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Homelessness: the imperative for a public health response

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It is a great honour to have been invited by the Public Health Association of Australia (PHAA) to give the 2020 Douglas Gordon oration for its third Prevention Conference.

Foremost, I would like to respectfully acknowledge the Traditional Custodians of this land on which Borloo (Perth) is located, the Whadjuk people of Noongar country, and pay respect to their Elders, past, present and emerging.

Given the topic of this oration, I also want to acknowledge that, sadly, homelessness is enormously over-represented among Aboriginal and Torres Strait Islander people in Australia, and this has to be addressed if we are to Close the Gap.

Introduction

Before I get into the oration *per se*, it is pertinent to provide some background context as to how I have ended up working at the interface of homelessness and public health.

Having accidentally discovered the field of health promotion after my undergraduate degree, much of my initial grounding was in the Western Australian (WA) Quit campaign and tobacco policy and legislation. But one of the things I love about the public health field is that there are core principles and strategies that are applicable to a range of health issues, and what we learn from one area can often be applied to another. So, I have been active across a rather eclectic mix of health issues over the years (including nature-play, veterans' mental health, prisoners, and the health benefits of everything from skateboarding to the health and social benefits of pets), but increasingly with a focus on social determinants, health inequalities and vulnerable population groups that tend

not to have a voice at either the research or policy table.

Fast forward to 2016, when I happened to read an article about the abysmal health of people who are homeless. And the rest, as they say, is history!

Cast your mind back if you can ... to a time before COVID-19 was a household name, before it in fact even existed ... an era where, as my sister recently noted, people blew on birthday cakes with candles and we all ate pieces of cake without a contagion care in the world ...

Cast your mind back to a time where it was still the fictional theme of dystopian novels that a rampant virus was loose in the world, and normal societal civilities would be suspended by frenzied panic buying of essentials, with those who can buy and store the most, the 'winners' ...

Not the lifetime ago that it seems, but just a few months.

It was in that pre-COVID world that I was invited to give this Douglas Gordon oration. In his seminal 1976 text *Health, Sickness and Society*,¹ Douglas Gordon said that if we believe social change prevents disease and promotes health, then we are compelled to be advocates for change.

He went on to say that 'some fire in the belly is a necessity' but stressed that emotional drives to advocate for the health and welfare of society need to be supported by data and evidence. This is timeless advice and sums up well the blend of research and advocacy I have sought to bring to the intersection of public health and homelessness over the past five years.

On nearly every measure of health inequality, people experiencing homelessness are vastly

over-represented.² This is grimly seen in an average life expectancy of fewer than 48 years. Multiple chronic health conditions are common, many preventable.³ Among people experiencing homelessness, we see the most extreme examples of poor health driven by adverse social, economic and often traumatic circumstances.

That many of our public health and prevention success stories in Australia have left behind this often invisible group is confronting; the majority still smoke, mental health, and alcohol and other drugs (AOD) issues are pervasive, and accessibility to preventive screening and oral healthcare is sparse. Even COVID-19 has starkly shown the heightened vulnerability of people who are homeless, and I will return to this later.

In this oration, my focus is not on convincing you that homelessness should be seen as a public health issue and priority. This speaks for itself. Rather, my focus is on how we in public health can tangibly help to prevent homelessness and its raft of associated health inequalities.

The body of this oration is anchored around four stories. These are just four of the 'people behind the statistics' in a country where there were more than 115,000 people homeless at last Census (2016), and by all accounts, this has increased since.

Each story gives a glimpse into the lived experience of homelessness and how this impacts on health. I will then share some of the ways in which a public health way of thinking, of building evidence, of framing advocacy and working across silos has made a difference. Each story also has implications for our broader prevention and public health efforts. The names used are not real, but sadly the stories are, and there are many others like them across our cities and towns.

Story 1 – Daisy

Daisy is an Aboriginal woman in her mid-late twenties. She has been in and out of homelessness for nearly half her life. The first time I met Daisy, she said: "I've been doing this homeless ever since I was 15 ... I grew up in child protection and foster care. I just kept running away all the time ... because I got split up from my brothers and sisters because I kept trying to run away to find them".

