



Health Conditions Among Unsheltered Adults in the U.S.

JANEY ROUNTREE, NATHAN HESS, and AUSTIN LYKE

SUMMARY

Little is known about the vulnerabilities and past experiences of unsheltered individuals or how they differ from individuals in shelters. This study adds to our understanding by analyzing new data from a survey (VI-SPDAT) given to homeless individuals across the United States. Health and behavioral health and trauma are significant contributing factors to loss of housing, particularly for unsheltered women. Unsheltered people continue to experience major and worsening health conditions while homeless. People with the longest experiences of homelessness, most significant health conditions, and greatest vulnerabilities are not accessing and being served by emergency shelters. Rather than receiving shelter and appropriate care, unsheltered people with major health challenges are instead regularly engaged by police and emergency services.

Although based upon analysis of more than 64,000 surveys, for a variety of reasons this data is likely not fully representative of the unsheltered or sheltered population. Nevertheless, this analysis provides the most comprehensive national picture of people experiencing unsheltered homelessness in the United States to date and compares their experiences with homeless individuals in shelters. While this study compares these two groups, it does not make causal claims. For example, while individuals who are sheltered report on average fewer health and mental health conditions, the data does not support a finding that shelter is the cause of improved health. In fact, it is just as likely that people who are unsheltered for long periods of time are those who cannot access shelter for a variety of reasons. The findings do reinforce the importance of stable housing as a social determinant of health and as essential for ending homelessness, for people in both groups.

BACKGROUND

On a single night in January last year there were an estimated 553,000 individuals experiencing homelessness in the United States. Nearly 200,000 of these individuals were unsheltered, sleeping on sidewalks, in parks, in cars, or in other outdoor locations.¹ Little is known about the vulnerabilities and past experiences of unsheltered individuals or how they differ from individuals in shelters. This study adds to our understanding by analyzing new data from the Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT) survey given to homeless individuals across the United States.

The VI-SPDAT is a short survey designed by OrgCode Consulting to help communities assign housing and prevention services according to the seriousness of an individual's needs. The survey has a total of 27 questions, including questions about physical health, mental health, age, gender, race, police contacts, emergency room visits, recent trauma, and other issues. It allows communities to meet federal requirements for intake assessments, is provided for free, and is widely used throughout the country. The VI-SPDAT recommends “no housing intervention” for scores three and under, “an assessment for Rapid Re-Housing” for scores between four and seven, and “an assessment for Permanent Supportive Housing / Housing First” for scores of eight and above.

ACKNOWLEDGMENTS

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DATA AND METHODOLOGY

In order to learn more about the unsheltered homeless population OrgCode agreed to share a non-representative convenience sample of VI-SPDAT survey data from more than 64,000 unsheltered and sheltered individuals in 15 different states with the California Policy Lab.² These data are an important source of information about a virtually unknown population living in crisis on the streets. That said, like all data sets, these data have certain features that could introduce bias

or measurement error in either direction; making the population appear more or less vulnerable accordingly. For example, neither CPL nor OrgCode has a way to measure how consistently unsheltered or sheltered individuals were assessed within each community providing data in this study. It is also possible that some providers may only choose to assess individuals whom they believe in advance will qualify for or be prioritized for homelessness services. For a more detailed explanation of the data used for this analysis, and potential biases, please see the Appendix. Additional details on the data used, including the results of linear models used to determine the significance of observed differences in outcomes by demographic characteristics of the sample can be found in the accompanying Technical Appendix available online.³

RESEARCH QUESTIONS

This study focuses on the following four questions:

1. What are the self-reported causes of homelessness for unsheltered and sheltered homeless adults, as measured by the VI-SPDAT assessment?
2. What are unsheltered homeless adults' health conditions and vulnerability and how do they compare to sheltered adults?
3. How long are unsheltered homeless adults unstably housed and how frequently are they accessing emergency shelters?
4. How frequently do unsheltered and sheltered homeless adults interact with law enforcement or utilize emergency services?

