Human Services Committee
1-27-26
Testimony H.594

Thank you for the opportunity to speak with the Committee this afternoon. For the record, my name is Jonathan Farrell, I am the Executive Director of the Committee on Temporary Shelter, better known as COTS, in Burlington and I am a resident of Burlington as well.

First, let me talk about H.594, also known as the Temporary Emergency Housing and Accountability and Return Home Programs. There are a few issues with its design, including unrealistic shelter stay limits, case management requirements, and eligibility requirements which others have already talked about, and I'm sure there will be more testimony about.

There are a few concepts within this bill with which I agree. We should have a measure of accountability in our shelter system. I disagree with the concept that guests in shelter should only engage with what they want, when they want, and only if they want. The purpose of shelters is to help people move from shelter to permanent housing. Guests in our shelters should have the expectation to engage in that process ***to the best of their ability*** while they stay in shelter. There are occasionally folks who use shelter for inappropriate reasons, and shelter providers should be able to exit those people from the shelter, freeing up the resource for the next person who needs a bed. There is a lot of nuance in "***engagement to the best of one's ability***", and shelter providers must be trusted to make those decisions.

Another aspect of this bill's intentions with which I agree is that the GA Emergency motel program does need to contract. It's not the solution to our crisis of homelessness and affordability. Motel rooms are isolating, often barely habitable, and placing folks in motel rooms can leave them no better off than when they entered, and often they are worse off for being in the motel. However, this program must be ramped down thoughtfully with other alternatives in place.

H. 594, however, misses the mark in its attempt to redesign our shelter system. Our shelter system, designed to move people from shelter into appropriate housing, actually functions. It has a stable base of funding, a state-wide view of the issue, shelter habitability inspections, metrics, and results. Our shelter providers know how to interrupt generational poverty, connect people to services and benefits, to provide opportunities for those who have fallen on hard times, and to allow folks who are recovering the opportunity to do so. We will always have a need for such services in our

communities, and I implore this committee to recognize that our shelter system does not need redesign, nor does it need its established funding mechanisms upended.

The issue with our shelter system is that it has become the default infirmary, the default psychiatric ward, the default system for substance use disorder, and the default system for folks with physical and developmental disabilities.

In COTS fiscal year 2025, we had 161 single individuals stay in our Waystation shelter. The Waystation is a program shelter, that is it carries an expectation of engagement in housing navigation services. 70% of our guests in that program shelter identified having one or more disabling conditions which include substance use disorder, mental health conditions, physical disability, chronic health conditions, or developmental disability. 61 of those guests moved into permanent housing.

In COTS fiscal year 2025, we hosted 191 single individuals in our Warming Station, a low-barrier shelter that operated for 4 months in the winter. Of those guests, 80% reported one or more of the disabling conditions: substance use disorder, mental health issue, physical disability, a chronic health condition, or developmental disability. 1 guest moved into housing, and a few moved into the program shelter.

The COTS Daystation is a drop-in center for those 18 and up who are experiencing homelessness. We offer a daily meal, showers, laundry, mail, internet, computer access, access to our shelter program, our services, and host many community partners who serve the same population. We are open 365 days a year and see 80 to 100 people per day. Most months, we see about 400-450 unique individuals, the month of November we saw 698 unique individuals in this program. 698.

Over 60% of our daily Daystation guests are experiencing unsheltered homelessness. These guests are also experiencing acute symptoms related to substance use disorder, mental health, physical disabilities, chronic health conditions, and developmental disabilities. They cannot take care of themselves in a shelter or in a motel room. They need specialized services. They need experts in these fields to build rapport with them, to coordinate their care, and to help them get to a place and time when they can engage in shelter and housing services and secure a sustainable place to live.

This is the vast majority of the unsheltered population in our area. I want to be clear, this is the long-term result of structural changes made to our systems of care beginning in the 1980's, the result of increasingly addictive and destructive street drugs, and the result of isolation from the pandemic, and not the fault of folks in our state who are doing incredibly difficult work in these fields with limited resources.

Here is what we need to focus on.

