The Washington
LEGAL CLINIC
for the Homeless
A Voice for Housing and Justice

Committee on Health
Oversight Hearing on Department of Health
March 6, 2013
Testimony of Amber W. Harding

Thank you for the opportunity to testify before you. For the last decade, I have worked at the Washington Legal Clinic for the Homeless, primarily focused on the intersection between health and shelter and housing needs. The purpose of my testimony today is to highlight the connection between one's living environment and one's health. As Shaun Donovan, the Secretary of the U.S. Department of Housing and Urban Development has said: "When we think of improving the health outcomes of Americans, we often think of better medicine, lower health care costs, and smarter prevention strategies. But in many ways, safe, decent affordable housing is just as important."[1]

While we believe that housing is a human right and that all DC residents should have access to safe and affordable housing, as the founder and director of the Legal Clinic's David Booth Disability Rights Initiative, I have seen firsthand the particular impact that lack of adequate housing can have on those with serious health conditions. In DC, where our HIV infection rate is officially characterized as an epidemic, people with HIV/AIDS are hit particularly hard by homelessness.[2] My first year as an attorney, I worked with a woman with HIV/AIDS who was staying at the large communal family shelter of the day, DC Village, with her children. She caught every bug that went around because of all the shared space. When I met her she just had been hospitalized three times in one month, was just getting over pneumonia, and had been told that that her T cell count was dropping rapidly. I helped her request a move to an apartment-style shelter but there was no immediate opening. She died before she could move. This didn't have to

[1] http://www.spotlightonpoverty.org/ExclusiveCommentary.aspx?id=53e6df1f-e7a8-4453-a390-b438ce410106

[2] We strongly support the DC Community Coalition's recommendation for a comprehensive HIV/AIDS strategy that considers factors beyond just testing and treatment for the affected population.

happen—in fact, studies show that mortality rates decrease by 80% when people with AIDS are provided housing.[3]

Just recently, we met a man who was diagnosed with HIV three years ago. After contracting pneumonia from staying in a cramped, communal shelter and almost dying as a result, he decided that he would try his chances on the street instead. (There are no non-communal shelter options for people without minor children.) He tries to eat well and rest, but that's hard to do on the street. He has a doctor and has access to medication, but his medication upsets his stomach and makes him lose control of his bowels. Since he does not have consistent access to a bathroom, he decided to stop taking his HIV medication. Now he is no longer HIV positive. Instead, he has AIDS and his T cells are dangerously low. He cannot protect himself from sexual assault on the street, and his assaulters are not concerned about protection. People who are homeless are at much higher risk of being infected with HIV *and* with infecting others with HIV.[4]

It's not just people with HIV/AIDS whose health deteriorates rapidly in shelter and on the street. Seniors suffer far graver health consequences than their younger counterparts when they experience homelessness. One 88 year old woman lost her home after many years. She had a hard time sleeping at night because of the hundreds of other people around her. Her memory soon suffered, to the point where she frequently couldn't remember who her attorney was. One day, while standing in line in the cafeteria, another resident pushed her and she fell and broke her hip. She went into a nursing home, where she remained until she was placed in the Housing First program by the Department of Human Services. Although she never fully recovered her mobility or her independence, her memory and general health improved greatly once she was in housing.

Good health cannot be separated from good housing. With housing, people with diabetes can finally cook for themselves and regulate their insulin better, sometimes without shots. Those with immune-suppression disorders get sick far less often, and their immunities strengthen. Those with immense pain whose meds were stolen regularly in shelters or on the street for their black market value finally have some relief from numbing pain. Housing can literally be a lifesaver for people with serious health conditions.

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[3] Wolitski, R., Kidder, D. & Fendton, F. (2007). The effects of housing status on health-related outcomes in people living with HIV: A systematic review of the literature. *AIDS & Behavior,* 11(6) / Supp 2: S167-171.
[4] Aidala, A. & Sumartojo, E. (2007). "Why Housing?" *AIDS & Behavior*, 11(6) / Supp 2: S1-6.

The Homeless Services Reform Act states that the Department of Health has a seat on the Interagency Council on Homelessness (ICH). We encourage the Director to take a more active role in the ICH to advocate for housing as a cost-effective and powerful health intervention for people experiencing homelessness. We also encourage this Council to work with Mayor Gray to devote significant resources towards ending homelessness for the elderly and for people with serious health conditions, such as those with HIV/AIDS and those judged to be most vulnerable to dying on the street or in shelter by the Department of Human Services' assessment tool.[5] In particular, we ask the Mayor and the Council to devote the large majority of the $100 million investment in affordable housing towards meeting the urgent housing needs of the DC residents who are homeless.

[5] We support the Fair Budget Coalition's proposals to end homelessness for the elderly ($7 million) and people with HIV/AIDS ($3 million) in FY14. We also support the Coalition's recommendation to increase investment in the Housing First program by $13.5 million to serve 540 chronically homeless households.