Episode: Ethics Talk Videocast Transcript – Caring for Homeless People During COVID-19 Pandemic

Guests: Bobby Watts, MPH, MS, CPH
Host: Tim Hoff; Audiey Kao, MD, PhD
Transcript by: Cheryl Green

Access the video and podcast **here**

[bright theme music plays]

TIM HOFF: Welcome to another special edition of *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. This episode is an audio version of a video interview conducted by the Journal's editor in chief, Dr Audiey Kao, with Bobby Watts, the Chief Executive Officer at the National Health Care for the Homeless Council. He joined us to talk about the pressing need to care for the homeless population during the COVID-19 pandemic. To watch the full video interview, head to our site, JournalofEthics.org, or visit our YouTube channel.

DR. AUDIEY KAO: Good morning, Bobby, and thank you for being a guest on *Ethics Talk* today. [theme music fades out]

DR. BOBBY WATTS: Oh, good morning. I very much appreciate the opportunity. Thank you.

KAO: As you know, Bobby, on any given night in America, more than half a million people are homeless. This vulnerable population is disproportionately older and people of color. They also have more medical and behavioral health conditions. What new challenges does this pandemic present to homeless individuals who already face long-standing health inequities?

WATTS: Thank you for that excellent question. As you've pointed out, people experiencing homelessness are already underserved by the mainstream medical system. Often they are not able to access the care. Often when they do, they don't feel welcomed by the mainstream medical system. So, there's a tendency to stay away. So, not only do people experiencing homelessness suffer from higher rates of medical conditions—every single medical condition is overrepresented among people experiencing homelessness—but they have less access. So, during this time of this pandemic, when there is unprecedented strain on the health care system, it becomes even harder for people experiencing homelessness to gain access.

One of the things we are really concerned about is if we got to the point, or if we get to the point, where we have to think about rationing care. I was raised in New York, lived most of my life in New York. So, I am now following what's happening in New York very closely. And there was a period where they felt they were really going to have to decide who gets a respirator for how long. And if we reach that point in some underserved communities where they are under-resourced communities, will they treat everyone equally, or will they value some lives more than another is a great, great concern.

You know, when we're speaking about people experiencing homelessness, one of the great things about this pandemic—one of the great and horrific things about this pandemic—is that people experiencing homelessness are not able to follow the two basic

guidelines of the CDC. If you're living in a shelter, it's very hard to practice social distancing. You don't have control over where your bed is placed. And if you are unsheltered, if you're living in an encampment, for the most part, you don't have access to running water. So, where everyone is asked to maintain social distance and then to wash your hands frequently with running water for 20 seconds, these very basic personal health and public health measures are out of the reach of many people experiencing homelessness. So, we are really concerned, and we're doing what we can to educate people experiencing homelessness, educate the medical providers, and educate policymakers so that they can make sure that people experiencing homelessness are getting the services they need during this pandemic, not only for their good, but for the public health's good.

KAO: Right. Yeah, no. I mean, I think the point you raise, which most of us take for granted, which is being able to wash our hands, is a big mountain to climb for those among us who are homeless. And as you know, one of the other challenges in responding to this pandemic, which is difficult to do, is to shelter in place when one has no home or shelter. So, some states like California, which has the nation's largest homeless population, have begun to move homeless people into alternate care sites such as hotels and motels to protect them from coronavirus exposure and infection. However, such efforts have been slow and uneven, hampered by red tape and local opposition. What do you think contributes to these barriers, and what can be done to overcome them?

WATTS: Thank you. I think there are two sets of barriers. One is the barrier from the larger community where people are saying, "I don't want this motel to be filled with people experiencing homelessness. I don't want this to become the COVID motel in my community." I understand that. But I really believe that what Governor Newsom said when he introduced some of these initiatives in his State of the State address, actually, just right before the pandemic really hit California, he stated that we recognize and appreciate local sovereignty. But it should not come at the cost of recognizing other people's basic human rights. I'm paraphrasing him. And I think this has been a long-standing problem that we need to recognize: that people have a basic right to existence. As one of our homeless patients has said: people exist in time and space. So, we have to, everyone has to exist somewhere.

So, as the United Nations rapporteur on housing and extreme poverty put it, the way it is represented or it's manifested in this country is different than it is in other countries. There is more tolerance for the fact that if you aren't, people can't be in a home, they have to be somewhere. So, we need to kind of move as a society. At the same time, believe me, we're not saying that encampments are shelter and shelter is housing, and we need to make sure we have housing. That's the ultimate solution. But until then, we have to recognize people's basic rights to exist. And we believe health care and housing are human rights.

