses and substance abuse disorders can live independent and dignified lives.

Research undertaken by Dorvil et al explores the ways in which housing has played a pivotal role in the recovery process for mentally ill individuals. Through interviews conducted with mentally ill individuals in a number of different housing settings, housing was found to be a tool for coping with mental illness, a judgment-free zone where mental illness was accepted, and a place for self-development.

The purpose of providing a historical perspective of supportive housing and the trends that have led to its creation is to contextualize supportive housing as a relatively recent solution to a dual crisis in housing availability and mental health treatment. Although many tireless advocates across disciplines center the homeless population, one of the biggest motives for the widespread adoption of Housing First and the supportive housing model has been that both are proven methods to remove individuals experiencing homelessness from city streets, where they have the potential to create negative impressions on potential residents, customers and tourists. Additionally, both models are much cheaper than allowing individuals to continue to live on the streets, where their presence puts demands on law enforcement, emergency response teams and other municipal resources. The most recent transition to these models of homelessness outreach and housing are echoes of earlier trends in mental health care in America; the persistent determining factor is the balance of costs and opportunities to the relevant government entities.

**Supportive Housing - Contemporary Perspectives:**

Although there are many individuals committed to the mission of supportive housing, the model itself, popularized by its cost saving benefit to cities more than its effectiveness (which might often be conflated as the same thing), is worth interrogating from a more qualitative perspective.
Several such studies have been conducted, primarily focused on the experiences of supportive housing residents. Most of these studies have been grounded in research that asks questions and analyzes trends later rather than attempting to prove a certain theory.

One such study is Bengtsson-Tops et al.'s study, “Living in supportive housing for people with serious mental illness: A paradoxical everyday life” which found that for the 37 supportive housing residents interviewed, many of the things that they liked the most about their living situation also had a negative side that reflected the things they disliked the most about their living situation. The authors found that supportive housing residents experienced a sense of belonging, security, trust, privacy, independence, relaxation, and well-being, but also a sense of neglect, ignorance, dependency, being lost, boredom, and resentment. The authors found that while having their own room made residents feel that they had a private place in which they could relax and that living amongst others in similar situations made them feel that they were a part of a community, they also found that residents felt socially isolated and that their lives were organized around treatment, which they felt alienated them from their own notions about their personal identities.

Brolin et al explore a similar paradox in their article, “Residents’ perceptions of the most positive and negative aspects of the housing situation for people with psychiatric disabilities.” The authors find that while residents enjoyed the independence and the security of having their own apartment, the availability of helpful staff nearby, and the location and opportunity to engage in activities and hobbies, they also felt uncomfortable in the building and the neighborhood and often experienced social isolation.

In “Striving for meaning—Life in supported housing for people with psychiatric disabilities” Brolin et al. aimed to find the primary concern of supportive housing residents in regards to their living situation. The major concern that the authors identified was that supportive housing residents felt that their living situation deprived them of their self-determination. The authors compare their findings to the findings of other similar studies of institutionalized persons, namely prison inmates and nursing home residents. The likeness of supportive housing settings to these other institutions raises additional concerns about their effectiveness as part of a treatment program for severe and persistently mentally ill individuals.

Still, other studies, like the narrative study conducted by Nelson et al, “A Narrative Approach to the Evaluation of Supportive Housing: Stories of Homeless People Who Have Experienced Serious Mental Illness” showed that the lived experience of many individuals living in supportive housing was much better relative to their lives before becoming housed. The interviewed participants cited an increase in feelings of control over their conditions, better access to resources, and greater levels of support as changes they experienced since becoming housed. This study, aimed at relative conditions in participants’ lives before and after being housed in supportive housing, is valuable. Individuals may always have criticisms of their current living situations, so examining how residents themselves feel about whether living in supportive housing improved their quality of life compared to homelessness sheds light on the efficacy of the model.

The experiences of supportive housing residents are informed by their past and their diagnoses, but there are also a number of external factors that influence supportive housing residents’ well-being. While a resident’s past and their diagnosis are factors that residents must ultimately work through on their own time, some of these other factors, such as the quality of service providers
and building quality and design are elements of the supportive housing model that can be improved through study.

It may seem obvious, but a key component of supportive housing is the support that goes along with the housing provided to formerly homeless individuals. As Dr. Tsemberis said at the Georgia Supportive Housing Conference this past November: “Housing first does not mean housing only.” The quality of care that supportive housing staff are able to provide to residents has a significant impact on the overall experience of living in supportive housing.

Kerman et al explore the experience of supportive housing staff in their article, “Towards the Quadruple Aim in permanent supportive housing: A mixed methods study of workplace mental health among service providers” which points to several troubling trends. The staff that were interviewed reported several concerns that contributed to low morale and increased stress among service providers. The authors grouped these sources of stress into three major areas: Sisyphean endeavors, a lack of occupational support, and the wear and tear of continuous exposure to crisis and chaos. The category of Sisyphean endeavors involved being routinely asked to perform tasks that were beyond the scope of their expertise or job description or that were extremely difficult to perform. The lack of occupational support included low pay, unresolved tensions between team members, and unfair balances in workload. The wear and tear of continuous exposure to crisis and chaos included a lack of preparedness for the situations that might be faced during a given workday, workdays that seldom truly ended at 5:00 PM, the death of residents, and continuous exposure to stories of trauma.

The categories of Sisyphean tasks and lack of occupational support in Kerman et al. are particularly interesting takeaways, as they both suggest that the demands of a well-functioning supportive housing site are perhaps much higher than what is currently practicable. Rising to meet those demands might involve incorporating a greater presence of medical and psychiatric services onsite at congregate sites and providing organizations and staff with more funding to be able to provide higher salaries to staff and to be able to spend more on clients.

Another study by Janice McCarthy and Geoffrey Nelson incorporated both resident and staff interviews to evaluate two key processes within supportive housing: social support and control in the residence. Their study found that while residents were mostly satisfied with the amount of support and control they had in their residences, there were areas in which staff exerted unilateral control over decision making without consulting the residents concerned. Supportive staff also reduced residents’ feelings of privacy, but did contribute positively towards helping residents attain a higher level of competence in managing their affairs independently, relating with others and improving self-esteem.

Privacy is something that multiple studies have identified as lacking within supportive housing sites. The feelings that residents express about having their personal privacy invaded is something that can originate with the presence of staff on site, as was studied by McCarthy and Nelson, but it can also originate from surveillance measures implemented in supportive housing sites, as Boyd et al. explore in their article, “Supportive housing and surveillance.” The authors found that all supportive sites profiled in their study had some form of digital surveillance. These surveillance systems were usually monitored by a security desk at the entrance of the building. Security desk employees regulated the common spaces of supportive sites by logging the coming and going of residents, their guests and even professionals entering and exiting the building by requiring the presentation of government issued IDs and the signing of a log book upon entrance. The study also found that there were cases of site-specific coercion, where
Residents were compelled to participate in on-site programming or else risk losing their housing or experiencing some other form of punishment. Strikingly, the authors also found that police officers were able to gain entrance into buildings with greater ease than other individuals and that they were frequently present.

Residents of supportive housing commonly raise surveillance and the invasion of personal privacy as concerns. The degree of surveillance seems to be born out of the contradictory reality of supportive housing, which simultaneously aims to foster independence, while offering support. The independence that supportive sites aim to offer is often not possible without the support of staff, who assist residents in achieving a level of independence through clinical interventions and assistance navigating welfare and medical systems. Other literature has explored privacy in supportive sites in concert with other elements of the built environment, namely Friesinger et al.’s mixed methods review of existing literature, which examines resident well-being, social identity, and privacy. Although the authors are not generating new research in their article, the article provides a valuable synthesis of more than one hundred studies discussing the interplay between supportive housing residents and the built environment. The authors indicate that independent settings received more positive responses from tenants compared to congregate settings with respect to the level of tenant psychiatric distress, recovery, residential satisfaction and adaptive functioning. Higher physical quality of independent supportive housing, richer amenities and smaller-scale were all associated with lower mental health service costs and greater residential stability. The physical quality of the neighborhood also impacted well-being indicators, with recovery and stability being less likely in more deteriorated neighborhoods. Those in congregate settings reported higher quality of life in buildings with areas for tenants to rest or to control their environment or to interact socially. Buildings that were purpose-built were found to work better than those that had been converted into congregate supportive housing.

Elements of the built environment including larger scale buildings, siting along busier corridors, crowded quarters, and diminished building quality are correlated with higher incidence of mental health problems and higher levels of stress. In America, out of practical necessity, most housing developed or renovated for use as supportive housing features some combination of these conditions. The planned development of supportive housing is not generally received popularly by neighborhoods, even within more urban areas, and their siting within these dense urban locations may in some ways exacerbate the mental health conditions of their residents. Despite these findings, siting lower density supportive housing in more low density locations may not comparatively improve resident well-being, as these locations typically allow less opportunity for mobility and lower access to resources.

Measures of social-identity and privacy were both found to be vital to understanding how the built environment impacts supportive housing tenants. Many residents in independent settings were allowed more freedom and were able to cultivate a feeling of belonging to the neighborhood around them and, as Friesinger et al. puts it, “a feeling of being a citizen.” The authors make an important point in noting that in some independent settings and in most congregate settings, the existence of on-site service professionals and surveillance technology placed ostensibly for the safety of building residents actually erodes residents’ sense of self. This erosion of the sense of self was due to unequal power dynamics between on-site staff and tenants. Additionally, constant surveillance led tenants towards the feeling that their identity consists of their diagnosis as a mentally ill person, and not their status as an independent citizen of their community. When a building design includes heavy surveillance, on-site mental
health staff, and constant police presence, the authors argue that supportive housing sites are in essence the same “total institutions” that their predecessors, the asylums, were.

The authors interrogate whether or not supportive housing has significantly shifted the treatment of the mentally ill from the practices of the asylum system. The authors tend to believe that supportive housing is not deinstitutionalization of mental health facilities, but rather the creation of mini-institutions that they refer to as “exitutions.”

The literature generated about supportive housing environments raises further questions about their efficacy in reintegrating residents into the community and as healing environments. Though there are several studies that look into the impact of supportive housing environments on well-being, identity, and privacy, few or possibly none directly interrogate supportive housing as a healing space. Housing has been found to be a key part of the recovery of mentally ill persons; however, its efficacy as a tool for social integration has been found to vary depending on the type of setting that mentally ill persons are housed in. While supportive sites may connect individuals with networks for support beyond the building, some residents expressed the sentiment of being sequestered into a “mental health ghetto.”

The study of environmental psychology connects the built environment to both physical and mental health recovery and bears relevance to the discussion of supportive housing as a healing environment. Cameron Duff identifies three components of positive healing environments in their article, “Atmospheres of recovery: Assemblages of health:” atmospheres of sociality, atmospheres of safety and belonging and atmospheres of hope and belief. These components that make a place a productive place for recovery involve opportunities for social interaction, feelings of security and a feeling of optimism about one’s condition. Aspects of supportive housing, including invasions of personal privacy and autonomy, stifling self-determination, and high levels of contact with other individuals experiencing mental illness, are not always conducive to fostering these key elements for the recovery process.

While there are many positive elements of supportive housing, primarily the provision of a safe and secure place to live accompanied by wrap-around services, it remains important to continually assess how well supportive housing functions as a place for resident recovery and for fostering greater independence. A major criticism of supportive housing is that it is more for the benefit of the general population than the residents themselves, serving as a convenient place to warehouse a population that many view as undesirable. The stigmatization, alienation and general lack of care for mentally ill persons is not a new facet of our society. The attempt to control, criminalize and regulate the mentally ill on behalf of the comfort of the general population goes back centuries. The stigmatization of this population manifests itself in our cities through the concentration of severely and persistently mentally ill individuals experiencing homelessness in service dependent ghettos, a segregation that has continued in some ways into the solution to this problem, supportive housing.

In recent years, there has been greater discussion around the de-stigmatization of mental illness, though individuals who experience mental health issues still face barriers that can prevent them from being fully accepted within our society. The forces of gentrification and financialization, however, continue to disrupt the re-integration of historically marginalized individuals back into our society. As a practical reality of development finance and available rent subsidies, the housing for this group exists largely in a category of its own, as they are often unable to pay rent themselves and are reliant on public programs to assist them in paying for shelter.
The call from academics and researchers in the fields of city planning and public policy for a “right to the city” continues to go unheeded in America, meaning that even as we grow to accept those who experience mental health issues, their integration into the fabric of mainstream society may still be far from practicable. The right to the city challenges the dominant urban development models that prioritize profit and the interests of the wealthy over the needs and desires of urban residents, particularly marginalized and disenfranchised groups, such as those who live in supportive housing. The concept of the right to the city emphasizes the idea that all people have a right to actively shape and participate in the creation and use of urban spaces. It is a collective right that includes the right to access and use urban resources and services, participate in decision-making processes that affect the urban environment, and contribute to the cultural, social, and economic development of the city. As it stands, poorer residents, including those who live in supportive housing, are limited in the ways that they are allowed to participate in the shaping and enjoyment of the city.