SNAPSHOT OF THE SAMPLE POPULATION

There are clear demographic differences within the OrgCode sample compared to the general United States population and national estimates of the sheltered homeless population, especially among African Americans who are overrepresented in our sample.⁴ Initial analysis of the data, however, found that the largest share of the differences in reported outcomes could be attributed to shelter status and gender. Differences by race or ethnicity were comparatively small for most outcomes. We found no differences by geography or community type in all but one of our outcomes. Consistent with other outcomes though, the observed difference was small relative to the effect of shelter status.⁵ Ongoing analysis and consultation are

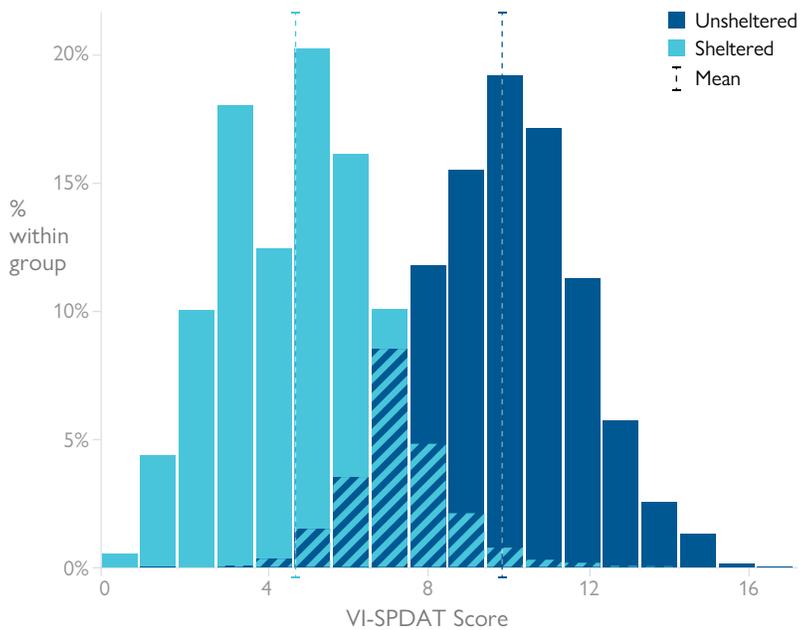
needed to consider whether there are important implications within this data for efforts to create racially equitable systems for preventing and ending homelessness.

The average unsheltered adult in the sample is male (81%) and has a median age of 47. A slight majority of the unsheltered population is living in the West (51%) and most live in an urban area (89%). Finally, a little over half of the sample is white (57%).

The average adult in shelter is also male (77%) and has a median age of 45. The largest proportion also lives in the West (33%) and in an urban area (81%), but is more likely to be African American (60%).⁶

The mean VI-SPDAT score for unsheltered people was 9.9 compared to 4.7 for sheltered people; unsheltered women's mean VI-SPDAT score was 12.

FIGURE 1. Distribution and mean VI-SPDAT score by shelter status

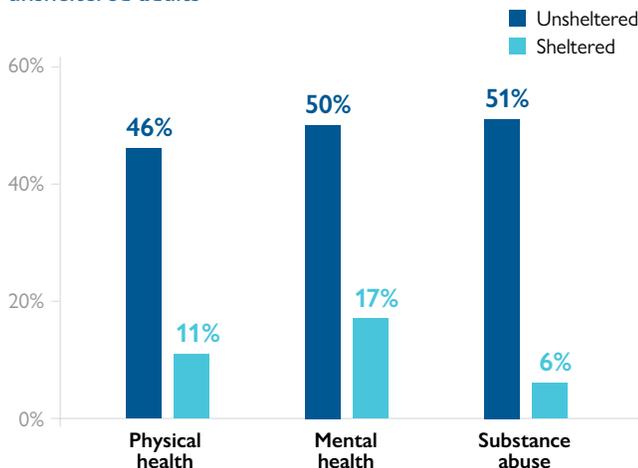


Note: Sheltered and unsheltered VI-SPDAT responses drawn from the same set of 15 areas across the United States. Size and population density of the areas varies. Sample is not constructed to be representative, and is not assumed to be.