1. We need Care Coordinators, experts in substance use disorder, health care, and developmental disabilities in our daytime drop-in centers. Referrals to services do not work. People who are in the depths of addiction, or a mental health crisis, or who have chronic disabilities cannot get to an appointment. Folks in active psychosis cannot navigate a shelter setting or meet with a housing navigator. We need the providers onsite daily to meet guests, build relationships and trust, and to navigate complex systems of health care to get people into the correct service.
2. We need those same experts in the overnight shelter in the evening to support those who are returning from physical or substance use rehab, while they live in shelter and engage in services.
3. To be clear, the goal is not to turn our shelters into infirmaries or psych wards, these experts will divert folks to the appropriate treatment, and support their post-treatment stay in shelter while they engage in housing navigation.
4. We need to invest in residential treatment beds for substance use disorder, for mental health, and for health care.

Allow me to illustrate. We have raised money through the temporary opioid settlement funding and through private donors to have recovery coaches from the Turning Point Center of Chittenden County full time at the Daystation, 7 days a week, and in the evenings at the Waystation 7 days a week. A person who had been in and out of our shelter and many other services for more than a decade showed up at the Waystation, heavily intoxicated on a brutal winter night and was given a temporary overflow bed. An overflow bed is a cot in the lounge where they could be monitored by staff, so they did not die. They wanted to be admitted to the shelter program, and we asked them to meet with a recovery coach in the morning. They did, and shortly after were offered a 14-day treatment bed at Valley Vista. That turned into an offer for a 90-day treatment program, which has been accepted. When they complete treatment, they will have a bed in our shelter, recovery coach support daily and in the evenings, and access to housing navigation.

A 71-year-old woman with a chronic health condition and co-occuring mental health issues has been staying in shelter. Previously, they were unsheltered, living on the streets, and coping with UTI and other health issues. Because Community Health Centers is funded to be in our Daystation 2 times a week, and in the Waystation 2 evenings a week, through temporary opioid settlement funds, she has the medical help she needs, and the people who know how to navigate the medical system. Our shelter staff run shelters, which is difficult work in its own right, and they cannot be health experts, cannot manage medications, cannot arrange appointments, or navigate the complexities and eligibilities of our health care system.

An individual experiencing homelessness was discharged from the hospital to St. Albans, because his chart said he had family there. He had not lived there in over 20 years and had nowhere to go. He managed to find his way to Burlington and the Waystation, staff provided an overflow bed, and he was examined by CHCB staff. An appointment was made for him the following day, and COTS got him to the appointment. He was treated and was able to follow up with medical staff in the following days at the Daystation. This intervention made it possible for this person to be admitted into shelter, and able to engage in housing navigation services. As an aside, we have a nurse from UVM Health in the Daystation once a week. They are able to help navigate some folks in the health care system, but the need is overwhelming for one person a few hours a week. This nurse confirmed that dozens of homeless individuals have the note DC/DS on their chart – discharged to Daystation.

In Summary:

1. Please stop tinkering with shelter funding and shelter design – it is solving the wrong problem. Keep shelters adequately funded through HOP and OEO, there will be a need for shelters until our housing affordability and supply is addressed.
2. Please do not repeat the flaws of H.91 that tried to give funding to CAP agencies to create services in which they hold no expertise, such as substance abuse and mental health services.
3. Thoughtfully shift GA funding from motels to the Department of Health and its Division of Substance Use Programs, the Department of Mental Health, The Department of Aging and Independent Living, and the Economic Services Division, to provide experts in the field to our daytime and overnight shelters. We need expert Care Coordinators at least 5 days and evenings a week, who can build relationships with our guests, diagnose, triage, and arrange care management for those in the throes of mental health issues, addiction, and medical disabilities. That's the problem we need to solve. We need to better coordinate our existing health care systems, evaluate the need, and if necessary, provide residential treatment centers of all varieties where people experiencing homelessness can get the help they need before entering a housing-focused shelter system. I believe my colleagues at the State are aware of this need and willing to do the work and to direct funding to meet this need.
4. There will always be a need for a limited pool of motel rooms to solve immediate crisis. We often have people and families show up at our offices with nowhere to go on a Friday afternoon. A reasonable supply of motel rooms for short duration will provide an immediate solution that can be followed up in a few days.

Thank you.