In the intervening period before true integration is realized, it is important that we approach a greater level of understanding about what supportive housing looks like in practice. From these observations, we must, develop guidelines for future developments in supportive housing so that they are more capable of fostering healing environments in which individuals are treated with dignity and empowered to live more independent lives.

**Key Question**

This paper will build on the existing literature by exploring the environmental factors that supportive housing residents and staff feel are influential on the quality of life of supportive housing residents. Quality of life can be defined simply as the standard of health, comfort, and happiness experienced by supportive housing residents. Although this study utilizes grounded methods of data collection and analysis, there are several quality of life indicators that I felt had relevance, due to my past experience in working in supportive housing. Some of the influences that I hypothesized might be most influential were the quality and location of supportive programs, the interactions between residents and program staff and resident feelings of isolation from a sense of community.

**Data**

The data used comes from interviews conducted with supportive housing staff and residents. All persons interviewed as part of this study live or work in New York City. All personally identifiable information has been removed and interviewees’ names were not recorded at any point during this study. With consent from interviewed subjects, interviews have been recorded in order to assist with recall and to ensure accuracy.

In order to collect the data used in this study, I traveled to New York City between December 22, 2022, and January 4, 2023 for the purpose of identifying interviewees and conducting interviews. The primary method of outreach for supportive housing staff was by phone, utilizing past contacts within the supportive housing network of New York City. I interviewed five total staff, three of whom are currently working in supportive housing, and two of whom previously worked in supportive housing. For outreach to supportive housing residents, many of whom do
not have a reliable method by which they can make phone calls, the method of outreach required a mediating party. For this purpose, I contacted the organization SHOUT NYC, a tenant organizing group for supportive housing residents founded in 2021. My contact connected me with three members of the organization who were eager to be interviewed for this project. Supportive housing residents were provided with financial compensation for their participation in this study, which amounted to $15.00 for each interviewed resident, a sum which was sent via USPS certified mail to the addresses that participants provided.

The choice to interview more staff members than residents is based on the idea that supportive housing staff are the most experienced observers of supportive housing environments and are intimately acquainted with the needs and sentiments of residents. As observers, staff provide an excellent resource for gathering information about what supportive housing looks like in practice. While supportive housing is a person-centered practice and interviewing supportive housing residents has provided additional insight into how supportive housing functions, staff are positioned particularly well for the purposes of picking up on general trends and observations, making the data collected from staff slightly more generalizable despite the relatively small sample of staff members.

I would have liked to have more supportive housing staff participants in this study from beyond my own network, as the small sample size and my familiarity with some of the interviewed staff members reduces the generalizability of any findings of this study. One obstacle that I encountered when I was initially contacting supportive housing staff members was that staff members felt that in order to talk with me, they would need to get permission from their supervisor. Almost always, their supervisor would tell them not to speak with me. Although outreached staff were informed that their personal information and the names of their organizations would not be disclosed in this study, the organizational desire to avoid unnecessary attention managed to pose a limit on my ability to gather interviews. Additionally, supportive housing staff are generally already overworked and underpaid, and many may not have a personal desire to speak with me about their work on their own time.

Although I attempted other methods for contacting residents, the method by which I was most effectively able to obtain resident interviews was through a representative of SHOUT NYC. Because of the interviewed residents’ enrollment with this organization, study participants may have been more likely to harbor negative feelings about supportive housing than residents who are not members of SHOUT NYC. The technical barriers that exist which make contacting supportive housing residents more difficult required that this method of outreach be utilized if I wanted to interview any supportive housing residents for this study, but the biases of interviewed residents may reduce the generalizability of the data collected through resident interviews.

While several interviews were conducted in person, a number of the staff and all three of the residents that I was able to contact were unavailable during the time period that I was in New York City. For this reason, a number of interviews were conducted virtually, utilizing Teams and phone calls. Five interviews with supportive housing staff were recorded with permission in the process of conducting this study via the iPhone Voice Memo app or the record function in Microsoft Teams. The three interviews conducted with supportive housing residents were all conducted over the phone and recorded with permission using an external recording device.

The completed recordings of each interview were added to a Dropbox folder, after which, the file was deleted from my iPhone and computer. The iPhone voice memo app names each recording
according to the physical location, adding a built-in level of anonymity for interviewees. For example, a file name might be something like “Clinton St.”.

The interview recordings were reviewed and individually summarized for ease of use. Data was organized and grouped to address the questions of interest of the study. The review process of each interview included the use of a transcription software, Otter.ai. Response summaries were then written using the interview guide template. This mode of organizing the data allowed for responses to be matched with topics that correspond to the questions of interest in this study.

**Methods**

The method of grounded, ethnographic research was applied to the data collected. Ethnographic research was the best fit for this study because, while many metrics could be employed to measure the questions of interest, qualitative grounded in personal experience allows for a more nuanced exploration of the questions. In the complicated and multilayered supportive housing environment, raw numbers would likely only tell a partial story. The relationships between supportive housing residents and their environment are often unquantifiable.

While I entered into this project with my own ideas about supportive housing, I felt that it was important to have a grounded approach to analyzing my data. My experience is limited by the simple fact that I am one person and supportive housing is a system of thousands of individuals who either live in supportive units or work to support its operations, and I wanted to see what themes and ideas arose naturally from asking questions. My questions were intended to assess how well supportive housing staff and residents felt that supportive housing lived up to its goals of providing adequate shelter, providing supportive services to residents, and assisting with recovery and social reintegration. I also asked questions about the way space was used and what relationships looked like between staff and residents.

The questions that were posed to supportive housing staff were as follows:

1. What services do you provide to your clients/residents of supportive housing?
2. Where is your office in relation to the residences of your clients?
3. What impact do you feel the location of your office has on the relationship you have with your clients?
4. What impact do you feel the location of your office has on your ability to assist your clients?
5. Do you feel that there is a clear delineation between resident space and staff space?
6. What role does staff play in shaping resident space? (How do you feel that provider presence on-site impacts the use of spaces that are neither residents’ units nor designated work spaces, such as lobbies and hallways)
7. What goals do clients most often request or require your assistance in achieving?
8. What do you feel your role is in helping clients achieve more long-range goals?
9. How often do clients “graduate” to other, more independent forms of housing?
10. If clients do not graduate/not many graduate: Why do you feel that clients do not graduate at higher rates?
11. Do you feel that supportive housing is useful in aiding residents to achieve healthier, more independent lives?
12. What defines a good client relationship and what sorts of things might lead to a bad client relationship?
13. How do you feel that race interacts with the model of supportive housing and the provision of services?
14. Where are your clients coming from? (culturally, racially, ethnically, gender identity, sexual orientation, physical location, etc)
15. Do you feel that the environment of the building is conducive to client recovery?
16. How connected do you feel your clients are to a community outside of the building that they live in?
17. How well do you feel the supportive housing site that you work at creates opportunities for residents to integrate with the surrounding neighborhood?
18. What does the community among residents look like inside of the building you work at?
19. What programs do your clients participate in that you feel are most central to their health and wellbeing?
20. What services or programs would your clients benefit from accessing that are currently unavailable or that they are unable to access?
21. Do you feel that institutional or organizational demands impact the services provided to your clients?

The questions that were posed to supportive housing residents were as follows:

1. How did you come to live in supportive housing?
2. Where were you before you were housed in your current residence?
3. Do you ever return to that place or any other place that you lived prior to moving into your current residence?
4. Were there any people or organizations that were helpful to you in finding your current residence?
5. How has your life changed since you moved into your current residence?
6. What qualities about your current residence do you like and which do you not like? Why?
7. What qualities about your current building do you like and which do you not like? Why?
8. Do you feel that you have autonomy over your space at your current residence?
9. Do you feel that building management treats you with respect? Have you had any issues dealing with building management?
10. Does your building have community spaces and do you utilize these spaces? Why or why not?
11. How connected do you feel to your neighbors?
12. Do you feel connected to a neighborhood or community that is not your current neighborhood and community? How often do you visit that place and connect with that community?
13. What is your relationship like with supportive housing staff like?
14. How well are you able to access the services, amenities and resources that you need on a daily and weekly basis

Analyzing the data collected through a grounded, ethnographic lens allowed for the major themes and conclusions of this research to emerge organically, rather than imposing a theory to be proved right or wrong. The grounded, ethnographic approach was particularly well fit to this research project, as it allowed for the incorporation of nuanced perspectives on supportive housing. Ultimately, the analyzed data resembles a dialogue more than a purposeful march towards an answer about the efficacy and humanity of supportive housing, which feels fitting given the complex and extremely human area of study.
The interviews conducted were analyzed using the constant and comparative method, which involved identifying themes and patterns that emerged from the data, comparing them to existing data and developing categories that reflect the data. Applying a constant and comparative method was most appropriate as it allowed for the identification of patterns and themes across the interviews. The constant and comparative method involved repeatedly comparing and contrasting the data collected to identify similarities and differences and to develop a more comprehensive understanding of supportive housing.

Open and axial coding were then used to organize the data and to identify patterns and themes that emerged from the interviews. The use of open coding first allowed for the exploration of the data in an open-ended and inductive manner, which allowed for themes and patterns to emerge from the data without preconceived categories or theories. Axial coding was then applied to provide a greater level of organization to the data, and allowed for the identification of relationships between codes to create more focused categories.

In order to complete the initial open and axial coding process, I reviewed the transcripts of each interview and entered quotes into a Word document. I then associated each of the quotes with an open code and attached various axial codes to provide additional layers of detail. The unique open and axial codes were then entered into an Excel workbook. The open codes were then also combined in various ways. For example, two open codes, ‘Spatial Relationships’ and ‘Quality of Life’ were combined to form another unique code, ‘Spatial Relationships and Quality of Life’ as many of the responses pulled from the interview transcripts related to two or more of the emergent themes.

In the process of coding, four code categories emerged in addition to Quality of Life: Spatial Relationships, Relationships Between Residents and Staff, Community and Resources, and Institutional Factors. These categories are defined in the following ways:

- **Spatial Relationships**: quotes assigned this code pertained to the way the physical environment, both inside and outside of supportive housing sites, impacted residents’ quality of life. Examples of the physical environment include the condition of the building in which interviewees lived or worked in, the size of apartments at the program, and the ease with which residents were able to access other parts of the city from the supportive housing residence.

- **Relationships between Residents and Staff**: quotes assigned this code pertained to the way in which interactions between supportive housing residents and staff impacted resident quality of life. Responses that were assigned this code do not include statements about the relationships between residents and other building staff, such as maintenance or building management, nor between residents and outside service providers such as doctors or social service employees (such as HRA and Social Security). Perhaps because this research utilized interviews with staff and residents, the relationship between staff and residents emerged as a major influence on resident quality of life.

- **Community and Resources**: statements assigned this code pertained to the way in which supportive housing residents’ degree of connection to community impacted residents’
quality of life. Community can be difficult to identify and many forms of community emerged as influential on quality of life. Some interviewees identified community as stable relationships with formal support systems, such as a substance abuse treatment program. Other interviewees identified sources of community that were more informal, such as the support of friends, family, or a broader network (i.e. the New York city art community or the LGBTQ community). These forms of community existed both within and outside of supportive housing programs. Throughout the interview process it also became clear that community could serve both positive and negative functions depending on what defined the community. Community was also identified by both residents and staff as serving a key role in the recovery process.

- **Institutional Factors:** statements assigned this code pertained to the way in which systems beyond the immediate supportive housing setting and supports influenced residents’ quality of life. While this category is a bit of a catch-all, many of the responses that were ultimately assigned this code detailed influences that ranged widely. These influences included interactions with outside service providers such as maintenance or building management staff, as well as outside service providers such as doctors or social service employees. These influences also included general issues with the experiences of navigating systems, as well as experiences rooted in the ways in which resources have historically been distributed in our society.

Within the results section supportive housing staff will be referenced as “staff” and supportive housing residents will be referenced as “residents.”

Results

The following section details how supportive housing residents and staff describe how Spatial Relationships, Relationships Between Residents and Staff, Community and Resources, and Institutional Factors influence resident quality of life within supportive housing programs in New York City. Although these four general areas of influence have been identified as distinct categories that influence resident quality of life, there is significant overlap between each of the categories. These overlaps will be addressed in the discussion section.

Spatial Relationships

The ways that residents experience their physical surroundings play an important role in shaping the quality of their lives in supportive housing programs. The influences of these physical aspects of supportive housing environments fall roughly into three sub-categories: building common spaces, residents’ dwelling units, and resident access to the city.