FINDINGS

The analysis finds stark differences between people who are unsheltered and people who are sheltered. Unsheltered people — especially unsheltered women — report profoundly greater health challenges, higher rates of experiences of violence and trauma, and longer lengths of homelessness than people who are staying in shelters. The higher rates of health conditions and vulnerability for people experiencing unsheltered homelessness begin even before people lose their housing and are also seen early in their experiences of homelessness. These findings raise questions about whether emergency shelters are serving people with high health needs when they initially become homeless. Finally, unsheltered adults are engaged by police and emergency services much more regularly than sheltered individuals.⁷

FIGURE 2. Physical health conditions, mental health conditions, substance abuse-related loss of housing for sheltered and unsheltered adults⁸

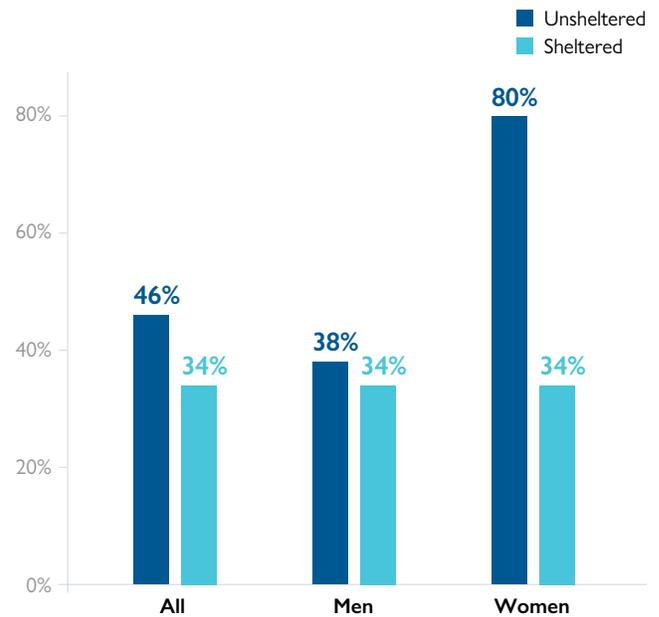


Health and behavioral health care needs, and experiences of abuse and trauma, are major factors in loss of housing among unsheltered people, most especially for unsheltered women.⁹

Unsheltered people were more than four times as likely to report that physical health conditions had contributed to loss of housing as sheltered people (46% vs. 11%), nearly three times as likely to report that mental health conditions had contributed to loss of housing (50% to 17%), and more than eight times as likely to report that use of drugs or alcohol had contributed to loss of housing (51% vs. 6%).

Significant portions of both unsheltered (46%) and sheltered people (34%) reported that experiences of abuse and/or trauma had caused their current spell of homelessness. Unsheltered women however reported abuse and/or trauma as the cause of their homelessness at much higher rates (80%) than either unsheltered men (38%) or sheltered women (34%).

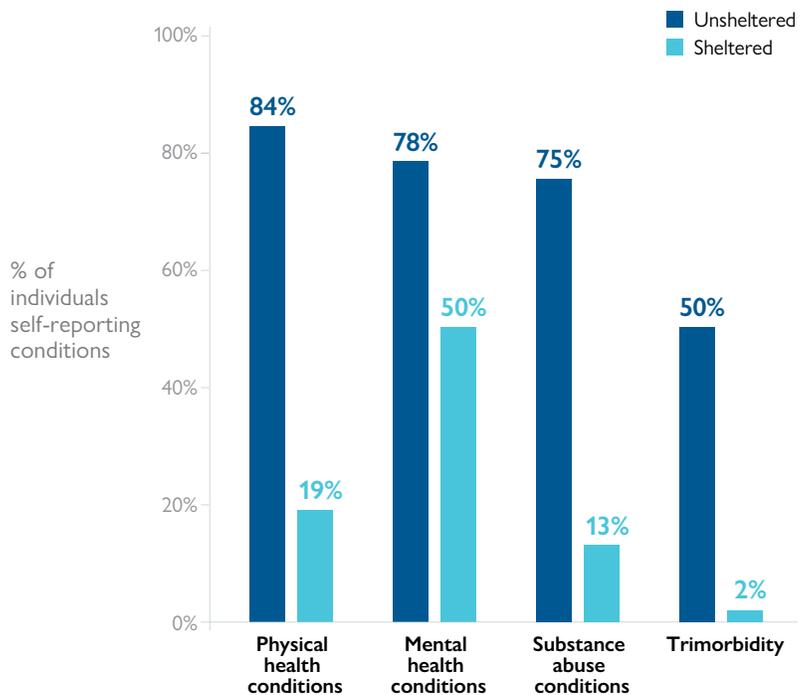
FIGURE 3. Unsheltered and sheltered adults who experienced trauma¹⁰



Unsheltered people continue to experience major and worsening health conditions while homeless.

