From: Anne N. Sosin, MPH
To: House Human Services Committee
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Subject: Testimony on Data on Homelessness

For the record, my name is Anne Sosin, and I am a public health researcher and practitioner based at Dartmouth College. Since 2020, my research has traced the use of housing policy as part of Vermont's COVID-19 response. I have also co-led research on homelessness and health equity. As part of this research, I have interviewed 60 residents in the General Assistance Emergency Housing in both the Upper Valley and the Northeast Kingdom.

Today, I would like to use my testimony to do three things. First, I would like to briefly review some of the evidence on the impacts of failing to avert a surge of unsheltered homelessness. Second, I would like to review the evidence on solutions to homelessness. Finally, I would like to lay out some evidence-based recommendations, including principles to guide the reform of the General Assistance Emergency Housing program.

I. Where We Are Now

I would like to begin by giving you a picture of where we are currently. Our choices over many decades have created a situation where a large and growing shortage of affordable housing is pushing growing numbers of Vermonters into housing precarity. Sometimes, a crisis such as a catastrophic medical event, sale of their place of residence, increase of rent, or natural disaster will push Vermonters on the margins of the housing market into homelessness. When they do lose housing, those without formal and informal supports may enter a free fall that leads to a cascade of adverse events, including new or exacerbated substance use or mental health challenges, difficulty maintaining employment or education, and accumulating impacts on their health and well-being. The absence of robust safety nets and investments in policies grounded in evidence at the scale needed is also making it harder for Vermonters to exit homelessness and leading to chronic impacts on health, housing security and well-being after doing so. As I will explain shortly, this freefall also comes at a large and growing cost to our public institutions, communities, hospitals, and schools. It adds the boarding crisis in our emergency department. It is contributing to exploding overdose deaths. It is straining schools, libraries, and public services.

Homelessness: A Crisis of Housing and Not Unhousable Vermonters

Vermont has reported the second highest rate of homelessness in the country for the second year in 2023, and its 18.5% one-year increase in homelessness was higher than the growth seen nationally.[1] Many have speculated on the causes of these trends. Research shows that housing supply and affordability, not substance use, mental illness, poverty, climate, local political context, availability of services, account for regional variation in homelessness.[2,3,] These individual level

[1] "The 2023 Annual Homelessness Assessment Report (AHAR to Congress) Part 1: Point-In-Time Estimates of Homelessness, December 2023," n.d.
[2] Gregg Colburn and Clayton Page Aldern, *Homelessness Is a Housing Problem: How Structural Factors Explain U.S. Patterns* (Oakland, California: University of California Press, 2022).

characteristics may help to explain who loses housing or struggles to exit homelessness but do not account for the trends that we are seeing in Vermont or nationally.

Vermont currently has an estimated shortage of 40,000 housing units and a large and growing gap between housing costs.[3] The state's housing wage, the cost to afford a two-bedroom apartment at fair market rate, is currently estimated at $25.54.[4] Prior to flooding that depleted Vermont's housing stock further, the National Low Income Housing Coalition estimated in 2023 that Vermonters earning minimum wage in Vermont would need to work 61 hours, or 1.5 jobs, to afford a one-bedroom apartment. I've pulled some local listings for jobs to underscore the growing challenges that many Vermonters face securing and maintaining housing.

Housing is Health

Many of you are familiar with the links between homelessness and health. We have very strong and consistent evidence showing that all people experience homelessness, not simply those perceived as vulnerable or in poor health, are at greater risk a broad range of adverse health, across the lifespan.[5,6,7] Research shows, however, that unhoused people who are unsheltered face fare worse outcomes that those who are sheltered. Unsheltered people confront greater health risks, experience higher rates of chronic disease, utilize healthcare with greater difficult and report increased mortality compared to those who are sheltered.[8,9,10]

Involuntary displacement, or sweeps, are a growing threat to many people who are unsheltered, including in the state of Vermont. These policy choices have immediate, well-documented harms to health and survival that include dramatic increases in the risk of death. Researchers modeling the population level health effects of involuntary displacement found a significant increase in overdose deaths for those who faced continual involuntary displacement versus no displacement.[11] Continual displacements were associated with up to a 46% increase in

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[3] "Out of Reach: Vermont | National Low Income Housing Coalition," accessed January 13, 2024, https://nlihc.org/oor/state/vt.