Common Spaces

During the time that I worked at a supportive housing program, I was introduced, not uncoincidentally, to the concept of the panopticon. A panopticon is a design of institutional building with an inbuilt system of control, and is a term that was first coined in the eighteenth century by Jeremy Bentham. The idea of the panopticon was first applied to prison
environments, where Bentham imagined a building design in which one guard could observe every inmate from a single vantage point while none of the inmates would ever be aware if they were being observed or not. The design would lead to “perpetual visibility” which Bentham theorized would lead to greater discipline and self-control among the inmates. While the panopticon design itself is ultimately tangential to this study’s results, the responses of residents and staff pertaining to communal spaces within supportive housing programs focused heavily on the elements of observation and policing that they experienced as a central component of these spaces, which generated a feeling of institutionalization for some.

The communal spaces of supportive housing programs include the lobbies, entranceways, and the hallways of residential floors, in addition to staff offices. Other communal spaces may function like a lobby space, such as a mezzanine level that includes seating and tables, a rooftop space which is freely accessible to tenants and staff, and private community greenspaces. In addition to these lobby-like spaces there may be other freely-accessible specialized spaces, such as libraries, gyms, computer labs or community rooms. In many of the newer programs that interviewees lived and worked at, the inclusion of these amenities was prioritized and the rooms were not excessively regulated. The existence of these positive community spaces contributed towards increasing resident quality of life; however, these spaces often have less-through traffic.

These common spaces have the shared quality of being freely accessible to residents and staff. Both groups are acutely aware of this and have complicated thoughts and feelings about this shared accessibility. The ability of staff to access and exist freely in these community spaces allows them to observe residents’ behaviors. The opportunity for observation is something that residents and staff recognize as complicated. On the one hand, staff observation of residents can allow staff to notice when resident behavior requires intervention and can allow for deeper understanding of resident patterns, ideally allowing staff to provide better support to residents. Observation can, however, be experienced as an invasion of privacy, not only by residents, but by staff who recognize that with the access that they have to residents, they have the ability to wield a degree of power over them.

Because staff are able to observe communal spaces, they are able to take notice of things like a resident who reports they have stopped using substances but suddenly appears intoxicated. This observation may lead to candid conversations between residents and staff and be the genesis of a goal towards recovery. Concerning observations can also lead to unplanned emergency hospitalizations, which can be traumatic, stressful or viewed as unnecessary by the resident. Communal spaces can also be valuable to staff as they allow staff to build rapport through more casual interactions; for example, a staff member might strike up a conversation with a resident about the weather, their plans for the weekend, or something related to the circumstances of their interaction, which can create a feeling that staff are almost like a neighbor.

Resident awareness that staff are observing communal spaces can also discourage them from utilizing common spaces altogether, particularly if they have an awareness or a suspicion that their behavior might draw attention from staff and lead to unwelcome interventions. Some residents place a high degree of importance on avoiding staff altogether, orienting their entrances and exits from the building to ensure that they do not interact with staff. Aside from the observational elements built into program common spaces, some residents also found common spaces to be unpleasant because of the presence of other residents who may bother them or potentially pose a threat to them. Common spaces are also used differently by
supportive and non-supportive tenants, as supportive tenants tend to be around more often during the day and may spend more time in common spaces as a result. This may lead to non-supportive tenants having negative feelings about supportive tenants or about the building as a whole.

“The first building I worked in, people were around more and used the hallways and the lobby as those public spaces in a way that was perceived negatively by the tenants that were non-supportive, because their neighbors might have been panhandling or being loud, or causing disruption to what you would think of as a nice place to live. But in the first building they also didn’t have those nicer spaces to convene. So you have to put yourself in the perspective of the clients; if you’re home all day, and you don’t want to be in your apartment, where are you going to go? And if you’re used to being around people on the street, you want to be around other people, so you’re gonna go to the lobby or into the hallway, or into the staff office.”

Building common spaces can also be policed by building management. One staff member recalled that at the program at which they worked, building security would take issue with residents hanging out in the lobby and would encourage them to move along or to return to their apartments:

“Security took the position of saying, ‘Okay, you have to keep moving, move along, the lobby is not a place to hang out’. Residents could come to the lobby to get their mail, submit a work order at security, go to the maintenance office or tenant services, but then they were supposed to keep moving along. I think on the one hand, that sounds kind of sad, because it does feel like the lobby should be a place where people can gather, but, they had to weigh that against a lot of the issues that were coming up with being in the lobby.”

The use of communal spaces within supportive programs can also be highly regulated, with rooms referred to as “community rooms” actually kept locked most of the time and only made available to residents when a staff member was present. Some residents take issue with the way in which community rooms are controlled and believe that the control of those rooms is part of either a conscious or unconscious effort to discourage residents within programs from getting too well-acquainted with one another.

“Another guy I met, we have six floors, and they're very small, so it can be hard for us to get to know each other, but another guy shared his concerns about tenant organizing, and his opinion, was that the main housing organizers were trying to deter us from forming a tenant group. Also, the rules that a lot of us are facing in our buildings can deter community from forming. For instance, if we wanted to use the room, like a community room, we have to have an employee with us, so if we wanted to have a tenant’s group, how fair is that if we wanted to have a tenant’s meeting that we’d have to have a member of the staff with us?”

The furnishings of communal spaces can also discourage the use of these spaces. Furnishings of supportive housing programs are susceptible to bed bug infestations and soiling due to the fact that the population of supportive housing programs are sometimes in the process of transitioning out of homelessness and may still lack some of the hygiene skills that many
consider basic. One staff member recalled the way that furnishings ultimately impacted the use of lobby space:

“At the first program I worked at, the lobby was initially a place where the clients could hang out and they had chairs and you could sit down there. Over the years that I worked there however, a combination of many major bedbug infestations with the furniture in the lobby, and the chaos that could ensue in the lobby and because of all the comings and goings and the drug trade and all of that, they not only did away with the furniture so the lobby was no longer a place where you could sit and hang out, but it also became a place where you couldn’t stand and hang out.”

This same staff member described the way that another part of the building, a mezzanine level overlooking the lobby, successfully served as a space in which residents felt welcome and avoided some of the pitfalls of the lobby.

“There was a mezzanine where you could hang out, and I think it was mostly well used. There were a limited number of tables and chairs, so it wasn't like everybody could be there all the time, and it was like it was out of the way, in terms of there wasn't a lot of traffic around there. It was good because sometimes staff could meet with clients on the mezzanine as long as the client was okay with it. If you had a client who actively had a bedbug infestation, it was a good place to meet with them, because it was easy to exterminate the furniture there.”

For all of these reasons, residents may view common spaces as unpleasant or purely functional places and can contribute towards a feeling that they are living in an institutional setting. While residents may consider aspects of these spaces unpleasant, these same aspects are advantageous for staff who are able to freely observe residents' behaviors and provide clinical interventions when necessary.

**Dwelling Units**

As detailed in the historical portion of this text, supportive housing in New York City grew out of the push to preserve single-room occupancy hotels in order to house very low-income residents of the city. Most, if not all, of the residents of these SROs would have been homeless without that important supply of deeply affordable units with low barriers to entry. Some of the preserved SRO hotels have become supportive housing programs, and the acronym SRO is still used to describe many of the supportive units in New York City. During my own time working as a case manager at a supportive housing program, which was a converted SRO hotel, I felt that the rooms themselves created a feeling of transience. I couldn’t help but feel that even though the units were described as permanent supportive units, the fact that they had previously functioned as hotel rooms generated a pervasive feeling of temporariness.

This feeling of transience was one that, as it turns out, was not one that I was alone in feeling. Many of the residents and staff that were interviewed echoed similar feelings about their living situations, which stemmed primarily from the size of the dwelling units in which they lived. Additionally, one resident in particular voiced that building management had initially justified the small room size to them on the basis that community spaces were included in the building and
that access to those spaces would compensate for all that the room lacked in size, however the reality of living in the building was much different:

“The apartments were smaller than what was legally required, because their justification was that in our building there were these common areas built in, so therefore, people wouldn’t really be in their apartments, but they really wouldn’t allow you in the common areas where there was one TV and people would fight over it, so the common area justification didn’t even really apply.”

Besides the feelings of transience and claustrophobia, staff also expressed that unit sizes were often too small to realistically promote residents’ health and well-being, especially for residents who were limited in their mobility and required additional assistance within their unit.

“The apartments for the formerly homeless clients who have a psychiatric and or substance abuse disorder, are too small. I don’t think that their quality of life can be optimized living in such a small apartment and I wonder a lot about what effect living in such a small space has on them with maybe one window. The other issue with the apartment sizes is that you wind up with people who are wheelchair bound living in those small apartments, and they shouldn’t be living there. They get in there and the reality is that they can be in there in their wheelchair, and there’s the bed, and there’s the dresser, and they can’t move, and they can’t have another person in here to help them because it’s too small. I think that’s a serious issue. I’m not in a position to change it. If I had the power to, I would remodel the building so that there were maybe 20 apartments per floor instead of 52. Then people could have space and live with more dignity. The building I work at now, however, the apartments are beautiful and I would personally live in one of those.”

The problem highlighted in the quote above can have profound impacts on a resident’s health and well-being. A person with mobility issues may have difficulty keeping their unit clean, and the space supposed to be a home can actually become very unsafe for someone with mobility issues. These issues can snowball to the point where a unit may become so unclean that a home health aide, who might be able to help a resident keep their space clean and safe, will refuse to enter the apartment, creating a catch-22.

Small unit size also imposes significant constraints on residents’ storage space. For some who have lived the street homeless lifestyle for years, there can be a strong desire to secure all of their belongings. On the street, this was limited to what they could carry in a bag or in a shopping cart, but in a residential setting they can fill their entire room. Clutter of this kind can be considered abnormal; however, there are many residents with a normal amount of belongings that make a very small space seem cluttered and out of control. The feeling that one’s personal space is cluttered can be experienced as stressful by residents and viewed as detrimental to health by staff.

Small unit size is informed by the reality that the residential square feet of supportive housing developments are much less valuable to developers and building management companies than market rate or even lightly affordable square feet. Additionally, the aim of supportive housing in many ways is to get as many people off the street and out of site as possible, so developers are incentivized to put as many apartments in one building as possible. As a result, projects often
include many very small units, which can lead to more opportunities for conflict and greater wear and tear on the building.

While practical financial realities may limit the size of supportive units, it is important to take note of the way that smaller units can actually be a detriment to individual programs and to the overall project of supportive housing. Residents living in units that they feel are too small can rob them of their dignity, induce stress, and pose a safety hazard for those with physical disabilities.

During the data collection process I spoke with three individuals who either lived or worked in supportive programs constructed in the last five years. Small unit size was not an expressed issue in these newer developments; however, other features of dwelling units indicating poor quality construction impacted resident well-being. One of these newer programs was described by a resident in the following way:

“In my case the owner, the landlord, the agency, might have good buildings because I think they have over 1,000 units that are divided across different projects or buildings. So some of them might be good quality, but for instance, the one I live in is really not. It's the exact opposite of their best and from what I've been told by people who live here, it had to do with a subcontractor. Whoever got the contract to build the actual building sent it to a subcontractor. And every time that happens, somebody pockets money and less money goes to the actual building of the building. Somebody built it with sub quality materials. I live on the second floor and I can hear people on the sidewalk having a conversation, even if they're not yelling at each other. I hear my next door neighbor. The walls between her apartment and my apartment are thinner than most people’s walls in their own house. And so I hear her scream, I hear her sneeze, I hear her laugh. I hear her on her phone, I hear her radio, I hear her television, and I'm supposed to be able to actually sleep and relax or have a phone call in my apartment, and I can't because of what she does. My upstairs neighbor has caused five floods in two years, and he has a history of flooding my apartment before I moved in. When he floods my apartment, it'll end up sparking the electric box, which then causes the fireworks to appear in my apartment, so then the fire department has to come and cut off my power supply, and I have to go somewhere for two weeks until they can finish drying out my apartment. And so that's just an example of how these buildings are not exactly built appropriately.”

In addition to the small size of dwelling units, units often lack basic amenities, such as a full kitchen, which can make eating healthy food on a limited budget nearly impossible. Despite these drawbacks, dwelling units are one of the great strengths of supportive housing, as they provide residents with a space that is essentially their own. Having a secure place to live can contribute towards greater feelings of stability and autonomy among residents who have had long histories of street homelessness and general housing insecurity.

**Resident Access to the City**

Just as common spaces and building amenities can increase quality of life for residents, so too can siting a supportive housing program in the right location. The program that I worked at was located in a busy part of Manhattan, and while its central location and access to transit allowed residents to access many other parts of the city, there were barriers that still negatively
influenced residents’ quality of life. While transit stop entrances were immediately adjacent to the building, the nearest elevator-accessible entrance was two blocks away. This may not seem far, but for anyone with mobility issues, two blocks can pose a substantial barrier to accessing transit, especially in an area where crowds can make it difficult to navigate sidewalks. Some of the elderly residents were genuinely scared to go outside during the day because of how overwhelming the crowds of people were for them. Outside observers taking notice of the program’s location may feel envy for those who lived there due to its centrality and access to transit; however, program siting considerations for residents require added sensitivities to the needs of this population.