At the time of VI-SPDAT assessment, unsheltered people are more than four times as likely as sheltered people to report a physical health condition (84% vs. 19%), nearly one and a half times as likely to report a mental health condition (78% vs. 50%), more than five times as likely to report a substance abuse condition (75% vs. 13%), and 25 times as likely to report all three conditions concurrently (50% vs. 2%).

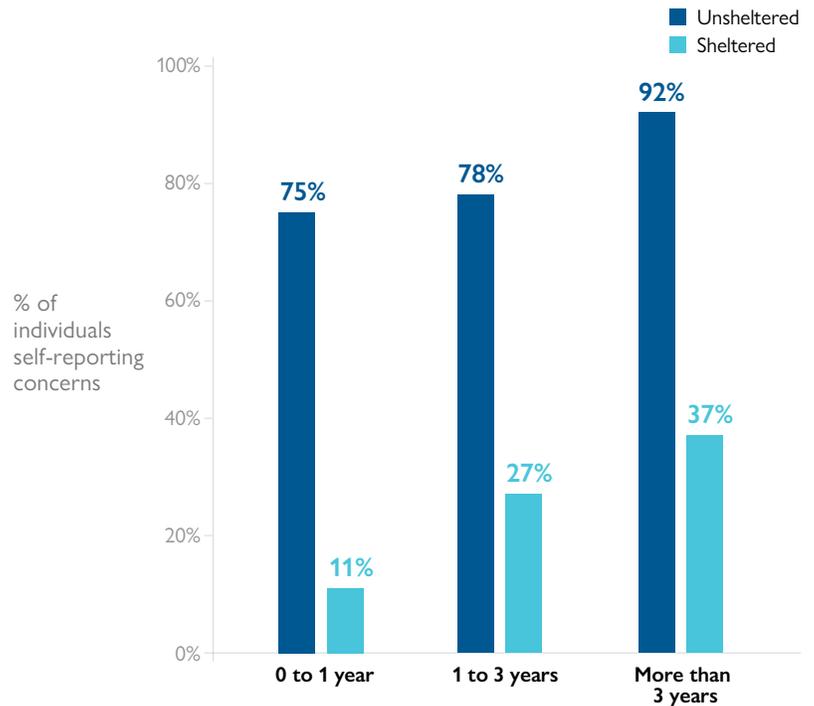
FIGURE 4. Physical health, mental health, substance abuse, and trimorbidity by shelter status¹¹



Even unsheltered people who have been homeless for less than a year report much greater presence of health conditions than people who have been homeless for greater than three years but who are sheltered (75% vs 37%).

Shelter status also affects respondents' experiences of having basic needs met. While just 3% of sheltered individuals report difficulty meeting basic needs, 50% of unsheltered individuals report difficulty taking care of basic needs like bathing, changing clothes, using a restroom, and having access to food and clean water.

FIGURE 5. Physical health conditions by shelter status and length of time unstably housed¹²



People with the longest experiences of homelessness, most significant health conditions, and greatest vulnerabilities are not accessing and being served by emergency shelters.

Unsheltered people reported lengths of time since last stably housed that were on average more than six times longer than sheltered people (2,632 days vs. 410 days) — and unsheltered women reported an average of 5,855 days since they were last stably housed.