[4] "How Housing Costs Drive Levels of Homelessness | The Pew Charitable Trusts," accessed February 8, 2024, https://www.pewtrusts.org/en/research-and-analysis/articles/2023/08/22/how-housing-costs-drive-levels-of-homelessness.

[5] Diana B. Cutts et al., "Eviction and Household Health and Hardships in Families With Very Young Children," *Pediatrics* 150, no. 4 (October 1, 2022): e2022056692, https://doi.org/10.1542/peds.2022-056692.

[6] Megan Sandel et al., "Unstable Housing and Caregiver and Child Health in Renter Families," *Pediatrics* 141, no. 2 (February 1, 2018): e20172199, https://doi.org/10.1542/peds.2017-2199.

[7] "Housing And Health: An Overview Of The Literature" (Project HOPE, June 7, 2018), https://doi.org/10.1377/hpb20180313.396577.

[8] Jessica Richards and Randall Kuhn, "Unsheltered Homelessness and Health: A Literature Review," *AJPM Focus* 2, no. 1 (October 29, 2022): 100043, https://doi.org/10.1016/j.focus.2022.100043.

[9] Kirsten A. Dickins et al., "Mortality Trends Among Adults Experiencing Homelessness in Boston, Massachusetts From 2003 to 2018," *JAMA Internal Medicine*, March 13, 2023, https://doi.org/10.1001/jamainternmed.2022.7011.

[10] D. S Morrison, "Homelessness as an Independent Risk Factor for Mortality: Results from a Retrospective Cohort Study," *International Journal of Epidemiology* 38, no. 3 (June 1, 2009): 877–83, https://doi.org/10.1093/ije/dyp160.

[11] Joshua A. Barocas et al., "Population-Level Health Effects of Involuntary Displacement of People Experiencing Unsheltered Homelessness Who Inject Drugs in US Cities," *JAMA*, April 10, 2023, https://doi.org/10.1001/jama.2023.4800.

hospitalization and a 56% decrease in initiations of medications for opioid use disorder. Continual involuntary displacement was estimated to contribute to an additional 16% to 24% additional deaths among unsheltered people experiencing homelessness who inject drugs. In short, policy choices on housing and shelter also should be understood as policy choices on the overdose crisis.

Community Level Impacts

Many believe that eliminating funding for homelessness eliminates the costs or visibility of homelessness. This is not borne out by research. Policy choices that lead to unsheltered homelessness simply displace the impacts and costs from homelessness budgets and funding streams to municipalities, health systems, criminal systems, schools, public services, and businesses. I would like to highlight some of the research and data to bring some of these many impacts into focus.

Decisions on sheltering policy have immediate and often unforeseen implications for healthcare and service providers. Massachusetts' experience provides further insight into some of the potential impacts of defunding emergency shelter. A 2018 study published in *Pediatrics* led by homelessness expert Dr. Megan Sandel found large increases in pediatric emergency department utilization and costs following a 2012 policy change to limit eligibility for emergency shelter in Massachusetts.[12] Although child homelessness increased 1.4 times between 2010 and 2016, emergency department visits for child homelessness increased thirteen-fold during this time. Only 26% of children had a medical complaint. The average costs of emergency department visits for the study population were more than four times higher than the cost of emergency shelter, and 89% of payments for emergency department visits were made through state-based insurance plans.

Unsheltered homelessness also imposes significant, well-documented costs on communities and public institutions. Studies have estimated the costs of homelessness at upwards of $30,000 per year per person.[13] A 2019 HUD-funded study documented significant expenses for municipalities responding to encampments. 90% of these costs were absorbed by municipalities.[14] Most of these costs are not supported by HUD funding.

II. Where We Need to Go: Evidence for Action

Vermont can reimagine a system that has robust safety nets that both prevent people from falling into homelessness but also that prevent episodes of homelessness from leading to this cascade

[12] Amanda M. Stewart et al., "Pediatric Emergency Department Visits for Homelessness After Shelter Eligibility Policy Change," *Pediatrics* 142, no. 5 (November 1, 2018): e20181224, https://doi.org/10.1542/peds.2018-1224.