Neighborhoods in New York City are far from equal, and some have experienced historically low amounts of public investment. Underinvested neighborhoods present both opportunities and challenges, as the costs of development in those neighborhoods are often significantly lower than in other parts of the city that are more rich in resources, but that very lack of resources can negatively influence residents’ experience of living in supportive housing. A supportive housing staff member that worked in the Bronx detailed the influence of neighborhoods on residents in the following way:

“I think features of the neighborhood influence the degree to which residents are able to integrate into the surrounding neighborhood. If there’s bad infrastructure around the building like at the first building I worked at where there’s potholes all over the place, and it’s not safe, and there are buses going really fast, it’s not a pleasant neighborhood, so people don't want to leave the building, there is nowhere they can walk to that's nice. Whereas the building I work in now is really nice, there are parks within walking distance and there’s a lot of retail, restaurants, transit, it's really easy to get into Manhattan. So people definitely do consider the neighborhood as part of their experience”

The way that the shelter system and similarly the supportive housing system function in New York City often means that those seeking shelter will be assigned to a shelter or provided a housing opportunity that is far removed from the parts of the city that they know well. In addition to feeling that the neighborhood around the building is not pleasant, the added layer of being unfamiliar with the neighborhood can lead to feelings of isolation and dislocation.

Many of the residents and staff that I spoke with either lived or worked in supportive programs in the Bronx. While the need for supportive housing is great in the Bronx and many of the residents placed in supportive units in the Bronx are life-long Bronx residents, there are also many cases where residents are placed in the Bronx because it's the first option given to them after a long period of experiencing homelessness. Residents moving to the Bronx for the first time may ultimately end up feeling disconnected from all that is familiar to them. The current systems in place do not make it practical for every supportive housing resident to end up living in a unit in or near the places that they are familiar with. This does, however, raise questions about whose considerations are prioritized when supportive housing programs are constructed, as placing residents within neighborhoods that they are familiar with already would go a long way in stabilizing residents.

The siting locations of supportive programs often stem from practical considerations, such as financial feasibility, neighborhood interest in the project, and organizational needs. A staff member that worked in the Bronx had this to say about the supportive programs that they worked in:
“At the first building I worked at there was a hospital located across the street and that was a great and useful resource for us as staff and for residents who needed medical care, but it was just one amenity. This new building has a workforce development office and a grocery store, it’s opening so I think that’s one of the movements with supportive housing is providers and developers saying ‘We’re gonna get this housing and something that the neighborhood and residents need in the same building’, which I think it’s good but it’s not enough, You need the whole neighborhoods to be nice resource rich places to live.”

Prioritizing organizational and staff needs in the first instance certainly made coordination with the neighborhood hospital much simpler, but as they noted, the hospital was essentially the only real amenity in the area and not everyone who lives in supportive housing will utilize that amenity regularly. Additionally, a hospital can be a noisy neighbor with constant comings and goings of emergency response vehicles, which can increase residents’ stress levels and contribute to an atmosphere of chaos in the adjacent neighborhood. In the second case that the staff member mentioned, the building was constructed with amenities that not only benefited the residents of the building but also neighborhood residents. These amenities undoubtedly confer benefits onto the residents in ways that are unique, and simultaneously anchor a disinvested community around the supportive site, which many communities might attempt to isolate. The last point that the staff member made reflects that even high-quality supportive programs in disinvested locations cannot single-handedly increase the quality of a neighborhood. Ideally, supportive programs would be available in all parts of New York City, which would allow for residents to be housed within a neighborhood that they are familiar with, and ensure that supportive sites are not being relegated to more disinvested neighborhoods within the city.

Locating supportive programs evenly throughout New York City would be an ideal scenario. Short of this provision, ideally supportive sites would be well connected to transit so that residents could access services and communities that they feel affiliations with. A lack of transit can lead to significant strain on residents that need to access services that may not exist within the neighborhood their program is located in. One resident described their experience in accessing health care services in the following way:

“My health care’s all on the Upper East Side, and I require quite a lot of appointments to manage my health conditions. During COVID, it wasn’t necessarily a problem because I didn’t have to travel anywhere for appointments, but then once restrictions were lifted, I had all these appointments to catch up on like other people did. Essentially door to door, it could be almost a three-hour commute for me to get there, and back, and it was exhausting to the point where I was really mentally depleted. Sometimes I would miss my appointments, because it was just too overwhelming to think about; changing all the trains and getting there, that was a little bit too much for me to process.”

Not only can a lack of transit make getting around the city inconvenient for a population that is heavily reliant on public transportation in order to access services, jobs and other supports; it can be highly isolating to be living in a place that lacks transit connections. If it is difficult for a resident to travel to see friends, family or even service providers that they feel a connection with, it is likely that those relationships will cease to offer the same level of support that they would if transit connections were more robust.
“I was put in a facility that was way out in Brooklyn, a mile away from a subway station, and in a really terrible neighborhood on the outskirts of Bed Stuy, not really even Bed Stuy. It was a huge detriment in terms of my being able to navigate. Because I do have so many physical health appointments, and then I wasn’t able to utilize the free things about living in the city that make it worth it, I was really quite isolated.”

For those who face obstacles to utilizing transit, there are other options available in New York City, including Access-A-Ride and Med Answering, which provides transportation services through rideshare companies like Uber and Lyft and is Medicaid reimbursable. Both of these services require a level of competence with smartphones or computers in order to schedule rides to and from the places that residents would like to go. The elderly, who represent the most obvious group that would benefit from these need-based transportation services, are often unable to use technology well enough to practically utilize them, which can lead to a lack of follow-up around medical care and increased feelings of isolation.

While practical considerations of siting supportive housing programs can ultimately dictate where these programs are located, there are many benefits to siting programs in locations proximate to community resources and high-quality transit connections. These include increased desire to engage with the neighborhood that programs are located within, decreased feelings of isolation, and the ability to maintain relationships with personal networks, care professionals, and other resource providers.

Relationships between Residents and Staff

A defining component and integral part of the residential experience of congregate supportive housing is the presence of supportive services on site. The data collection process revealed that the relationship between residents and staff was key to resident quality of life, as staff are a highly influential part of these programs with the ability to make living in supportive housing either a more positive experience or a more negative one.

“I think that the sad truth is that supportive housing’s ability to help residents live healthier and more independent lives depends a lot on the service providers and the organization and the housing. So much of the services and the quality of the care depends on who you’re working with. You could be living in the same place and have two separate people you’re working with, and one just far exceeds another in what they’re doing in the job. Think of any job, there’s going to be a bad doctor, there’s the old joke that goes ‘What do you call the doctor that graduates last in their class? Doctor.’”

For many residents of supportive housing, traumatic past experiences limit their capacity to form new connections and rekindle past meaningful connections. Relationships with staff can end up being some of the most important in their lives. This section is divided into four subsections: support and invasion of privacy; trust, boundaries and opportunities for genuine human interactions; staff turnover; and racial dynamics.

Support and Invasion of Privacy
Throughout the data collection process, a key theme that arose was the tension between staff wanting to provide support and positively influence the lives of residents and residents desiring to live independent lives without interference from staff.

“I think it depends on clients’ individual differences. I think that some clients or residents find it comforting to know that they have support that’s accessible to them so close by. For others, I think it feels very much like they’re like children, and like we’re babysitting them, or we’re watching them. I think for those who have historically experienced a great deal of trauma at the hands of the systems in place, that there is inherently a structural imbalance in power. So I think staff presence on-site can be a reinforcement of a power structure. On the other hand, as a service provider, I think it gives you the ability to observe the flow of an environment in its natural form. But I also wonder whether that is its natural form since you’re observing it. So I do think that there’s that aspect of it. In terms of safety, I think for clients it’s helpful because you are really able to understand someone’s day-to-day schedule if you have the routine of seeing one individual every day, or you’re really able to follow up with them pretty closely. But I also think the goal of supportive housing, or at least the way I see it, is to provide an empowered and supportive space for people to live independently, and seek services in a way that benefits them. And it raises the question of whether you are disempowering someone by being there all the time? Or making them feel like it’s a jail that you can’t leave? So I think it’s a very fine line, I think it depends a lot on the individual and the service provider.”

There were two main types of relationships that existed between residents and staff. The first group of residents welcomed the built-in support system on site. These residents may have had issues and goals that they sought out staff support work on, or may have had little need for interactions with staff but appreciated their presence. Within this group were residents who sought out support from staff, but were displeased with the degree to which staff were able to assist them, describing staff as “incompetent” and “lacking integrity.”

The second group had no interest in interacting with staff. While resident interaction with staff is not necessarily a requirement of any supportive site, staff are required to outreach residents on a regular basis even if they refuse services every time. This group may have had issues which were apparent to staff and other residents of the program but were not interested in working with staff to address those issues. Within this group there were also more high-functioning residents who generally did not require any assistance from staff. These residents either made a point of avoiding staff or were busy to the point where they were rarely at their apartment during staff work hours. Staff often recognized the invasiveness of their role, particularly as it related to non-engaged residents who they would be required to outreach regardless of their interest in services. Invasiveness could be passive, such as the types of observation possible in the common areas of a program, but could also include more active forms of invasiveness, such as key-ins into resident apartments:

“I almost think of it like you’re in high school and you’re in the lunchroom. You are in a space where you are with your friends and you’re free to have a conversation. But you are acutely aware of the supervision and the monitoring. And so I think that does inform the way in which people move about spaces, the ways in which they are meeting, coming and going, aiming to be a bit more unseen, or being hyper aware of employee schedules. I can think of clients who
would only leave the building before nine and come back after five. And I do think there’s some merit to being aware of that. A client might think ‘Okay, well, if I want to maximize my privacy, and I’m not required to see these people, then I do want to avoid the areas in which I might be forced to have a conversation because as much as it is not mandatory, it can be very challenging to avoid being engaged with service providers’ given the access that a case manager or social worker might have. For example, key-ins, that’s not a thing in independent housing. A key-in is the biggest invasion of privacy, and the circumstances in which staff would actually utilize key-ins are really pretty subjective. It has a lot to do with the service provider. I mean, there can be more strict enforcement of it when someone hasn’t been contacted or seen in a month, or if someone that’s seen regularly suddenly isn’t around, but I can think of examples where someone just wasn’t answering the phone and they keyed in. I think being aware that no space is really your own, or no spaces inaccessible to the organization that provides the services does inform a shared mentality among clients that nothing really belongs to you and that you’re just temporarily holding this space, and that nothing is really safe.”

Trust, Boundaries, and Opportunities for Genuine Human Interaction

Despite the tension between privacy and support, interviewees generally agreed that a positive relationship between resident and staff relied on building trust. Staff felt trust was best built through establishing themselves as someone who could effectively help residents achieve their most tangible goals, such as helping them to obtain a cell phone or to re-obtain a benefit that had been discontinued. Staff also voiced that they felt the most meaningful relationships came out of opportunities to cut across the structural power imbalances and connect with residents as people rather than just as clients.

“In terms of creative engagement, I could think of an example of clients whom I worked with who I would let teach me something. All of this is based on relationships and I think a lot of times in the relationships that exist, there’s this idea that we as workers are somehow in control of something, or that we have control over clients, which in a lot of ways is true. The fact that we can exert control really does take away clients’ autonomy in a lot of ways. I think giving clients the opportunity to tell us what they need, and really let them guide the services, and also letting them be an expert on something were all things that I found to be really beneficial. I think sometimes people are afraid of some of the clients who live in supportive housing, just because there can be some chaos, but that’s just like anything in this world, like anyone’s life I really can be chaotic. And I think really just treating them like equals, and giving them power does a lot for relationships.”

While opportunities to cut across the unequal power dynamic between residents and staff have significant value for both staff, who are able to build better rapport with residents, and residents, who feel more dignified and respected, these opportunities can be professional gray areas. Ultimately staff aim to maintain control of situations in which the boundaries between resident and staff become less clear.

“I think you have to grapple in this role a lot with the question of ‘What are the boundaries of my job?’; and consider how what you are doing is ultimately being
a human that's interacting with another human. But your boundaries are definitely tested in a supportive housing setting because people will come to you with anything in an engagement. You're engaging with the expanse of human potential and historically people who are in this position have not had appropriate boundaries, so they're gonna test your boundaries and try to see what's the most we are willing to do for them, and you have to figure that out as a service provider."