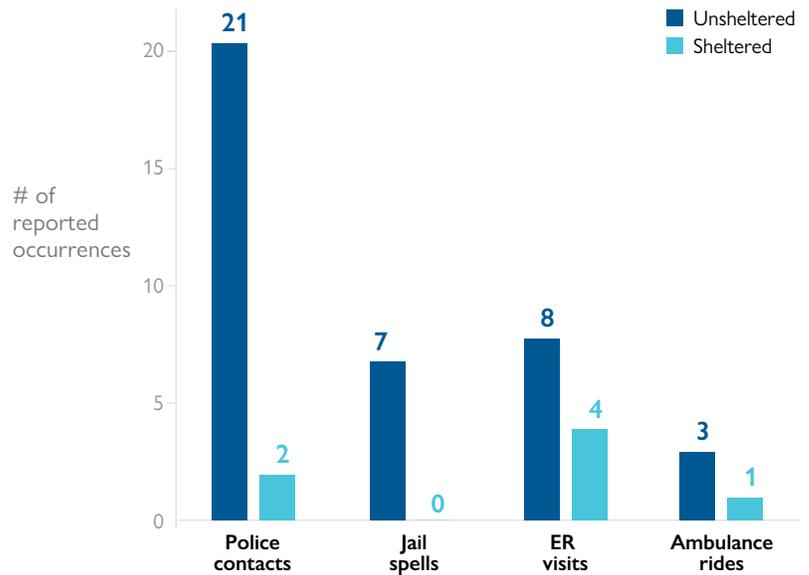
Most people who were assessed while unsheltered are not using shelter with any significant frequency. Unsheltered women reported spending an average of 18 nights in shelters over the previous two years; unsheltered men reported an average of 44 nights in shelter. The median for both was even lower; for unsheltered women it was just four nights in the last two years, and eight nights for men.

Compared to people who are sheltered, unsheltered people with major health challenges are much more regularly engaged with policing efforts and emergency responses.

Unsheltered individuals report ten times as many police contacts on average (21 compared to 2) in the previous six months, and were approximately nine times as likely to report they had spent at least one night in jail in the last six months (81% vs. 9%). Police contacts are not necessarily related to enforcement and can be any type of interaction with police.

Unsheltered people were more likely to report at least one visit to an emergency room in the last six months than sheltered people (94% vs. 74%), reported twice as many visits (8 vs. 4), and were nearly three times as likely to report at least one trip in an ambulance over the same timeframe (74% vs. 29%).

FIGURE 6. Police contacts, jail spells, emergency room visits, and ambulance rides in previous six months by shelter status¹³



KEY INSIGHTS & FUTURE RESEARCH

These findings provide substantial evidence that unsheltered homelessness is a housing issue, a public health and health care issue, and a personal safety issue. While the ultimate answer is to house all homeless individuals and prevent others from experiencing homelessness, addressing the problem at the moment will require mobilization of efforts and resources from multiple sectors and systems, not just from programs currently dedicated to preventing and ending homelessness. Below we discuss in detail key insights and questions for future research.

- For those people who were surveyed, health, behavioral health and trauma are significant contributing factors to loss of housing, particularly for unsheltered women. Future research should explore the role that lack of access to adequate health and behavioral health care, plays among the causes of unsheltered homelessness.
- Whether people are unsheltered or sheltered, they report worsening health conditions the longer they are homeless. This finding is consistent with the many studies that have found permanent housing to be a social determinant of health.¹⁴ Future research should focus on documenting effective strategies for moving people from the street and shelters into permanent housing.
- People with the longest experiences of homelessness, most significant health concerns, and greatest vulnerabilities are not accessing or being served by emergency shelters. As policymakers design interventions for unsheltered homelessness and balance investments in emergency housing and permanent housing, they will need to consider whether emergency housing is adequate or appropriate for a highly vulnerable population, half of whom are trimorbid.

APPENDIX: Additional Notes on the VI-SPDAT Data

OrgCode provided de-identified VI-SPDAT survey data, including answers to individual questions on the survey, for over 64,000 single adults age 25 or older. Service providers in 15 states representing all regions of the country collected the assessments over a three-year period from 2015 through 2017. Non-disclosure agreements between these communities and OrgCode prohibit identification of individual communities.

The sample is a “convenience sample” of data voluntarily provided to OrgCode by individual communities for the purposes of research and is not meant to be nationally representative. Our analysis found no statistical significance of geographical region (West, Midwest, Northeast, Southeast, Southwest) when controlling for sheltered status on any of the outcomes in this brief.