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Daisy suffers from a myriad of serious health conditions, including type 2 diabetes, liver disease, hepatitis C, asthma and complex mental health issues. Like many of her rough sleeping peers, she's a person experiencing drug dependency. Her account of how she began using meth mirrors what I have heard from other women surviving on the streets. "When you sleep, you've got to keep one eye open. It's hard to fall asleep because you're always worrying about what's going to happen. That's why I turned to drugs, to keep me alert."

Daisy's diabetes has been exacerbated by life on the streets. Like many people sleeping rough, she relies on soup vans and other food relief, and her diet is often high in sugar and salt. One of her reasons for wanting a house is so she can have a fridge to store insulin and food in.

Daisy is worried about her diabetes and often gets her blood sugar levels checked by the Street Health nurses from Homeless Healthcare. But as its founder, Dr Andrew Davies, often notes, people's health will inevitably deteriorate without a safe and stable place to sleep or call home.

When I first interviewed Daisy, she was in temporary housing and on track for something more permanent. I wish I could stand here today and share some good news. But Daisy epitomises the complex life circumstances of many people experiencing homelessness in Australia. Their pathways out of homelessness are rarely linear, and are more akin to a game of Snakes and Ladders.

In the intervening years since I first met Daisy, she has been in and out of various accommodation, in and out of prison, and in and out of a violent relationship. Her health is dire for someone so young. And her entrenched trauma is a barrier to both physical and emotional healing.

But all is not bleak, and it has been inspiring to see the raft of services and people who have not given up on Daisy and others like her. One of these is the Street Health outreach service I mentioned, which is out each weekday in the central business district (CBD) of Perth, combining medical care with a strong social determinant of health focus. Its nurses use the opportunity to dress a wound or take blood pressure to build trust and are proactive in connecting people to housing and other support options. So, you can imagine how aghast I was a few months after first meeting Daisy when I learned that Street

Health was going to have to shut down due to a lack of funding.

"Well that can't happen," I declared to a colleague and to Homeless Healthcare. That marked the first of many moments where having a suite of public health advocacy skills and experience proved invaluable.

We quickly developed a number of evidence-based case studies that showed that this street health outreach was seeing many people who have fallen through cracks of the healthcare system. Also, that it was attending to health issues that would otherwise worsen and require hospital admission. We instigated some media advocacy, and a journalist well known to many of us in public health, Cathy O'Leary, ran a compelling story in *The West Australian* about the imperative to continue this valuable service. This led to a story on Radio National, and a philanthropist came to the rescue and fully funded it for a year. We have continued to evaluate Street Health's impact,⁴ not only on health but also as a conduit for connecting people to housing and other critical supports. The generous philanthropic funding has continued, and in the wake of COVID-19, the Health Department has recently provided funding to expand it.

I started with Daisy's story in this oration because it is a sobering reminder of the crucial need to be sensitive to the factors that underlie what we in public health may refer to as 'unhealthy lifestyle choices'. When I first interviewed Daisy, I sat with her outside her temporary accommodation while she smoked. For someone who has been active in tobacco control for decades, this was clearly not in my comfort zone. But in that moment, what mattered most was listening to Daisy and her story, and for her to feel accepted, safe and not judged. I was also acutely aware of the role of trauma in the coping responses and behaviours of people whose lives are characterised by adversities. Adversity after adversity in a way that few of us can begin to imagine.

Story 2 – Craig

Craig is a man who developed schizophrenia in early adulthood. He retreated from mainstream life and was homeless for the next 26 years with minimal contact with the medical or psychiatric system. By his mid-fifties, the harshness of life on the streets had taken a severe toll on his health. He had increasingly severe back pain which limited

his walking, so he spent most of his time in a wheelchair. Other health problems included chronic obstructive pulmonary disease (COPD) as a result of heavy smoking, hepatitis C from intravenous drug use, and heavy alcohol use.