[13] Sharon A. Salit et al., "Hospitalization Costs Associated with Homelessness in New York City," *New England Journal of Medicine* 338, no. 24 (June 11, 1998): 1734–40, https://doi.org/10.1056/NEJM199806113382406.

[14] Rebecca Cohen, Will Yetvin, and Jill Khadduri, "Understanding Encampments of People Experiencing Homelessness and Community Responses: Emerging Evidence as of Late 2018," *SSRN Electronic Journal*, 2019, https://doi.org/10.2139/ssrn.3615828.

of adverse events that both results in significant individual and population level harm and imposes significant impacts and costs on communities.

Solving Homelessness

While Vermont's growing crisis of homelessness may appear inevitable or intractable, a large body of research and examples from other settings provides us a very clear path for addressing it. Decades of research demonstrate that the vast majority of people experiencing homelessness can be successfully housed with positive outcomes. Several randomized control trials, often seen as the gold standard of evidence, observational studies, and large-scale program evaluations in the US and other settings have demonstrated that the vast majority of people experiencing homelessness can be housed using a Housing First approach.[15,16,17,18,19,20] Research has also shown that while housing alone doesn't solve all problems immediately or fully, it leads fewer encounters with the criminal justice system, use of emergency healthcare services less frequently, and increased utilization routine healthcare more frequently.[21]

We have real world examples of what is possible when these evidence-based approaches are brought to scale. Houston and Milwaukee have embraced the data-proven practice of Housing First and have made dramatic progress in reducing homelessness. The Veteran's Administration also uses a Housing First approach. Homelessness among veterans dropped 50% between 2009 and 2019 decreased by 50% even as homelessness increased nationally.[22]

What is Housing First?

I want to take a moment to explain what we mean when we talk about Housing First. Housing First is both a practical programmatic approach as well as a philosophical orientation. Housing First often refers to permanent supportive housing using the assertive community treatment, or ACT model, which developed by Pathways. Housing First also refers to a set of principles that can be applied across the spectrum of homelessness and housing services. Core components of

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[15] Verughese Jacob et al., "Permanent Supportive Housing With Housing First: Findings From a Community Guide Systematic Economic Review," *American Journal of Preventive Medicine* 62, no. 3 (March 2022): e188–201, https://doi.org/10.1016/j.amepre.2021.08.009.

[16] Jack Tsai, Alvin S. Mares, and Robert A. Rosenheck, "A Multi-Site Comparison of Supported Housing for Chronically Homeless Adults: 'Housing First' versus 'Residential Treatment First,'" *Psychological Services* 7, no. 4 (2010): 219–32, https://doi.org/10.1037/a0020460.

[17] Vicky Stergiopoulos et al., "Long-Term Effects of Rent Supplements and Mental Health Support Services on Housing and Health Outcomes of Homeless Adults with Mental Illness: Extension Study of the At Home/Chez Soi Randomised Controlled Trial," *The Lancet Psychiatry* 6, no. 11 (November 2019): 915–25, https://doi.org/10.1016/S2215-0366(19)30371-2.

[18] Maria C. Raven, Matthew J. Niedzwiecki, and Margot Kushel, "A Randomized Trial of Permanent Supportive Housing for Chronically Homeless Persons with High Use of Publicly Funded Services," *Health Services Research* 55, no. S2 (October 2020): 797–806, https://doi.org/10.1111/1475-6773.13553.

[19] Clare Davidson et al., "Association of Housing First Implementation and Key Outcomes Among Homeless Persons With Problematic Substance Use," *Psychiatric Services* 65, no. 11 (November 2014): 1318–24, https://doi.org/10.1176/appi.ps.201300195.

[20] Meghan Cunningham, Mary, "Breaking the Homelessness-Jail Cycle with Housing First," n.d.

[21] "'Housing First' Increased Psychiatric Care Office Visits And Prescriptions While Reducing Emergency Visits," accessed February 2, 2024, https://doi.org/10.1377/hlthaff.2023.01041.