The unique setting of supportive housing also allows staff to interact with residents around their struggles with substance use and mental illness in ways that are radically different from other providers. In our society there are often stigmas assigned to both mental illness and substance use. In the context of supportive housing, these issues are more normalized and therefore easier to talk about and to provide support around without the feelings of shame or the fear of judgment that residents might experience in other settings.

Residents seemed to agree with staff on the importance of trust and interacting in ways that made them feel equal and dignified. Residents made it clear that any sign of incompetence or lack of integrity in staff made them question the purpose of the relationship. One resident described a situation that involved their neighbor and the program’s administrator in which their neighbor’s puppy was repeatedly able to open its owner’s door and escape into the halls of the building. This resident described how the program administrator essentially campaigned to have the dog removed from the building on the grounds that it had bitten people, a claim which no resident was willing to support. The resident eventually confronted the program administrator and explained that the issue was that the door handle allowed for the puppy to escape unsupervised. Shortly after this conversation, building management replaced the door knob of that resident’s apartment and there were no subsequent escapes by the puppy. Another resident described how they had gone to staff in the first weeks after they had moved into their unit to ask for a list of local food resources and they were unable to provide them with information and suggested that they reach out to other residents in the building. Both of these instances eroded trust in staff and gave residents the impression that staff were unable to help them and merely enjoyed wielding power over residents arbitrarily.

Staff felt that coming into new environments where there was already an established program culture could be difficult because it was easy to seem incompetent as someone new on the job. New hires come into supportive programs untrained and have to be prepared for residents to come with them with anything. Besides this, staff voiced frustration with the fact that rules often change and that the systems in place don’t work well, and as a result staff can often seem more incompetent than they really are. Having career longevity at a program did not seem to make much of a difference, as changing rules and cumbersome systems perpetually undercut staff's ability to have all of the answers that residents need.

Residents also felt that “newer” staff members were easier to interact with because they were able to talk with them in a more straightforward way. Residents expressed that they found it disturbing to watch the ways in which new staff members would come in and seem to slowly sour on the job after a few months of working at their program:

“When you get the newbies, they are nice and fresh, and you'd pull them aside, and there was some real sincerity and real connection. Some of the people that left, let me tell you, if they were given training, and channeled in the right way, they were some of the most emotionally intelligent, resourceful people, people
that were really just good people that you could tell didn't have the professional skill set and training behind it. Without knowing clients’ stories, they knew enough about people and cared enough about people to be good, caring case managers. But somehow, within a very short period of time, literally within months, generally, they would sour and it was a very stark experience. So what they're being told and how they're being treated, I can't imagine what would be involved to lead to what I saw; seeing someone disintegrate to that level. I can't insert a narrative that I don't know, only what I witnessed, and to see people struggle was hard to see. There were a few people, a few case managers, who would pull you aside and just say, ‘Oh, look I gotta do this. I'm knocking on your door, because they're really on me, and I have to get this done’. It's still mind boggling as I'm trying to process it and I wonder how it all happens? But I do know from dealing with higher ups, how much they just blatantly lie to you as a client. I would ask them about what my options were, as far as moving out, and no one ever mentioned the voucher, or what the process was to convert from a program to another voucher or any of that.”

Staff Turnover

Residents also had a shared feeling that staff turnover was a disruptive factor in their lives within supportive housing programs. These relationships, which are supposed to supply residents with a sense of stability and dependability, often last only for a few months or a year. Many residents felt that because staff turnover was so high, that it wasn't worth their time to engage with staff or to open up in a meaningful way because they would have to start that process over again with someone new in a short period of time. While staff can provide a stabilizing force to residents whose lives have rarely felt stable, staff turnover can reintroduce another element of disruption and inconsistency into the lives of residents:

“I'd have to say the key disruptive factor in supportive housing with regard to the relationship between residents and staff is the fact that there's a high turnover for staff. I've looked on Indeed, and I believe for my particular provider, the entry for a case manager was $17 an hour in New York City. I mean, that's pretty ridiculous. I don't know what they constituted as the required skill sets other than a high school degree, which I have no problems with, when it comes to people being qualified in terms of their interpersonal and emotional skills. I don't think it matters much what someone's educational attainment is with this kind of job. The whole purpose of these not for profits is to put people over profits, but it's not functioning like that. Not if you're having people at the top making a million dollars a year, and they've got like hundreds of millions in the bank. I'm not saying that people aren't worthy of high salaries if they have a high skill set, they should be rewarded for that, but really, when you look at their hierarchical structure, you've got a million at the top and then $17 an hour for those that are actually interacting with the people that they're supposed to be serving, which is ultimately the reason why these organization supposedly exist. You would see them come in, and actually have the possibility of being really great case managers, and then there's the whole one bad apple spoils the bunch, where all of a sudden this light switch just flips, and they can become super sour, and hostile to the tenants, and then they leave. Then there's always that one director who stays who you question whether they even like themselves, let alone other
people at all. Sometimes corporate people would come in and spout out all the correct phrases, but there’s just this sense of complete inhumanity behind it all.”

Racial Dynamics

An element of supportive housing in New York City that is recognized but not discussed enough is the racial power dynamics that exist between residents and staff, which can greatly influence the ways in which residents and staff interact. Through the data collection process, every respondent reported that the population of the programs that they lived or worked in were primarily people of color and that the staff were predominantly white. Because staff hold a position of relative power within supportive programs and white individuals also hold positions of relative power within our society, the imbalance in the power dynamic can become intersectional. For residents of color who have been institutionalized by the criminal justice system, or who have had other negative interactions with white people, even with well-intended white staff, the trauma of racist systems in our society can cause residents to implicitly distrust staff members.

“Most of the clients at the supportive housing program I work at are black and brown people; they identify as African American, Hispanic, many are Puerto Rican or Dominican and there are less white people. I’m a white provider working with a majority black and brown population, and I have to be really aware of how my whiteness can be perceived. Clients can feel uncomfortable, I can be seen as an oppressor and that can be informed by negative experiences that clients have had with white people in the past. I have to be very aware of my own white privilege and the power dynamics between white people and black and brown people. I think I’m very aware of that and I think I try to cut through those things by providing an unconditional positive regard and being polite, which can make a big difference. I think it’s also important for white workers to be open to conversations with black and brown clients who might be uncomfortable working with them about that discomfort and that in itself can go a long way in building trust and trying to demonstrate what the worker might be able to do for the client. It’s also really important to have black and brown people in the service as service providers. Also, many of our clients have been incarcerated, and they’ve been incarcerated for a long time, and having an awareness of how that can affect how they interact with service providers, or how they interact with people in perceived positions of authority is important. It’s important to think about and also just understanding or approaching the work with an understanding that you’re going to interact with clients who have a very different worldview than you, because they’ve had such incredibly different experiences than the experience that you’ve had. I’m thinking of somebody who I’m working with right now who has a totally different worldview and a totally different understanding of things than myself, and being able to recognize that without challenging the client over it is important because at the end of the day I’m not in a position where I have all the answers.”

While white staff must be cognizant of the disparities between their experiences and those of residents of color, there are many aspects of case management work, such as providing unconditional positive regard, which can be universally employed and can contribute towards reshaping residents’ often understandably negative perceptions of white staff members. Another racial dynamic between residents and staff that was reported was that residents occasionally had a preference for white workers:
“The building I work at now and the building I worked at before, they both have had all white staff. I think it makes a difference in how staff engage with each other to some extent and also in how staff relates to the clients. I think I’ve heard a lot of clients talk about how they want white staff because they say that white staff actually work and that other staff members don’t, which is not true, but that’s the perception. Additionally, I think a lot of that perception is because white people are respected more in many settings within our society, such as if you go to a doctor’s appointment or something like that with a client, but I think it varies from client to client.

White staff can in other instances be preferred by residents, as they enjoy greater privilege within our society, and often are treated with greater respect by outside service providers, making their job easier than it might be for black and brown staff members. While this undoubtedly a reflection of a deeply racist system, white staff can sometimes be an asset to residents, as they act as advocates for black and brown residents who might otherwise be ignored or treated with less respect. The work that black and brown staff members are able to do with and on behalf of residents is of the same quality as white staff members, however, it is important to acknowledge the ways that our deeply racist society can put up barriers not only for residents of color but also for staff members of color.

Community and Resources

Many of the people who end up becoming residents are individuals who have struggled with maintaining relationships across their life for a variety of reasons, most often related to substance use and mental illness.

“I think there’s a lot of stigma that goes along with pretty much every identity that resides in a supportive housing community. I do think it’s really sad to think about the lack of community and support that was available. But I mean, some people had a few people they worked with, some had family far away that they were able to connect with, but oftentimes, not much.”

An important aspect of supportive housing is helping residents to rebuild that support network by connecting or reconnecting with communities that align with their interests and identities.

“A lot of people came to New York from other places and some people were born and raised here. A lot of the people who came to New York came at a certain time for their art, and a lot of people that are attracted to the arts, because maybe in the places that they came from, they felt like misfits. For some who came to New York, it was because of their particular gender expression and where they came from at the time there wasn’t awareness or understanding about it so they felt like misfits in that way as well. Even in New York City, people from those groups had trouble.

These forms of community existed both within supportive housing programs and outside of them. This section is divided into four subsections that will discuss the influence of community on quality of life in supportive housing programs, and are as follows: resident backgrounds, positive and negative forms of community, community and recovery, and extended community.
Residents Backgrounds

Residents of supportive housing in New York City are anything but monolithic. A coworker of mine once invoked Tolstoy to describe the diversity of issues that residents dealt with. Tolstoy said 'All happy families resemble one another, but each unhappy family is unhappy in its own way,' which is not to say that all residents are actively unhappy, but only to say that if there was one commonality among residents, it would be the diverse set of unhappy ways in which they found themselves homeless. These unhappy histories and traumas exert active influence on residents' present day realities.

“It’s not just about how staff approach clients, but also clients having the comfort to show up on the site and work with staff. Very often people are coming from relational trauma, and very often they’re coming from situations where there may have been a gross violation, or betrayal of trust with professionals in the past. That can really impede any opportunity for there to be an emotionally connected experience. But many people know what they need, enough so to get their needs met. If you open your eyes and give them space, there’s a balance.”

Residents’ histories and traumas may have been part of the reason they found themselves homeless in the first place. These experiences include burned bridges with sources of support and traumatic events, leading to the loss of a key source of support, such as a parent, spouse, sibling or close friend. Community is central to supportive housing because it is often the loss of community in the first place that has contributed towards a resident’s homelessness. All of us belong to one form of community or another, and these connections to community, when positive, help us in ways that may or may not be immediately obvious to us. They can offer us places to stay when we need them, or introductions to job opportunities, or emotional support during difficult times. A commonality among residents is their lack of community resources in a time of need, and their ongoing difficulty with maintaining positive connections that can provide them with needed support.

“Sometimes my supervisor compares clients to porcupines, in that she feels that they’re all really just soft, gentle, kind creatures, but that they have the spikes, because the world around them is predatory, and so in order to survive, they have to have an outer protective measure, but in reality, ideally, they’re just these little tiny guys.”

Positive and Negative Forms of Community

The difficulty that residents have in maintaining connections to community has two main implications. First, residents are susceptible to connecting to communities that reinforce negative patterns. Second, conscious efforts by staff to create positive forms of community or to direct residents to existing positive communities can have a large impact. Regardless of whether staff try to create positive forms of community for residents to connect to, communities do tend to form within supportive housing programs with both positive and negative functions.

Communities of necessity seem to form in supportive housing programs, which stems from the fact that most everyone living in a supportive housing program in New York City lives well below the poverty line and as a result, a sharing economy of sorts can arise. Community can be built
around sharing resources like food and other goods and around participating in program-sponsored events. A program that an interviewed staff member worked at offered a Wednesday morning coffee hour, Thursday morning senior meals, Tuesday evening dinners once a month, program-hosted movie nights and other outings to Yankees Games and movie theaters. All of these events were well attended by a core group of residents that were interested in being involved in more positive forms of community within the building.

Another staff member reported that in their building, residents held their own tenant meetings monthly and that a strong sense of community had grown out of those meetings, which provided tenants with a feeling of empowerment and provided them with a venue to voice their ideas and concerns within the program. While staff-led community building efforts can have great benefits for residents, staff also pointed out that since staff can be an unstable element within supportive programs, it can be much more valuable for residents to create their own sense of community.

Ideally, I think the community should be as resident led as possible, because staff turns over, so you don't want staff to be too big of a part of promoting the community because if they leave, you don't want the community feeling to go with them. The staff are not going to work there forever. So in general I think that supportive housing should promote a tenant driven community as much as possible. I do lead events occasionally, such as a self care group, and the residents that have come, I asked them if they wanted to lead a self care group, and they did, and they do a great job, and they get like a $25 gift card if they do that. I think we need to compensate people when they're doing work. So that's been a big thing. We say that we want to have residents create a sense of community, but like that in itself is work, so they should be compensated, if they're doing that. "

One staff member felt strongly that supportive housing should be better integrated with more spiritual support systems, as they felt that those who were connected with religious or other spiritual organizations had an additional layer of support.