These data are an important source of information about a virtually unknown population living in crisis on the streets. That said, like all data sets, these data have certain features that are important to understand before interpreting the results of our analysis. In particular, there are several aspects of the data collection process that could bias the results “upward,” making the population appear more vulnerable, or “downward,” making the population appear less vulnerable. First, all responses to VI-SPDAT questions are self-reported, and individuals may not answer every question. Before the data was sent to CPL, OrgCode coded non-responses as “no,” which prevents CPL from independently measuring how many questions were not answered. It also presents a potential downward bias of unknown magnitude on responses. In addition, OrgCode recommends that workers wait to administer the VI-SPDAT until the third contact with an unsheltered individual, and up to two weeks for sheltered individuals to allow trust to be built between the two people. Actual practice can vary from place to place and may bias the answers in either direction.

Moreover, neither CPL nor OrgCode has a way to measure how consistently unsheltered or sheltered individuals were assessed within each community. It is possible that some providers may only choose to assess sheltered or unsheltered individuals whom they believe in advance will qualify for or be prioritized for homelessness services, which could bias the results upward. Finally, men and African Americans are overrepresented in the OrgCode data compared to recent national data on sheltered and unsheltered single adults.¹⁵

The California Policy Lab builds better lives through data-driven policy. We are a project of the University of California, with sites at the Berkeley and Los Angeles campuses.

This research publication reflects the views of the authors and not necessarily the views of our funders, our staff, our advisory board, or the Regents of the University of California.

Endnotes

- 1 2018 Annual Homeless Assessment Report to Congress: <https://files.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf>
- 2 Data presented in this brief have not been reweighted to correct for potential sources of bias in selection.
- 3 Readers interested in a more technical discussion of the data and methods can also access an online technical appendix at the following address: <https://www.capolicylab.org/wp-content/uploads/2019/10/Technical-Appendix-for-Health-Conditions-Among-Unsheltered-Adults-in-the-U.S.pdf>
- 4 The United States population is 13% African American; African Americans account for 47% of the US sheltered homeless population and 27% of the US unsheltered population; African Americans in the VI-SPDAT sample account for 60% of the sheltered population and 37% of the sheltered population. 2018 Annual Homeless Assessment Report to Congress.
- 5 See Technical Appendix for results from linear regression models that use shelter status, gender, age, community type, and geography as predictors for each outcome included in our findings.
- 6 A detailed breakdown of the sample demographics can be found in the online technical appendix.
- 7 Police contacts are not necessarily related to enforcement and can be any type of interaction with police.
- 8 We found large statistically significant differences between the overall sheltered and unsheltered populations, and by gender within sheltered status. Differences by race/ethnicity were smaller or insignificant.
- 9 Full text of the questions asked in the VI-SPDAT is: Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health? Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of a mental health issue or concern? Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past?
- 10 Full text of the question asked in the VI-SPDAT is: Has your current period of homelessness been caused by an experience of emotional, physical, psychological, sexual, or other type of abuse, or by any other trauma you have experienced?
- 11 Figure four shows the percentage of individuals who responded “yes” to at least one of five questions relating to physical health, one of four questions relating to mental health, and one of two questions relating to substance abuse. Individuals are trimorbid if they answered “yes” to at least one question in each of the three groups of concerns. The full text for all 11 VI-SPDAT questions relating to physical health, mental health, and substance abuse conditions can be found in the online technical appendix.
- 12 Figure five shows the percentage of individuals who responded “yes” to at least one of five questions relating to physical health grouped by the length of time individuals reported since their last stable housing.
- 13 Full text of the VI-SPDAT questions after the prompt “In the past six months, how many times have you...” are as follows: “Talked to police because you witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told you that you must move along? Stayed one or more nights in a holding cell, jail or prison, whether that was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between? Received health care at an emergency department/room? Taken an ambulance to the hospital?”
- 14 Shaw, Mary. (2004). “Housing and Public Health.” *Annual Review of Public Health*, Vol 25, 397–418. [doi:10.1146/annurev.publhealth.25.101802.123036](https://doi.org/10.1146/annurev.publhealth.25.101802.123036). See also Hetherington, K., & Hamlet, N. (2018). “Health and Homelessness.” In Bonner A. (Ed.), *Social Determinants of Health: An Interdisciplinary Approach to Social Inequality and Wellbeing* (pp. 195–210). Bristol: Bristol University Press. www.jstor.org/stable/j.ctt22p7kj8.20
- 15 2018 Annual Homeless Assessment Report to Congress