By 2015, he started to present frequently to hospital emergency departments, asking for assistance with housing and medical issues. He was generally discharged rapidly however as 'not having an acute problem'. One of his hospital discharge summaries stated that he had been given a taxi voucher to return to the bridge under which he 'lived'. This horrified me at the time and still does. But I stress that the point of sharing this is not to blame our hospitals. The reality is that hospitals across Australia discharge homeless patients back to the street every day due to intense bed pressures and because there is literally no other alternative available.

Craig is nonetheless a good news story, as through the work of the Royal Perth Hospital (RPH) Homeless team he was housed in an aged care hostel in late 2017 and ceased to present to hospital. The fact that he had spent so long out of mainstream life that he didn't know how to use a TV remote control has stuck with me ever since as a compelling rationale for the need for earlier intervention and prevention.

I tell Craig's story because it got me thinking about how we might be able to apply some of the economic and return-on-investment arguments that have been an effective platform for public health advocacy in Australia.

When we looked at Craig's hospital use, it was on an upward trajectory as his health deteriorated. In the two years alone before he was supported to get into an aged care hostel, he accrued 69 emergency department presentations and 84 days in hospital, equating to a cost of more than \$302,000 based on the average cost for WA hospitals at the time.⁵

Evaluating what works to reduce the economic burden of homelessness on our strained health system has gone on to become one of the hallmarks of our team's research and advocacy. This is not without some ideological discomfort for me personally, as I would far prefer to just frame homelessness as a fundamental issue of human rights and health equity. But as Dr Amanda Stafford, the clinical lead of the RPH Homeless Team says: "The emotional appeal of 'doing the right thing' is no longer sufficient

for services to survive or to convince funders to support a program ... we need solid, reliable data for funding with compelling economic arguments”.

But has this made a difference, you may well ask? Whilst reluctant to ‘blow my own trumpet’, our collaborators in the health and homelessness sectors are quick to attest that the pragmatic economic arguments in our evaluation and advocacy work have made a real-world difference.

Local examples include the use of our evaluation reports to help secure continued funding for the RPH Homeless Team⁶ and WA Department of Health funding for free flu vaccination clinics for people who are homeless. The latter project also provides brokerage funds to enable social workers and emergency departments to provide homeless patients with short-term accommodation to avert discharge to the street in winter. These evaluations show that a modest social expenditure in a hospital setting is able to reduce recurrent hospital presentations and smooth the path to longer-term accommodation, general practitioner (GP) care and community supports.

Lest I be seen as parochially Western Australian, at the national level, our research on the health and economic benefits of housing people who are homeless led to a presentation at a national senate inquiry on housing and homelessness, and we are working with people in other areas of Australia to build similar local evidence. More recently, it has been cited in the Productivity Commission report on mental health.⁷

Critical to the credibility of this research has been the forging of strong collaborations with homelessness services, housing providers and people in relevant government portfolios. Also, with health professionals who see homeless patients and who are often incredible champions for a social determinants of health approach. As Douglas Gordon himself exemplified, not everyone who is medically trained views health as through a narrow ‘medical model lens’. In fact, one of the most rewarding aspects of my work in homelessness has come from the opportunity to meet and work with an amazing range of clinicians and health professionals who are just as passionate and action-oriented about the social determinants of health as myself!

The cost of homelessness to the public purse is massive, not only in our hospitals but also

for the justice and child protection systems. The cost to human lives and health is of course even greater. Hence, we never present economic arguments around homelessness in isolation, always coupling these with the reality of the people behind the statistics.

Story 3 – Amy

Amy is a woman of similar age to myself, who in the past was a teacher and personal trainer. Five years ago, she was living in her car with her dog after escaping an abusive marriage. She has several mental health and addiction struggles exacerbated by trauma. Amy has been housed now for more than three years as part of the 50 Lives 50 Homes program in Perth, and like many in her situation, recovery – even once housed – has its ups and downs. Amy talks openly about this and reflects that in low times, her dog has been her main reason to keep living.