"I would have loved if we had some additional components or layers to our supportive services, specifically something spiritual or something in that category, because it was the people who engaged in that and sought that out that had an additional layer of support and an additional dimension to their experience that helped them. Whether it was people who were involved in the church, or whether it was people who practiced their own beliefs. I think it would have been great to have created opportunities for clients to have shared that with other people in the building. I think it's a big detractor from social work and mental health services that we don't build any more, because people are definitely looking for that. Some of the building management staff that worked in tenant services or who worked in the maintenance staff ended up acting like de facto chaplains."

Residents creating community among themselves can be incredibly positive and, as one staff member has detailed, these connections can be critical in times of crisis.

"To me the thing that is most central to residents' health and wellbeing is having positive relationships with their neighbors, I feel that is very beneficial. A really good thing about the building I'm at now is that people play dominoes with each
other, and know each other’s kids, and cook meals for each other, and just have that neighborly relationship. I think honestly, that’s the most important thing. The staff is not in the building on weekends and at night. We can’t babysit someone’s kids during an emergency, we can’t really do any of the things that life is made of when it comes down to it. So you need those neighborly relationships to really be able to do that.”

The community that can arise out of sharing resources can also generate negative forms of community. Low-income users of substances will often seek out other users of the same substance in order to dispatch their limited resources in a more efficient manner. This can lead to the creation of networks within supportive programs that are built entirely around the goal of acquiring and using substances. On the one hand, this form of community can be a form of harm reduction in the sense that using with others is safer than using alone. However, these forms of community can serve as a detriment to residents that are attempting to recover, and even in the short-run can be very harmful. These communities can lead to mass-overdose due to an entire network of residents using the same laced substance, as well as predatory relationships between residents, which can make residents feel threatened or otherwise unsafe in their own home.

“Inevitably, when you create supportive housing, you are going to wind up, even if it’s integrated between the regular low income who are just there for affordable housing, and the special needs people, you’re gonna wind up with a concentration of people with substance abuse disorders. If you are an impoverished person who’s using, you’re very likely to try to build a network with other users to get what drug you want to use. That was a major issue at the first program I worked at; of the sale of drugs and clients accepting money from drug dealers, or drugs from drug dealers, so the drug dealer could sell drugs out of their apartment. There was a ring of crack dealers in that area who they arrested a couple summers ago who were effectively preying on the residents of the program that I worked at, and I know it made recovery difficult for some people. It’s a very difficult situation, because on the one hand, you’ve got all the social services, lots of staff ready to send you to detox, to rehab, to connect you with the services that you need for sobriety; and then you’ve got people knocking on your door offering you drugs. It’s hard to know what to say, because I don’t think that it’s a good thing, but I would never say that we shouldn’t do supportive housing because of this issue. I still think that we should do supportive housing, and I also do feel strongly that sobriety, or any kind of drug testing should not be required or that housing should be contingent on sobriety. You’re not going to get sober without permanent housing. Having a concentration of people with substance abuse disorders in a building can be counterproductive, in some ways for someone who’s trying to recover, but I also don’t think the rest of the services that are supposed to be there outside of supportive housing are doing the best job or that they’re accessible enough or that there’s enough of them.”

Community and Recovery

Community was also identified by both residents and staff as serving a key role in the recovery process. Communities that were built around recovery in a more formal sense, such as AA or NA, were felt to be important forms of community and support for residents in the recovery process. More informal communities, such as the resident groups that formed out of mutual
attendance of program sponsored events and shared interests, benefited residents in recovery as it helped to recenter their lives around activities that were unrelated to substance use.

Staff also described the way that they felt that a building’s overall environment could contribute towards either aiding or hindering residents’ attempts to recover. While a building’s tone is unquantifiable, a key aspect of this insight is that one supportive housing resident’s ability to successfully recover is related to the ability of their neighbor to recover, and that in this way the concept of recovery and community are deeply interrelated.

“I think, as far as recovery goes within the setting of supportive housing, because you’re in a contained building with other people that likely have the same kinds of negative behaviors that you have, I think the community recovers together or decompensates together in a lot of ways. If you’re around other people that are using, and you’re in recovery, that’s not good, right. I think that’s how I can tie it more generally to the tone of the building. How people are doing definitely impacts how the individual is doing. So if the tone of the building is the feeling of ‘I hate this building that I live in, my health is bad’, then I think the individuals will also have that outcome.”

Given the interplay between community, use, and recovery, the presence of social services on site and their ability to connect residents to the necessary resources for recovery may not be sufficient to assure that residents are able to recover successfully.

“Tenants could be bad influences in terms of what other substances they’re doing, of which fentanyl is the big one. I don’t know much about street drugs at all, but I would see the effects of it, and I also would see how much people struggled with desperately wanting to be sober, and would still not get the support they needed. If you’re sending these people to programs, that can be great, but then you’re throwing them right back into the lion’s den when they go home. You can insert them into a recovery program, but they’re going right back into whatever exists back at the place they live and all of the stressors and triggers that exist there.”

Extended Community

Building on the limits of supportive staff in assisting residents in the recovery process, a repeated theme throughout the data collection process was the idea that supportive staff could not realistically provide residents with all of the assistance that they required, nor could the entire continuum of social service providers in New York City. Perhaps relatedly, one of the primary goals for many residents seems to be moving out of supportive housing into more independent housing situations. The process of moving out of supportive housing is not an easy one, and one staff member contextualized the idea of moving out in the following way:

“I think that group of people genuinely needs ongoing services, and I don’t think it’s an indictment on them, or on supportive housing’s failure to make them more independent. I think with them, being independent can mean a lot of different things. Maybe they’re fine, but they have to have a rep payee, and they have to go out and go someplace to take their medication every day, and they’re always going to need that. I don’t view that as a bad thing, especially if you compare it to the alternative, which is not having it at all, and then being homeless, again. I
don’t think that the purpose of supportive housing is to get people to be completely and totally independent. I don’t think that’s the point. Nor do I think that it should be. If that happens, that’s a wonderful thing. And certainly, enhancing independence is part of what we do. But if it was ever a goal that supportive housing was supposed to get somebody to a point where they can live totally independently, I don’t think that would be right at all. I think that would be doing an injustice to the population that we’re serving.”

While supportive housing staff can be very helpful in aiding a resident to reach a point of stability, and in aiding residents to thrive within a supportive housing context, it is ultimately outside of the scope of supportive staff’s role to assist residents with moving on to more independent forms of living. For residents that are interested in moving into more independent settings, it would seem that a key part of realizing that goal involves being able to independently navigate securing housing. This often requires connections with a community of people beyond supportive housing that are able to assist with this and other endeavors.

“The clients that I did see move into independent housing with no social support, normal housing, I found what they had in common was that they had a lot of outside support, meaning that they were very connected with the primary care, their church or whatever program they may have been involved with or they have a diverse group of friends who weren’t all in supportive housing. These folks were already separated from the homeless life and even though there were some using recreationally, they were not involved in our underground world. Those folks, I will say, were the ones that were able to move really without my help, and if anything, helping them might look like making copies or making phone calls for folks just to help them manage some of the more clerical tasks involved with moving.”

In addition to this recurring goal that many residents share, there are other reasons that being connected with a community beyond supportive housing can lead to more positive outcomes for residents. For one, the shared mental health and substance use struggles among residents within a program can impose limits on the combined capabilities of communities within supportive housing programs. By connecting with communities beyond the context of supportive housing, residents open up their access to resources and support systems that may help them both materially and therapeutically.

Residents may also seek to connect with other residents from different programs. One organization, SHOUT NYC, has provided an important venue for residents of supportive housing programs across all five boroughs of New York to come together to talk about their experiences. This organization and others like it can empower residents, whose experiences have often been discredited or deprioritized for the sake of organizational efficiency.

“That's one of the things that SHOUT did with SHNNY. SHNNY is the Supportive Housing Network of New York and SHOUT has also helped us interact with the Office of Mental Health, and also the Department of Health and Mental Hygiene and has called them out. They have no transparency, there's no accountability, there's been a lack of credibility. They keep saying, 'Oh, we'll take your complaints', or 'Oh, we'll help you', but there's no follow through. They don't even have legitimate, publicly viewable lists of complaints. They had no proof that I had called them and made a complaint two years ago, so they had no
documentation. I mean, I'm not surprised by this, that they had no documentation that I had ever made a call to them, and that they never followed back with me, of course they're not going to have documentation that is self-incriminating. I wonder though, to have fifty to sixty thousand supportive housing tenants in New York City; how many of us have ever tried to call these agencies, how many of us know how to call them about a complaint? How many of us have tried to call them to make these complaints, and then they've never called us back, so we just give up? And then they try to say, 'Oh, that never happened'. And we were surprised that we have had this happen to us. So we know it does happen, and I don't think they were expecting that. And so that's one of the things we keep fighting for now."

External communities are invaluable and cannot be replicated by staff efforts to provide support. Not only do external forms of community provide residents with connections to support systems that can help them weather difficult times, but external communities also provide residents with a chance to be seen in the way that they would like to be seen, which can be empowering as residents move from a mode of survival to self-actualization.

Institutional Factors

Supportive housing programs and the lives of residents do not exist in a vacuum. Some of the ways that the world outside of supportive housing and the systems that govern it affect lives have already been touched on, such as the way that neighborhood resources and access to transit impact residents' quality of life.

The lack of resources that our society allocates towards supportive housing programs and residents undoubtedly influences the quality of life of residents. Equally as influential are the systems in place which are responsible for allocating and administering those resources, which can often be confusing to navigate not only for residents but also for staff. The challenges that residents face and that staff assist them in facing are also informed by larger, more systemic failures within our society. This section is divided into four subsections that will discuss the influence of institutional factors on quality of life in supportive housing programs: upstream determinants, organizational disconnects, reliance on cumbersome systems, and a lack of program resources.

Upstream Determinants

One of the biggest upstream impacts on the quality of life of residents has been the general lack of affordable housing produced in New York City in the last several decades. The city has experienced nearly city-wide gentrification, which has in many places eliminated the naturally occurring forms of affordable housing that once existed in the city. Many of the individuals who live in supportive housing programs may have previously lived with mental health or substance use issues that were under control. However, trauma in their life or increasing inability to keep up with climbing rental costs caused homelessness, which is itself a traumatizing experience that can lead to the onset of new mental health and substance use issues and exacerbate existing conditions. For others, their homelessness may have been rooted in the simple act of getting older in a country where our social safety net does not always provide seniors with the resources they need to ensure their later years are high-quality.
Many of the residents of supportive housing in New York City are from black and brown communities in the Bronx or Brooklyn, which have been historically disinvested in, over-policed and disproportionately punished by drug laws. These systemic inequalities have shaped what the population of supportive housing looks like by subjecting these groups to traumas on a systematic basis.

For those from within New York, many of them came from the Bronx or Brooklyn and were black or brown and they came from communities that had historically been over policed and disproportionately punished by drug laws. The population of the supportive housing program that I worked at was disproportionately people of color from New York City who were experiencing intergenerational poverty. They were not the first person in their family from their generation, or from the generation before them or the generation before them, who experienced homelessness or mental illness, or institutionalization. I think the intergenerational nature of their experience was a major factor for many of my clients. I remember doing psychosocial assessments, and getting their family history, and there was rarely a time where there would not be another member of their family within immediate reach, that had not experienced something similar. There were a lot of high rates of suicidality in the families that these individuals came from. There were also a lot of older adults that were a part of the LGBTQ community, who historically have been a disenfranchised population who very often has not received culturally competent care. There were a lot of individuals with HIV and AIDS. Other things that have influenced what the population of supportive housing looks like in New York City would be the rampant city-wide gentrification that has made housing unaffordable across the board, and the general lack of senior housing in New York City.”

Overall, the population that resides in supportive housing come predominantly from communities that have been systematically under-resourced, subjected to unequal punishment under the law, disenfranchised, and ignored. The marginalization of these groups is something much larger than supportive housing alone is capable of addressing. While staff of supportive programs and other service providers who assist residents can provide culturally competent care, there is no undoing the traumas that have been inflicted by our society onto these individuals who represent some of the most deeply traumatized members of these marginalized groups. Belonging to these marginalized groups can in itself be a factor that negatively impacts residents quality of life, as they continue to be subject to discrimination and marginalization.

