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Journal
JAMA, 329(17)

ISSN
0098-7484

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Publication Date
2023-05-02

DOI
10.1001/jama.2023.4644

Involuntary Displacements: Making a bad situation worse

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Word Count: 1395
References: 14
Figures/Tables: None

Conflict of Interest Disclosures:
Dr Kushel reported being on the Board of Directors of Housing California and the National Homelessness Law Center outside the submitted work and receiving support from the National Institute on Aging (K24AG046372 and AG041860) and the Benioff Homelessness and Housing Initiative.

Each night, approximately 580,000 people in the United States experience homelessness; 40% do so in unsheltered settings (e.g., encampments, vehicles, and abandoned buildings).[1] Black, Latinx, and Indigenous Americans are impacted disproportionately.[1] Many people experiencing homelessness eschew shelter due to concerns about restrictive rules, safety and privacy, and the inability to keep belongings, pets, and partners.[2] In many regions, there are long wait lists for shelters. Despite this, in response to concerns about people living in public spaces, government employees conduct involuntary displacement of homeless encampments in which they forcibly move those living in encampments, throw out belongings and arrest those who refuse.[3] Although displacements may involve offers of shelter or, less commonly, housing, most result in scattering to other unsheltered places.[3] Local governments justify forced displacements based on concerns about health and safety, complaints of housed residents, and the need to enforce laws against sleeping in public. Occasionally, involuntary displacements garner significant media attention and protest, as happened with the recent displacement of residents of McPherson Square in Washington, DC. However, more often, they occur without interest or attention.

In this issue of *JAMA*, Barocas et al use closed cohort simulation models to explore the risks of involuntary displacement on people who use injection drugs.[4] They simulated separate cohorts from 23 United States cities, using city-level data (including the Centers for Disease Control and Prevention's National HIV Behavioral Surveillance data). They examined injection drug-related health outcomes, including overdose mortality, serious injection-related infections (SIRIs; e.g., endocarditis and skin and soft tissue infections), SIRI-related mortality, hospitalizations, initiations of medications for opioid use disorder (MOUD), and life-years lived over a 10-year

period, comparing two scenarios: “no displacement” vs “continual involuntary displacement.” Continual involuntary displacement was defined as persistent risk of being forced to relocate with a resultant disruption in health services. To estimate the changes in model parameters of displacement on people who use drugs, they used data from two empiric studies in Los Angeles and San Francisco, California. Using these methods, the population-attributed fraction of continual displacement to mortality was estimated.

They found a significant increase in overdose mortality (71-94%) at 10 years for those who faced continual displacement versus no displacement. It was estimated that continual displacements were associated with up to a 46% increase in hospitalization and a 56% decrease in initiations of MOUD. Continual involuntary displacement was estimated to contribute 16% to 24% additional deaths among unsheltered people experiencing homelessness who inject drugs. Noting the limitations in the data quality and precision, the authors recommend that these numbers should be used as general guides. However, they found that under no model were the results of displacement beneficial or even neutral to health and safety.

These results provide a sobering account of the health costs of involuntary displacement on the lives of people who are unsheltered and use injection drugs. Although those who use injection drugs make up the minority of those who experience unsheltered homelessness, they may be at elevated risk of negative health impacts.[5] Involuntary displacements may harm health through disruption in healthcare and social networks; loss of medication, documents, phones and other belongings; incarceration; and negative impacts on trust.[5,6] These mechanisms

would have negative health effects on all individuals who experience unsheltered homelessness, not only those who use injection drugs.

Both homelessness overall and unsheltered homelessness—with and without involuntary displacement--are associated with threats to health. Homelessness is associated with worsened health compared with housed populations living in poverty.[7] Poor health increases the risk that an individual becomes homeless. There is a bidirectional association between homelessness and behavioral health problems, including substance use, which tend to worsen with homelessness and have profound negative impacts on multiple health domains. There is a direct deleterious effect of homelessness on health. People experiencing homelessness are less likely to access longitudinal healthcare, less likely to adhere to medications and dietary recommendations, and less likely to be able to seek help for health problems in early stages. People experiencing homelessness have high rates of emergency department use and hospitalizations, longer duration of hospital stays, and higher rates of readmission.[8] The homeless population is aging, with more than one-third of homeless single adults now 50 years or older.[9] With the aging of the population, people experiencing homelessness have a high prevalence of chronic conditions. The current study does not address people with conditions other than injection drug use, but it is reasonable to assume that all people facing unsheltered homelessness and involuntary displacements would face increased risk of harm against a background of elevated baseline risk.

There is no question that unsheltered homelessness—with and without involuntary displacement-- creates risks to health and safety of those who experience it. People living in homeless encampments lack access to basic hygiene facilities, facilitating the spread of infectious diseases such as hepatitis A. They face

exposure to the elements, which are worsened by the climate crisis, an elevated risk of violence and disruptions to sleep, and unfiltered exposure to poor air quality and increased risk of burns due to fires used for cooking and heat. They lack access to electricity needed for lighting, internet, and phones. And yes—homeless encampments are unsightly and understandably disturbing to the surrounding community. The question is not whether living in unsheltered settings is dangerous, but rather what is the role of forced displacements in addressing the harm caused by them.

Homelessness rates in communities do not vary according to the rates of drug use or mental health problems in a community; instead, they vary based on the availability of affordable housing. Homelessness is most common in areas with a large disconnect between the incomes that low-wage households have and the availability of housing that the lowest income households can afford.[10] Unsheltered homelessness rates vary not only with the rate of homelessness in a community, but with the availability of shelter that meets the needs of those who experience homelessness.

The United States has a severe shortage of housing that is affordable for extremely low-income households, with only 36 units available and affordable nationally for every 100 extremely low-income households (defined as households that make less than 30% of the Area Median Income).[11] Rental subsidies, which allow low-income individuals to pay only 30% of their household income on rent with the Federal Government covering the rest, are limited, with only one in four households that qualify for the subsidies receiving them.[12]

There is an abundance of high-quality evidence supporting the philosophy of "Housing First" as the way to end homelessness. The Housing First model refers to addressing homelessness through low-barrier permanent affordable housing, rather than demanding that people progress through a series of temporary housing solutions (including shelter) on the way to "earn" the right to housing. Empirical evidence supports the use of Housing First, even for those with the most severe behavioral disabilities and those exiting unsheltered homelessness.[13]

Involuntary displacements, while politically palatable, rarely result in residents obtaining housing.[3] They are traumatic for those displaced and result in the loss of property and increased criminal justice system involvement.[3,6] They disrupt social networks and cause disconnections from outreach personnel, and loss of access to healthcare.[3,5,6] The Ninth Circuit ruling in *Martin vs Boise* forbade bans on sleeping in public unless all participants could be offered shelter. During the COVID-19 pandemic, due to concerns about displacements leading to spread of SARS-COV-2 via mixing of communities and concerns about people moving into shelters, where COVID transmission was high, the US Centers for Disease Control and Prevention recommended that communities cease displacement unless there was a housing plan.[14] Despite these concerns, involuntary displacements have continued, or increased, as public outrage about unsheltered homelessness rises.

There is no doubt that living in unsheltered settings is dangerous. Involuntary displacement does not offer protection and, as Barocas et al have shown, instead creates enormous risks to health and safety. The solution to homelessness is housing. Equipped with the evidence of harm of involuntary displacement, clinicians should speak out against involuntary displacement, and use their voices to advocate for the real solutions that will end the homelessness crisis.

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