Some of her goals once housed were around physical activity, connecting with the community, and her mental health. Amy’s GP suggested she join ‘On My Feet’, a running and support group for people who have experienced homelessness. She has found the program extremely beneficial to her physical and mental wellbeing and now wants to mentor others. When I last spoke with Amy, she commented on how her mental health has improved, she has cut down her smoking, is running, has met people at parks where she walks her dog and has been learning to be a barista.

As I have seen first-hand in the lives of people like Amy, and in much of our research, people need to be stably housed for health to improve significantly. This not only applies to conditions that require medical care, but also to the scope for effective prevention and health promotion. While people are homeless, they are often in survival mode, and their health is by necessity a lower priority.⁸ Seeking out those basic human needs at the bottom of Maslow’s hierarchy – shelter, food, water, warmth – is all-consuming, and feeling safe is rare.

Housing First, a model originating in New York, is premised on the philosophy that stable housing is an essential first step to addressing the complex health and psychosocial issues faced by people who are homeless.⁹

The 50 Lives 50 Homes program in Perth that we have been evaluating is based on this approach, and its aim is to house and support

the most vulnerable among rough sleepers.¹⁰ 50 Lives is a collective impact program involving organisations from various sectors in Perth, including homelessness, housing, health, police, Centre-link and services working with youth and Aboriginal people. In four years, 240 people have been housed in 186 homes. The shortage of affordable and public housing has been one of the biggest impediments to housing more people, an issue common across our country.

In our team’s evaluation of 50 Lives, its impact on health outcomes has been a substantial focus.¹¹ Among those housed for one year or more, there has been a significant decrease in the number of emergency department (ED) presentations and admitted inpatient days, compared to the year prior to housing.¹⁰ Mental health as a diagnosis in ED presentations has seen the biggest decline after people were housed and supported.

It is not news to anyone in public health that housing and shelter have long been recognised as vital social determinants of health, but what can we in public health do practically about this? Clearly, the dire shortage of affordable and public housing in Australia is not the core remit of the health sector. But, as noted in last year’s Douglas Gordon oration by Tarun Weeramanthri,¹² one of the important hallmarks of the PHAA is that it can have policy positions and engagement with “fundamentally important issues that impact on health, but are not owned by health”.

The homelessness and community housing sectors are strong advocates themselves, but the impact can be amplified if we add a public health voice to calls to reduce public housing waiting lists, to support people sleeping rough to get off the street, and to prevent people being released from prisons to homelessness.

Another way that the public health field can ‘do something’ about housing as a social determinant of health is to be generous in sharing our innovative ways of demonstrating that ‘prevention is cheaper than cure’.

This underlies much of our evaluating of real-world interventions to demonstrate that housing is a practical, cost-effective and upstream solution to the burden that homelessness places on the health system. But, as we know from public health advocacy, how we communicate that ‘prevention is cheaper than cure’ in ways that are clear, concise and speak to different audiences is

just as critical as the evidence itself. Timeliness is also critical for this type of research to be useful, so we have often foregone a future published paper to feedback findings quickly to services, funding agencies and government to inform planning and spending decisions.

Story 4 – Scott

Scott is a man I came across a couple of months ago outside a London tube station. It was when COVID-19 was starting to escalate globally, and England was in its brief ‘herd immunity’ phase. It was a cold night, and Scott was huddled with his dog and trying to read a novel by dim streetlight. I was with a colleague in London to attend a homelessness and health conference. We paused to ask if he would like something to eat and he said just for his dog. As there was only a fancy Marks and Spencer’s food store nearby, his dog ate well on gourmet chicken breast that night! Being good health promoters, we also got water, and for Scott, a clip-on light to read his books by.