Organizational Disconnects

Supportive housing programs are ultimately subject to funders and the requirements that they set forth for the recipient programs. Within the current system, this is essentially the only way that services can be provided to residents. Programs are given a set of requirements which all of the program staff are expected to meet and ideally serve the goal of supporting residents in a way that is both high-quality and financially efficient. The reality is often that funding requirements introduce an element into the interactions between residents and staff that feels unnatural. Goal setting becomes formalized, and ultimately shaped by funder requirements, which can lead to disengagement between residents and staff. Staff requirements to comply with funders can ironically result in a lack of engagement with residents and undermine funders’ overall goal of providing high-quality and efficient services to residents.
“The people that set the requirements for what the expectations are, even the goals are out of touch with the actual day-to-day service provision. On our treatment plans we would have to write in if someone smoked, and have smoking cessation as a goal, and that I think was one of the most perfect examples of the incongruity between the organizational goals and the actual day-to-day service provision, smoking cessation was usually not a goal for the client. It was not a pressing need for the client, however, our funding source wanted us to make a push for smoking cessation, because it was important to them. So every time we made a service plan, every six months, it needed to be included. I also think it’s very out of touch with the needs of the clients, and if they’re not aligned, clients are not open to being engaged. If program management believes that saying to the clients, ‘You have to take your medication’ is effective, I don’t think that’s realistic, and all it does is push people away. But I think providing services to people that are individualized that allows for more real contact and engagement in meaningful relationships involves some level of acceptance that you’re not necessarily going to meet benchmarks. There’s not always going to be a measurable outcome that you can write down or you could put on paper that is going to be able to encompass client growth.”

Staff felt that there was a lack of support and attention around some of the interventions that were either most central to their work.

“I felt like the organization didn’t understand the specific conditions of the program I worked at, which was much larger than the other programs that the organization managed services for. They were constantly trying to compare the metrics at our program to the other programs and it just didn’t make sense. I would have also liked to have seen more support around having fentanyl test strips and other drug testing materials available to try to make drug use safer. Also I would have liked to have seen more support for people and their pets and a lot of the informal work we did around supporting people’s animals, which were often such a big part of clients’ lives and their wellbeing.”

Staff also felt that the priorities of the city and of the organizations tasked with helping New York City residents experiencing homelessness to obtain secure housing were not equipping residents with the skills needed to thrive in the more independent setting of supportive housing. The transitional housing phase of a resident’s journey towards stable and independent housing is supposed to be a time when staff connect residents to resources and help them to acclimate to life off of the streets. The demand for transitional housing and supportive housing however, are both great, and therefore many individuals experiencing street homelessness transition from living on the street to supportive housing in a relatively quick amount of time. This is a positive in the sense that individuals are provided with stable housing; however, the fact that this process is often rushed and does not consider resident preferences can leave residents without the skills and resources necessary to thrive in supportive housing settings.

The rushed nature of the rehousing process can also present residents with an illusion of choice over where they live. As mentioned previously, the small size of supportive units can be a major detriment to the lives of residents with mobility issues, but when confronted with the choice of living in a small unit that belongs to them and living in a transitional housing facility where they may have to share a room or on the street, they will almost always choose to live in the small unit, even if it isn’t a good fit for them. One staff member worked with a resident who was placed
in a building a block away from the location where they were arrested and subsequently incarcerated for fifteen years. That resident had expressed multiple times that living there would likely be retraumatizing for them; however, they were not given any other choice and they ultimately elected to live in the unit that had been extended to them at that program.

Shelters receive their funding based on the number of people housed in them and not all of the individuals sleeping in shelters are viewed favorably by staff at shelters. As a result, some of the more difficult shelter residents are often sent into housing quicker than others, as shelter staff have a desire to cut down on the chaos at their own programs.

While some residents are rushed through from street homelessness to permanent supportive housing, other residents may come to live in supportive housing programs through other, more time consuming means. Because of the lack of affordable housing options in New York City, there are some residents who get placed in supportive housing sites after being chosen from a waiting list or housing lottery. Although many programs have done away with mandatory engagements of these non-residents the bifurcation of needs can be stark. Outreaching these residents who generally do not require assistance from staff can put an additional burden on staff whose time may be more beneficial to higher need residents. It is important to note that some non-residents who move into supportive programs through lotteries can sometimes have undiagnosed mental health or substance use conditions, or may suffer traumas in their lives while living in supportive housing, which can then lead to them requiring more support and attention from staff. Organizational classifications of residents and staff requirements according to funders can often be mismatched with the reality of what a specific resident needs while living in a supportive program.

Supportive housing programs are run exclusively by non-profit organizations in New York City, all of which are mission-driven to provide stable housing and supportive services to those who qualify. While this mission is itself a noble one, and direly needed, one staff member expressed their frustration at the limitations that providing services as a non-profit imposed upon the organizations that operate supportive programs. The main drawback that they cited of these limitations was that non-profit organizations could not take as political of a stance as this worker felt they needed to:

“Some of the organizational difficulties that come with working in supportive housing come from the fact that you can't be political at all, because it's a nonprofit, but I think that homelessness and housing are inherently political. So the question is, ‘How do you square that?’; you need to promote housing policy, but housing policy is political. So how can you do that as a non political entity? I think staffing is another big issue, and managing to retain staff when these are low paid roles that are very difficult, where the duties of the job itself can be very unclear and that require workers to care to some degree. How do you keep those staff? I guess the goal of the organization at the end of the day is to take care of the clients, and so staff are a secondary concern sometimes. I think also there are so many numbers and metrics required by funders, but it's hard to measure a lot of the work that case managers do, so that can also create tensions.”

Reliance on Cumbersome Systems

In the United States, many of the programs that receive federal or state funding are attached to labyrinthine bureaucratic systems. These systems can be a maze of paperwork, hold music and
agency officials who should but often don’t have the answers to residents’ benefit problems. One staff member reported that on an escort to HRA with a resident, whom they had made an appointment for in advance, they were directed at one point to a phone in another room of the HRA offices where they were instructed to wait for it to ring and that the person on the other end would assist them with the resident’s benefits issues. Kafkaesque stories of this kind are not uncommon for residents and staff. Residents reported feeling that organizations like HRA lacked integrity and that they seemed to be almost intentionally confusing to navigate. Staff also reported that the residents that they assisted often felt anxiety around whether their benefits would continue to be paid out to them, as there were many resident stories of benefits being shut off for unclear reasons.

“I think in general there are a lot of services that are difficult to access or the services that are in place, maybe it's not difficult to access them, but they're not very good. Finding providers that take their insurance and managing their transportation to and from appointments can be very difficult even with services like Med Answering Service which requires a client to be able to use a cell phone, which is not always easy. When it comes to HRA, public assistance, SNAP, Medicaid, and Social Social Security, that's where just thinking about it makes me anxious, because of the amount of time you either spend on the phone on hold, or going to one of the offices and sitting there for however long trying to understand what the representative is telling you. I just don’t think that those services are conducive to the kinds of people who we work with who really can have some challenges with either understanding what's going on, or following through or checking their mail, and when they have those difficulties then it leaves them vulnerable to situations in which they find that their benefits been turned off. We as the workers then have to investigate the question of ‘Why has the benefit been turned off?’ and sometimes the answer is something like ‘You didn't recertify’ and the client will respond by saying ‘Well, no one ever told me I had to recertify’. So I wish that Social Security and HRA could be better and more user friendly for people who have these kinds of issues. If you want to help those people who are street homeless who have severe mental illness or substance abuse, they need housing and they need money, and so if you're providing public assistance, or Social Security income, don't make it so difficult for them to get it, and don’t make it so difficult for the providers who are trying to help them. Because I don't find it easy to deal with those systems either, so I can't imagine what it's like for the clients to deal with it. I wish it were easier to communicate with emergency rooms. I think that it would be wonderful if we could have a system of substance abuse treatment centers that was much easier to access.

The services that are available to residents are highly fractional. There are many different providers that collectively are providing most of the services that residents are in need of, however the lack of coordination between them can make it difficult to connect residents with all of the services that they require to assure that their lives can proceed in a normal way. Staff expressed frustration at the systems in place designed to assist residents with recovery, and detailed shortcomings with the system that led to frequent relapse and made recovery difficult for residents who were interested in recovery.

“I think that the systems that we have in place outside of supportive housing, emergency rooms, hospitals, and, you know, rehab, you know, detoxes and
rehabs is broken for people who are trying to recover from serious substance abuse problems, because you could go to an emergency room, and the issue is that you're there because of a drug problem, and they will refer you to go to wherever, but then they're going to discharge you and you're gonna go home before you actually go to the detox and the rehab. And what are you going to do when you go home? You're more likely to relapse, to just keep using, and then not want to go to a detox or rehab. I think that emergency rooms should be pipelines into detox and rehabs, however, that works, or that there should be more of that built into the infrastructure of the existing hospitals. I don't think that is supportive housing's role. Supportive Housing is not there to be a detox and rehab. You can't have that be a part of supportive housing I don't think because then it would just be an institution. It has to just be housing, and then these other services are outside of the house. We often get asked ‘Don't you do substance abuse groups in the supportive housing?’ and we don’t and I’ve found that clients don’t like that idea at all, because they don't want their neighbors to know all their business. They don't want to go to NA or AA down in the community room with their neighbors. I mean, it's not so anonymous at that point.”

Staff also expressed that supportive housing programs did not have close enough relationships with some of the most frequently utilized entities beyond program walls, such as the police and visiting nurse services. While staff voiced that police were generally overutilized in supportive programs, they also felt that programs would benefit from having closer relationships with police precinct community liaisons, a relationship that they felt would have been helpful in addressing the concerns that police were being called to intervene in and more meaningfully resolve these concerns.

“I did always wish this was accessible to us in a meaningful way: having access to the liaison with the police department, or the precinct liaison who works closely with the community, in order to address some of the concerns that were going on with clients that had a high frequency of police being called. Something where we could have more meaningfully tried to address whatever was going on.”

Visiting nurse services were also identified as a group of service providers that supportive programs would have benefitted from a much closer relationship with. These relationships could benefit residents who have chronic medical conditions in avoiding frequent or lengthy stays at inpatient medical facilities.

“I think one thing that would really benefit our clients would be a more formalized relationship with visiting nurse services. I think that cost benefits wise some of the lengthier hospitalizations are caused by the fact that they didn't have more robust support, and they returned or they weren't open to more services or support when they returned. It would have just made more sense to have had, maybe twice a month, more focused medical care supplied by a visiting nurse.”

Supportive housing staff and residents exist within a highly fractional social service landscape and this lack of coordination leads to inefficiencies and lower quality of life for residents as negative outcomes for residents are repeated over and over without being meaningfully addressed.
Lack of Program Resources

A lack of resources available to supportive programs can also influence quality of life for residents. Programs that have more resources, either financial or programmatic, seem to lead to better outcomes for residents. Medical appointments and psychiatric appointments that take place onsite are better attended and can provide residents with additional sources of support in the environment in which they live.

*In highly structured programs that have a lot of resources, money, I think, is the major determinant, and having services in place that are accessible in the building. As much as you don't want everything in one building to the point where the place where you live is where you do everything, there are better outcomes for residential programs that have medical and psychiatric care on site. Those programs have less frequent hospitalizations and more person centered services, because they're able to see the individual in their home. There are less missed appointments, and better communication between case managers, social workers, and the psychiatric providers, as well as higher medication compliance.*

In addition to these resources that can improve the efficacy and supportive capacity of supportive programs, financial resources can also improve the experience of living in supportive housing for residents. As mentioned in the section on resident and staff relationships, the amount of money allocated to paying staff can have deep impacts on a program and the resident experience of living there. The low pay that the majority of front-of-the-line staff members receive contributes to burnout, low morale, and staff turnover, all of which can contribute towards a negative atmosphere within supportive housing programs and introduce constant disruption into the lives of residents who are often desperately in need of relationships that are stable and reliable.

Analysis

This study attempts to understand how environmental factors impact the quality of life of supportive housing residents. However, the study’s context falls short as it does not fully operationalize the concept of quality of life. The grounded method of identifying themes as they arose from the data collected during the interview process, however, did point towards the ways that different aspects of supportive housing influenced a somewhat nebulous concept of residents’ quality of life. The small sample size of interviewees and the lack of quantifiable metrics to analyze relationships between the influences identified and quality of life limit the validity and generalizability of this research. The experiences shared during interviews are all ultimately impressions of how supportive housing influences quality of life and should not be interpreted as the only set of perspectives that exist on the topic.

This section analyzes the ways that the interviewed staff and residents felt that the identified factors influenced resident quality of life in supportive housing. The identified factors are *Spatial Relationships, Relationships Between Residents and Staff, Community and Resources,* and *Institutional Factors.* Although each of the factors identified exerts individual influence on quality of life, these influences seem most appropriately understood as a composite, as *Institutional Factors* exert influence over all three of the other factors. Additionally, *Spatial Relationships* and *Relationships Between Residents and Staff* also have strong influences on one another.
Spatial Relationships

The neighborhoods in which supportive housing programs are sited influence residents’ quality of life. Neighborhoods with poorly maintained infrastructure, busy and crowded streets or noisy or noxious neighbors can decrease residents’ propensity to leave the buildings in which they live. Residents’ lack of engagement with the neighborhood around their residence and lack of transit in the area can lead to residents feeling isolated, as they struggle to connect with communities and support systems beyond their program. High quality connections to public transit can improve resident quality of life, as it allows residents to access the city in a much more meaningful way.