[22] "The 2022 Annual Homelessness Assessment Report (AHAR to Congress) Part 1: Point-In-Time Estimates of Homelessness, December 2022."

a Housing First include access to immediate access to housing–and absent housing shelter–with no readiness requirements, low barrier admissions criteria, choice, determination and dignity in both housing and services, services that are voluntary and designed to support housing stability, and clear accommodation and support for disability. Evidence shows that Housing First models offer far greater housing stability than "treatment first models," particularly for individuals who have experienced chronic homelessness.[23]

I also want to address some of the many misconceptions about Housing First. First, Housing First is not housing only, even though most people simply need affordable housing to end homelessness. Housing First is also not a one-size-fits model all but rather an approach that centers housing and meets the diverse needs of people who experience homelessness. Housing First needs to be well-resourced and implemented with fidelity to the model. Many programs claim to be practicing Housing First but only follow parts of the model. Indeed, the Veterans' Administration program has achieved such dramatic results because it has been consistently well-resourced and implemented with fidelity to the model.[24] Finally, Housing First programs and practices can't alone overcome a hostile housing market that generates homelessness more quickly than it can be resolved.

Evidence on Services

While the evidence on housing as the solution to homelessness is extremely robust, the available evidence on supportive services on housing retention is much more mixed. Part of this is due to the reality that less research has been conducted on services. Existing research suggests that some types of services may not only not contribute meaningfully to greater housing stability but also may undermine housing stability under some conditions.[25] Specifically, services that are delivered by the same agency as housing may threaten tenancy.[26] My Dartmouth research collaborator Professor Elizabeth Carpenter-Song conducted a decade-long ethnographic study of the experiences of families experiencing homelessness in the Upper Valley. In her 2023 book, she similarly described the ways that services and systems of care may undermine housing stability.[27] For this reason, separation of housing and supportive services and individual choice in use of services is central to the evidence-based Housing First model.

Interim Housing

While we know that Housing First, not shelter, solves homelessness, we also have a growing body of evidence that can and should guide our interim strategies. The widespread use of hotels

[23] Tsai, Mares, and Rosenheck, "A Multi-Site Comparison of Supported Housing for Chronically Homeless Adults."
[24] Stefan G. Kertesz et al., "Housing First on a Large Scale: Fidelity Strengths and Challenges in the VA's HUD-VASH Program.," *Psychological Services* 14, no. 2 (2017): 118–28, https://doi.org/10.1037/ser0000123.
[25] Marybeth Shinn and Jill Khadduri, *In the Midst of Plenty: Homelessness and What to Do about It*, Contemporary Social Issues (Hoboken, NJ: Wiley Blackwell, 2020).
[26] Liz McGrath and Nancy Pistrang, "Policeman or Friend? Dilemmas in Working with Homeless Young People in the United Kingdom," *Journal of Social Issues* 63, no. 3 (September 2007): 589–606, https://doi.org/10.1111/j.1540-4560.2007.00525.x.
[27] Elizabeth Carpenter-Song, *Families on the Edge: Experiences of Homelessness and Care in Rural New England* (Cambridge, Massachusetts: The MIT Press, 2023).

early in the COVID-19 pandemic offered a natural policy experiment on the use of non-congregate shelter. A growing number of studies provide compelling evidence that non-congregate shelter using hotels is superior to traditional congregate shelter.[28] Reflecting on this emerging evidence, homelessness scholars Deborah Padgett and Daniel Herman wrote in 2021 that, "Hotels should be used as long as necessary to replace congregate shelters, and those that can be converted to permanent apartment units should undergo needed alterations as soon as possible."[29]

I have also studied the use of motels for non-congregate shelter as part of my own research on homelessness and health equity.[30,31] As part of this research, I conducted interviews with 60 guests at motels in the Upper Valley and the Northeast Kingdom and also conducted interviews providers in the Northeast Kingdom. Consistent with other studies, motel guests consistently reported that stable shelter enabled them to access healthcare services, seek and maintain employment, and manage their health. While shelter facilitated other improvements, participants noted that even modest disruptions to shelter stability undermined access to care, employment, and education. Transfers between motel locations contributed to transportation barriers, created discontinuity in care, and exacerbated challenges navigating already fragmented systems. Some participants mentioned that they had started accessing care in one location and then lost healthcare or access to other services following a housing or shelter disruption. Periods of frequent relocation between locations significantly compromised the ability to prioritize healthcare. Families moving between shelter locations struggled to maintain education.