The other set of barriers are how well are these sites run? Are they inviting, or are they such that none of us would want to go there? Some of them we've heard are staffed and their procedures are in such a way that it's almost like a prison. It's like lockdown. You're not supposed to leave. You're not allowed to leave. Those are conditions that, not just for people who have been found to be infected, but just for people who may be suspected or they've been removed and placed in these motels and other settings because they're medically frail, they're elderly, which we applaud. But it has to be done in a way that is trauma-informed, that is respectful. We've heard some of larger facilities are manned by

the National Guard. Others have police officers stationed outside with messages you can't leave. Whether it's said or not, that is the impression that people are getting.

And we've known I'm from, again, from New York City, which has had a right-to-shelter for 30 years. And it's the reverse of where it is in most other countries where most of the people experiencing homelessness are in shelter versus on the streets. Because the shelters, by and large, are run by non-profits, and they tend to be more inviting, welcoming. They're meeting the perceived needs and the actual needs of the person experiencing homelessness. So, we applaud the idea of moving people from congregate shelters for their health and moving people from the streets and encampments for their health. But it needs to be done in the appropriate way.

KAO: Yeah, no. I hear what you're saying. I think that if we are all in this together, all of us have to fight, have to fight this NIMBY impulse, not in my backyard impulse. Because as you were saying, housing is really a human right, and we have to find ways of addressing that for those who don't have homes. And if we don't, it's not only going to hurt their health, but our health in the long run as well. So, I think your points are very well made.

WATTS: Yeah. Thank you. And one of the things I like to say is that people experiencing homelessness are more at risk than they are a risk because of their compromised immune system from the stress of living on the streets, of being in congregate settings continuously, of chronic sleep deprivation, whether you're in a shelter, in a room with 20 other people or you're living outside where cars and trains, there's an epidemic of chronic homelessness among, excuse me, chronic sleeplessness among people experiencing homelessness, all of which conspire to weaken their immune systems. So, they are more at risk of, once they are exposed to the virus, of it developing into disease.

KAO: Yeah. No, I mean, I think your points about not being able to sleep because there's too much noise, not being able to wash your hands, this is the state of those among us in society who are homeless, who have to confront not just the regular day-to-day challenges quote-unquote during "normal times," but we really have to step up during these abnormal times to do what we can, certainly in the near-term, but hopefully to figure out what we can do in the long-term. And in that in that respect, as you know, late last year before the pandemic hit, the U.S. Supreme Court declined to hear a landmark case on homelessness, letting stand a lower court ruling from the Ninth Circuit that protects the rights of homeless people to sleep in outdoor public areas such as sidewalks or parks if no other shelter is available. What do you think are the implications of this court decision to addressing the crisis of homelessness during and after this pandemic?

WATTS: We were really heartened by that ruling because it is moving us as a society a step closer to where much of the industrialized world already is in recognizing that housing is a human right. As my friend who's experienced homelessness said, again, people have to exist, people exist in time and space. And it's recognizing that you cannot punish someone because they don't have shelter or housing if society has not provided that. So, it's kind of moving us towards recognizing if there is a right, then there is also an obligation of society. Which is actually what was stated in the Declaration of Independence. We consider these rights to be inalienable: life, liberty and the pursuit of happiness. And it says that the purpose of government is to secure those rights for people. So, it's bringing us closer to the ideals of—I mean, again, we need housing for everyone, but at least it's saying—if we're not providing housing and someone can't secure it, that they can't be locked up. They can't be just put away. Their possessions can't be summarily destroyed or taken from them. So, I think it provided a really important framework prior to the pandemic

in shaping the response. Whereas many times the instinct of police is to say, “Just move along.” That’s what business improvement districts want. That’s what most people want. We don’t care where they go, as long as it’s not here. And it’s saying we have, as a society, have to move beyond that. So, that was really important because I think it gave the CDC a much firmer ground.

And we’re thrilled that we were able to give input into some of the guidances that CDC and HUD produced around this pandemic, reducing infections for people among people experiencing homelessness. But the CDC recommended that there be a moratorium on encampments sweeps during this period if there is no appropriate shelter. And that’s important because the Ninth Circuit is just for nine Western states and the territory of Guam. But CDC is issuing guidance, not enforce, but at least it is their guidance for the whole country, saying that you should not move people. They could be getting services in those encampments. And from a public health and epidemiological point of view, if they are at higher risk of being infected or having the virus, dispersing them without providing services, without knowing where they’re going is really counterintuitive and counterproductive for the public health. So, I think it made it much stronger.