Spatial Relationships and Relationships Between Residents and Staff

The physical layout of supportive housing programs often works in tandem with staff relationships with residents in influencing resident quality of life. These relationships are full of tensions. Supportive housing programs seem to have highly functional designs, which allow for efficient movement of residents and staff and allow for observation and effective crisis intervention. The presence of staff on-site can contribute to resident feelings that they are being watched, that their movements are being restricted and that they are living in an institutional setting. These feelings can all decrease residents’ quality of life as they are made to feel infantilized and generally incapable of acting independently. Interactions between staff and residents can also be highly racialized and reinforce power dynamics that risk retraumatizing residents with histories of involvement with incarceration and the criminal justice system.

Conversely, building designs and the presence of staff inside of supportive programs can also help to facilitate casual interactions between residents and staff, which can help to increase residents’ trust in and familiarity with staff. The presence of staff on-site can be a welcome support for residents that lack supportive networks outside of housing programs. The greater the amount of resources available on-site at a given program, the better the results seem to be for residents attempting to manage chronic physical and mental conditions, which can boost residents’ quality of life significantly. At the same time, residents can feel that a multitude of on-site resources is constraining and invasive, deteriorating their overall feelings of independence and the ability to exert control over their own lives.

Relationships Between Residents and Staff

Staff can serve as one of the most redeeming influences on resident quality of life, but they can also serve as one of the most disruptive influences. A lack of resources allocated to supportive programs vastly limits the amount of money available to pay supportive staff members. These low-paying jobs are some of the most difficult jobs available, and while they often attract individuals who are committed to the mission of supportive housing and who possess immense emotional intelligence, a combination of low pay and organizational demands can sour staff quickly and lead to a high rate of turnover. At the same time that organizations hope that residents will open up to the on-site staff and have productive working relationships with them, staff are leaving at such high rates that residents often do not see the point in engaging with staff. This leads to resident feelings that staff are a disruptive element in their lives rather than the stable one that they are supposed to be.
Community and Resources

The marginalization of this group has led to diminished community resources and damaged senses of community. Residents from these groups enter supportive housing programs with pre-existing traumas, a learned distrust for authority, and diminished support networks. These factors contribute towards an initial state of low quality of life upon entering supportive housing programs as they deal with the legacy of trauma and continue to face issues of discrimination and poverty.

Despite a general lack of connection with community among residents, the provision of stable housing can be a positive influence in allowing residents to repair and maintain relationships with others. Having stable housing allows residents the chance to not only travel to and from a safe and secure location to visit others, but also provides a venue to host friends and family. Stable housing can in itself become a tool for building and maintaining connections with others who can provide residents with supports that are beyond the scope of the work that staff are able to do with residents.

Positive and negative forms of community can develop within supportive housing programs. These communities often stem from the need to share resources in order to best utilize the limited resources that residents can individually access. Positive forms of community can provide residents with a built in network that is able to support residents in ways that staff simply cannot. Negative forms of community can form around the acquisition and use of substances and can have positive influences from a harm reduction standpoint. However, these networks can also lead to instances of mass overdose and predatory relationships between residents.

The concentration of residents with shared traumas and conditions within the same program can reinforce behaviors that are counterproductive to residents’ healing, recovery and feelings of safety and stability. Communities seems to inevitably form in every program, and while resident-led communities are the most valuable types, program staff can prime a program by creating opportunities for resident-initiated community to form by hosting events that allow residents to get to know one another.

Institutional Factors

The systems in place that are available to assist residents of supportive housing programs, such as HRA, Social Security, Access-A-Ride, Medicaid and Medicare, Med Answering, SNAP, Veterans’ Affairs, physical and mental health providers, and detoxification and substance use rehabilitation centers, can be incredibly difficult to navigate. The fragmentation of the services that residents need across so many different agencies can itself make residents’ lives more difficult, as they are required to stay on top of managing their benefits and any necessary recertifications.

Additionally, the services that do exist are difficult to access and can involve confusing or time consuming application and enrollment processes that do not consider the capabilities of residents. The experience of not knowing whether a benefit will continue can induce anxiety in the life of a resident and even when benefits are continued, lag periods do occur and can impose undue financial and psychological burdens on residents. Services such as detox and rehabilitation centers also seem to be broken in the sense that a lack of coordination between
residents and staff, emergency rooms, and substance treatment centers leads to frequent relapse among residents seeking recovery. The systems in place are undoubtedly taxing on residents. Staff do typically make navigating these systems easier and can serve as both a researcher and an advocate in service of residents, but this requires positive relationships between staff and residents.

**Institutional Factors and Spatial Relationships**

The lack of affordable housing in New York City contributes towards a number of quality of life influences within programs. The general lack of affordable units across the city not only exposes the least housing secure residents to ever greater probabilities of becoming homeless, but also drives up the demand for the affordable units that do exist. High demand for this kind of housing can lead to the development of programs with very small units to maximize the number of qualifying low-income New Yorkers that can be housed. The small size of these units can lead to feelings of impermanence among residents.

The resulting density of high-needs individuals can put added strains on the physical maintenance of the buildings themselves, which can lead to residents feeling that their residence is a chaotic, stressful environment that they do not take pride in or desire to share with others. The lack of affordable housing in the city can also lead to supportive housing being implemented as a blunt tool of sorts to address the needs of a diverse group of people broadly categorized as low-income. Organizational requirements around staff engagements of all residents of supportive housing regardless of need leads to discrepancies with the reality of resident and staff time and priorities, and diverts attention from supporting residents that are most in need of services.

**Other Considerations**

Beyond the four identified factors, supportive housing residents are individuals who have experienced at least some duration of housing insecurity or homelessness, and have often dealt with chronic homelessness which may have lasted years, if not decades. The causes of homelessness and the experience of street homelessness themselves exert an influence on the quality of life of residents even as they are permanently housed in supportive housing. These individuals are more often than not members of marginalized communities, and have faced discrimination and injustice on a systemic level, and continue to even as they transition into supportive housing.

Residents’ belonging to marginalized groups also tend to come from communities that have been historically over-policed and continuously disrupted, vastly limiting their social support and their ability to connect with resources that could have prevented their initial state of homelessness prior to being housed in supportive programs. The supply of affordable housing on a city-wide basis has also diminished in recent years with the onset of city-wide gentrification, which does not happen randomly, and is often the result of catastrophic investment in historically underinvested-in communities.

The discrimination that residents face as mentally ill or physically disabled persons in this society vastly limits the kinds of jobs that will hire them and limits the possibility that they can or even should be thinking about work as a personal goal or priority. Our current system is a market driven one, and in that system, it is difficult to enjoy a high quality of life without being
employed. It is easy to make the comment that supportive housing residents would be better off in general if they had more money coming in, however it is not practical in reality for many residents to work and that should not be a reason for depriving them of the same quality of life as someone who is able to work. We all have differing levels of ability and interests and the mere lack of abilities or interests that correlate to well-compensated jobs should not mean that people have to live tucked away on the margins of our society. Additionally, for many the benefits they receive are higher than any wage that they might be able to earn, which some can interpret as “gaming the system” but I tend to interpret as wages continually falling behind the seemingly ever-growing cost of living.

Conclusion

Supportive housing’s overall influence on resident quality of life is, perhaps predictably, a complicated one. No text could possibly capture just how complicated the lives of supportive housing residents are and it is impossible to generalize about the experiences of supportive housing residents.

What this research has made most apparent is the tensions that exist within and around the supportive housing model. While there is a dire need to house the unsheltered population of New York City, supportive housing tends to concentrate individuals with shared problems. Additionally, the model attempts to solve the extremely complicated problem of providing affordable housing for a larger set of individuals whose primary commonality is their shared inability to keep pace with rising rental costs in the city. The impact of concentrating these individuals can often mean programs filled with a high density of small units, which can have multiple negative implications on the physical conditions of the building on community within programs, and ultimately on the quality of lives of residents.

Concentrating individuals with similar conditions within supportive housing can also be highly effective from a service provision perspective. The provision of case management and medical and psychiatric care on-site can greatly improve the quality of life of residents who need and want to utilize services to achieve goals around health, wellness and independence. Alternatively, this same concentration of residents can be viewed as primarily benefiting staff, who are provided with ample opportunity to observe and to unnecessarily intervene in residents’ lives.

Staff interactions with residents can differ widely between individual residents and individual staff members. All of these interactions are mediated through organizational systems which work against the plain reality, which is that residents are just as human as staff. Sometimes this distance is necessary for effective clinical work to occur, other times crossing that distance and recognizing the complicated reality can be more useful.

The main point that recurred over the course of this research was that the thing that made residents feel the best about themselves and their situations were the opportunities they had to exert control over their own lives and to feel independent. Tension exists within this reality, as residents’ patterns and behaviors that led them to street homelessness prior to being housed in supportive programs routinely cause disruptions to their lives that prevent them from feeling in control or independent. Staff interventions can be helpful in holding up a mirror to residents and bringing them to new understandings about themselves that ultimately allow them to live healthier and more independent lives.
While it can be easy to think that supportive housing residents are fundamentally different from the rest of the population, such conceptions reflect a degree of naivete. It is true that residents require unique supports in order to live lives that respect their humanity. However as several of the staff I interviewed pointed out, we all require supports in order to get through life. We often take for granted the supports that we depend upon, such as public transportation, our relationships with family and friends, our physical and mental health, our income, and a thousand more things that contribute towards the semblance of a "normal life."

The goal of supportive housing seems to be to restore to its residents these supports that they lost or never had in their own lives, and to increase their quality of life in reintroducing these supports. While supportive housing, both as a model and as a field for committed staff can allow residents to make significant strides to do just this, all results occur on a case by case basis. There are some residents for whom supportive housing does provide a positive, stable environment and connection to resources and people that make all the difference in their lives. There are still others for whom supportive housing will likely never be able to fully provide support. There are some traumas that we as a society lack the skills or the wisdom or the gentleness to heal.

There are a number of interventions that would not necessarily rival the current supportive housing model but would rather complement the existing system. These could include focusing on repairing communities broken through decades of disinvestment and systemic injustices, introducing policies to encourage the construction of more diverse affordable housing options in New York City, and perhaps most importantly for existing programs, allocating more financial resources towards paying case management staff. Increasing pay to staff could increase the quality of staff, boost retention and increase resident faith in case management staff.

Throughout the research process, as I explored the concept of resident quality of life and all that influences it, I also considered what system might deal with the needs of residents better than the existing system. I can not claim to know a better way, but I feel that any alternative proposed must involve more community driven care. The scatter site model offers an alternative to the congregate model explored in this study, which allows residents to live among the general population, but lacks the degree of support that many residents require, and requires residents to be more self-motivated in caring for their physical, mental and social health. In the process of conducting these interviews one staff member suggested "a structure that mirrors something more like a summer camp or a kibbutz where it’s not pure anarchy and it’s not pure paternalism either, there’s something about how you help, like respecting and valuing ways people participate, even though it’s not explicitly about like power and control." I feel this is a valuable idea, as it addresses the fact that residents crave opportunities to exert control over their own lives.

There is a concept of a feeling of “spiritual homelessness.” Spiritual homelessness describes the experience of moving to an enclave of people from the same part of the world or the same culture and building a community in that new place, while constantly being reminded that this new place, seemingly made from all of the same materials of home, is not in fact home at all. I can not say that my life has exposed me to any experiences that would allow me to comprehend how profound the feeling of dislocation is for those who have been forced to leave their homes, but the concept of “spiritual homelessness” is one that has stuck with me. It’s a concept that I feel well describes the modern condition of community in America. Whether someone lives among the insular suburban landscape, or in a gentrifying urban neighborhood or in supportive
housing, the common thread, I feel, is the loss of community, and a general feeling of dislocation and discomfort even in the places that we call home. The residents of supportive housing had been homeless, but they weren’t anymore; was supportive housing a home?

In many ways, the question that supportive housing attempts to answer can be distilled down to: how do we all live together? The system as it currently exists demands value from people. Homelessness is caused by many interrelated factors addressed throughout this paper. Once housed, the quality of life of residents is ultimately impacted by structures of society and the built environment. In the end, the entire system is almost incomprehensibly brutal in the way that it erases the possibility of just being a human and that in itself having value. Perhaps hope lies in remembering the spiritual bond that connects us in the human experience.
Acknowledgement

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Works Cited