Read together, this growing body of research can help us to reimagine a new system of interim housing that is part of our strategy to address homelessness.

Recommendations

I would like to conclude today's testimony by offering evidence-based recommendations to guide the Committee's approach to solving homelessness and reimagining the General Assistance Emergency Housing Program.

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[28] Gregg Colburn et al., "Hotels as Noncongregate Emergency Shelters: An Analysis of Investments in Hotels as Emergency Shelter in King County, Washington During the COVID-19 Pandemic," *Housing Policy Debate* 32, no. 6 (November 2, 2022): 853–75, https://doi.org/10.1080/10511482.2022.2075027; Mark D. Fleming et al., "Association of Shelter-in-Place Hotels With Health Services Use Among People Experiencing Homelessness During the COVID-19 Pandemic," *JAMA Network Open* 5, no. 7 (July 27, 2022): e2223891, https://doi.org/10.1001/jamanetworkopen.2022.23891; Deborah K. Padgett, Lynden Bond, and Christina Wusinich, "From the Streets to a Hotel: A Qualitative Study of the Experiences of Homeless Persons in the Pandemic Era," *Journal of Social Distress and Homelessness*, January 9, 2022, 1–7, https://doi.org/10.1080/10530789.2021.2021362; Leah Robinson, Penelope Schlesinger, and Danya E. Keene, "'You Have a Place to Rest Your Head in Peace': Use of Hotels for Adults Experiencing Homelessness During the COVID-19 Pandemic," *Housing Policy Debate* 32, no. 6 (November 2, 2022): 837–52, https://doi.org/10.1080/10511482.2022.2113816.

[29] Deborah K. Padgett and Daniel Herman, "From Shelters to Hotels: An Enduring Solution to Ending Homelessness for Thousands of Americans," *Psychiatric Services* 72, no. 9 (September 1, 2021): 986–87, https://doi.org/10.1176/appi.ps.202100170.

[30] Sosin, Anne N., "Foundations for Health: Homelessness and Health Equity in the Upper Valley," January 2024.

[31] Sosin, Anne N., "Homelessness and Health Equity in the Northeast Kingdom," August 2023.

1. First, we need to commit to evidence-based Housing First as both the programmatic backbone and guiding strategy for our state homelessness response.
2. Second, we need to develop a comprehensive, data-driven plan on homelessness accompanied by metrics. These metrics should include targets for rehousing Vermonters, creating new non-congregate shelter capacity, and permanently affordable housing units created. In addition, we should be tracking eviction rates as a state.
3. Third, I would like to recommend that we need a separate entity dedicated to solving homelessness.
4. Fourth, we should establish the goal of eliminating zero unsheltered homelessness. While it will take sustained investments over time to end homelessness in Vermont, this goal can be achieved.

Finally, I would like to like to describe a few basic principles that should guide the Committee's work to reimagine the General Assistance Emergency Housing program. These principles are intended to compliment the specific recommendations offered by other witnesses.

1. **Pathway to permanent housing**: Design interim housing as a unidirectional path to permanent housing. Arbitrary time limits, night-by-night shelter, relocation between motels or other interim housing sites, and other disruptions to interim housing/shelter stability undermine housing, employment, healthcare, and education and will be avoided in the design and implementation of programs.
2. **Non-congregate interim housing/shelter** Utilize non-congregate interim housing options to the greatest extent possible. As an immediate priority, Vermont should avoid the use of mass congregate shelter.
3. **Align with evidence-based Housing First principles** This includes providing immediate access to shelter without housing readiness requirements, ensuring that supportive services are voluntary and designed to support housing stability, and adopting a harm reduction approach in interim housing settings.
4. **Address the needs and barriers for unhoused Vermonters with disabilities**: Many households experiencing homelessness in Vermont have one or more individuals with a disability. Many who are staying in the hotels remain there for reasons directly or indirectly related to their disability. Increasing the supply of interim housing that is geographically and physically accessible and also that meets the range of needs of disabled Vermonters should be a priority. Some of the new shelters are being sited in locations that are far from town centers. The Americans with Disabilities Act requires that people with disabilities have equal access to public services like emergency housing, and receive reasonable accommodations needed to access those services.

Thank you for the opportunity to testify today.