And the CDC, in their guidance, also recommended, which several cities are doing, is if you’re not providing housing or shelter, putting handwashing stations around the city for people without housing to use, especially near some larger encampments, providing portable toilets. So, these are basic human needs that were not being met. And now because of the pandemic, some cities are making halting steps towards providing that, and we applaud that.

So, the implications are obvious, and I’ll probably come back to this point again. The things that we are doing now in response to the pandemic to address the control of infection are the things we should’ve always been doing and the things that we should continue to do after this pandemic to prevent the next one and to advance health care and housing and human dignity as human rights.

KAO: Right. If I can follow up, with rights come responsibilities. So, I’ve also heard circumstances where shelters are available, but certain individuals who are homeless don’t want to go into shelters. So, can you speak to how one should look at balancing the right, so to speak, to be living in public spaces, but that there are shelters that are available for them?

WATTS: Yeah. I want to go back to the idea that the shelters have to be meeting the needs of the person, meeting their needs and their perceived needs. And it gets actually much more complicated during the time of a pandemic where sometimes, being in a congregate setting, especially if they can’t practice social distancing, you may be safer not in that congregate setting. So, some people have made the very rational choice we’ve heard of leaving to move outside in an encampment. Others, encampments are not better than being in a good shelter. So, it really has to be weighed: what are the conditions? So, some people, especially doctors who practice street medicine and mobile health clinics, go to encampments—and other outreach teams have worked where there isn’t sufficient shelter or as shelters have had to reduce their capacity in order to practice social distancing, so that fewer people can stay in there and the shelters—have worked to help make sure there are enough tents so people are not sharing tents, which happens fairly common, a fairly common practice in encampments. And to spread the tents out at least 12 feet apart all to reduce.

So, and again, I point to the example of New York City where there is a right to shelter, and when the system is not perfect by any means, but where it is at least well run enough that 95 percent of the people that are estimated to be homeless are in shelters versus on the streets. So, you have to design it well. And we're not talking about fancy bells and whistles. We're just making sure that it meets basic human dignity, that people are treated with respect, that they don't feel like they are a prisoner, and the very sound principles of trauma-informed care are practiced throughout the shelter, throughout the clinics. That's really what Health Care for the Homeless, the movement, which began in 1985, that's been part of our bedrocks of treating people with dignity, meeting them where they are, meeting their perceived needs. And in business, they say the first rule is to listen to your customer if you want to succeed. We don't do that very well in health care, but the Health Care for the Homeless programs and model, movement is doing that fairly well. That's been one of our bedrocks. And I think that's one of the reasons why together, we've been able to serve over a million people experiencing homelessness in the 300 Health Care for the Homeless programs around the country. People come back. We listen to the patients. The patients are empowered to speak. They're part of governing boards of the agencies, advisory boards, and also, they're part of the governing board of the council.

KAO: Yeah. No, I really appreciate your remarks and especially the point that I think what may seem to the majority to be irrational behavior really is rational from the individual person experiencing homelessness if the shelter alternative is less safe than their current condition. So, it puts the onus on all of us to be able to understand that and to address that issue.

WATTS: Mmhmm. Yeah.

KAO: So.

WATTS: Yeah, I began this work in 1985 as a live-in counselor at a rescue mission, and I was fascinated. These were guys who'd come in just for a night and then go back out. And I was fascinated. Why did they not want to go to the city shelters? And they said, "It's dangerous. It's unsafe." And then later—they were all run by the city, city government—later they've been run by non-profits and much, much better. So, the system, there are many, many more people that say, yes, I want to be in a shelter than on the street in New York.

KAO: Right. So, you've referenced a couple of times now this trauma-informed approach to taking care or addressing the needs of those among us who are homeless. As you know, in this current pandemic, medical respite programs are reassessing their policies, procedures, and practices so they can expand their capacity and support an overburdened health care system. I suspect, though, that many of our viewers have never even heard of medical respite programs. So, can you tell our audience about the origin and purpose of medical respite care and what health professionals can do to support these programs?

WATTS: Thank you. I am completely passionate about medical respite. So, I'm glad to talk about it. The first two medical respite programs began in 1985, one at the Boston Health Care for the Homeless program and one at Christ House in Washington, DC. And they really began as a response to an unmet need. And I'm really glad to say, in Boston at least, it was the patients of the program that said to the program, this is what we need. And that was really the genesis of their medical respite program.

Medical respite is a service or facility. They're designed for people who are experiencing homelessness that no longer have a clinical reason to stay in a hospital, but without it, the hospital would not have a safe place to discharge them. And then what happens is the person maybe is discharged back to their shelter, which is not really equipped to handle their needs, or to a friend's couch or sometimes to the street. And without the appropriate care, their care deteriorates that they end up back in the emergency room, back in inpatient for inpatient hospitalization, at great cost to their health and at great cost to the health care system.

KAO: Right.

WATTS: So, medical respite breaks that cycle. The very best programs, not only do they help them get back to health, but also, it's a gateway to permanent housing, more permanent supportive housing as the needs may be. But it is intended to be short-term care to stabilize someone so that their health can improve, and they don't need to go back to the hospital.

KAO: Yeah, no. Thank you. I think that's very informative. And we'll try to share some additional resources as part of this conversation. So, as we near the end of our conversation, I wanted to ask you about the issue of unemployment. As you know, unemployment is one of the major causes, if not the leading cause of homelessness in this country. With so many of our fellow Americans out of work due to the pandemic, what, if anything, can health professionals do to help ameliorate the situation?

WATTS: I'm so glad you asked that question, because one of the things about this pandemic is that it has brought into sharp relief some of the inequities, the inequalities, and the weaknesses of our health care and housing public policies and the systems. We are seeing a virus that does not respect state boundary lines. And yet whether someone can get care in one state or not or another depends, in this country right now, if you're poor or whether your state has expanded Medicaid, if you're a single adult. That is really not a good, sound way to run a public, to ensure the health needs of the public are met. We also are overly-reliant, or we are reliant, upon employer-based health care coverage. So, we've had 25 million people and counting so far that we know have lost their jobs. Many of them have also lost their health insurance at a time of a mass pandemic where health care is needed more and more. People are now saying, "I don't know if I can afford to go to the doctor," because they lost their health care coverage, because they lost their jobs.

What really should happen is, and really what health care professionals can do is really advocate for a change, advocate for universal health care. There are many ways to achieve it, but we are the only industrialized nation that does not have universal health care. You look at every other country: how many people have lost their health insurance because they lost their job? And the answer, in every industrialized country, the answer is zero. So, in my years of working as an Executive Director in a Health Care for the Homeless program in New York, when I would go to talk to our City Council or go to our state legislature, or we would take people to speak to Capitol Hill about the needs of people experiencing homelessness, the importance of health care for this population, the first person they want to hear is the person with the lived experience of homelessness. The second person they want to hear is the medical provider on the front line.

KAO: Hmm.

WATTS: What I had to say did not carry nearly as much weight. And as medical providers in this country, you really have a lot of clout. People will listen to you when they hear when you are speaking from the front lines and saying, “This system needs to be improved. This is not adequate. This is what we need.” So, one of the main things that I really would hope that the medical community would do, especially in response to this pandemic, where it’s pointing out the inequities, that they will say, we need universal health care. It should not be that where you live determines whether really you’ll get care or not, whether you’ll live or die or not. It should not be that the racist policies of this country are impacting health care and health status to the point where African-Americans, Native American Indians are much more likely to die of COVID than the rest of the population. In some areas, Latinos are overrepresented among deaths. So, we really need—one of the great, it will not solve all the problems—but in terms of access to health care, having universal health care is something that the medical community can advocate for. And I really hope that they would.

KAO: Yeah, I really appreciate your call to action and specifically to health professionals to use their voice because their voice can make a difference in promoting the health and well-being of our neighbors and those in our communities, whether they are known to us or not. So, I think I really appreciate your thoughts on this matter. And I just want to thank you for taking time to sharing your expertise today with our audience today, Bobby. Thank you.

WATTS: Thank you. And I just encourage everyone to visit our website. We have a lot of material around COVID. www.NHCHC.org/coronavirus. And a lot of information about how providers can ensure that the needs of people experiencing homelessness are met during this pandemic and beyond.

KAO: Yeah, I think we’ll definitely include that URL in this interview so people can access those resources. So, in addition, for more COVID ethics resources, please visit the *AMA Journal of Ethics* at JournalofEthics.org. And to our viewing audience out there, I want to encourage everyone to continue to practice physical distancing and sheltering at home. Your sacrifice is saving lives. Be safe and be kind. We’ll see you next time on *Ethics Talk*. [bright theme music plays]