Scott’s pathway into homelessness is a common one, marriage breakdown, lost his job, lost his way. I chatted again to Scott the night before we managed to get an urgent flight back to Australia. He mentioned his fears about COVID-19 for people like himself with nowhere to live. Getting accurate information, he said, was also hard unless he managed to walk by a store with a TV showing the news. This got me thinking a lot about how vulnerable rough sleepers back in Australia would fare in the then-escalating COVID pandemic.

We also had the fortuitous opportunity while in London that week to hear first-hand about the UK plan to prevent COVID-19 risk and spread among people who are homeless. A plan spearheaded by two highly regarded public health experts in communicable diseases, epidemiology and homeless health.¹³ But a plan that was also developed in close collaboration with the homelessness sector.

So, upon returning to Perth and enforced 14-day isolation, I threw myself into seeing how we could apply learnings from the UK (both what was and wasn’t working) to the challenges of COVID-19 in Australia; not only for people experiencing homelessness but also the services they rely on.

The COVID-19 pandemic has in some ways felt like a convergence of all that I have

learnt from years in public health, applied to homelessness. And I don’t mean just because it is a public health crisis. It is also that so many of the tried and true strategies we use in public health have proven invaluable for assisting the homelessness sector to respond, and I will touch on just a few of these today.

1. Firstly, having robust evidence to back calls to action. The early data from Wuhan and Italy showed that the chronic health conditions of heart disease, hypertension, diabetes and respiratory illness were risk factors for COVID-19 severity and fatality. As we know from public health advocacy, having local data is often critical to compelling action. So, we did some speedy analysis of these risk factors in Homeless Healthcare GP data and wrote a rapid Letter to the Editor of the Medical Journal of Australia (MJA).¹⁴ That published letter also emphasised how impossible it is to follow the precautions around staying home, frequent handwashing and social distancing if you live on the streets.

Recently, we had another Letter to the Editor published in the Health Promotion Journal of Australia.¹⁵ It highlighted that much of the COVID-19 vulnerability for people experiencing homelessness is due to preventable health conditions.¹⁵ More than one-third of our large homeless cohort in Perth had been hospitalised in the past year for one or more of the chronic conditions associated with a higher risk of COVID-19 fatality.

This type of data was been quickly shared with the homelessness organisations in WA racing to come up with a response plan. And from there, also incorporated into government briefings. At a practical on the ground level, we also turned the COVID risk factors into a screening tool that was used by homeless day centres and hospital social workers to identify those rough sleepers who most urgently needed accommodation.

2. A second public health application was to ensure the target group had access to relevant information. Scott’s comment about accessing COVID-19 advice had stuck with me. While I was feeling in ‘information overload’ about COVID, this was clearly not the case if you are out on the street. And much of the general information, with its strong focus on staying home, was not applicable to people living on the street. Such generic advice risked fuelling a sense of abandonment among those feeling left to fend for themselves. By this time, many of the food relief and drop-in centres people

rely on had had to scale back operations due to social distancing restrictions, and crisis accommodation and domestic violence refuges were full.

Tailoring information to be relevant to our target audience is key in health promotion, and so working with Homeless Healthcare and homeless services, we set about doing this for COVID. We got permission to adapt a UK COVID information sheet developed with people who have experienced homelessness. Symptoms to look out for and precautions to take were visually depicted, as poor literacy and cognitive impairment is common.¹⁶ Tips had to be relevant to the day-to-day struggles of being on the streets. Whilst it would not occur to me to ever share an asthma puffer, let alone a cigarette, these went into our fact sheets as ways to avoid COVID-19 virus transmission.¹⁷ Going to the internet to health information is not an option if you don’t have a computer or smartphone, so the info sheet was distributed through services at the coalface seeing people who are homeless.

For me personally, COVID-19 has further crystallised the benefits of getting involved at the coalface if we want to make a difference to health inequalities and if we want to have greater credibility with organisations and sectors outside of health.

So, from the confines of my isolation, I got involved in planning and implementing the WA iteration of accommodating rough sleepers in hotel accommodation and made myself available to homelessness organisations grappling with a major health pandemic. When released from isolation, I ended up one Saturday morning down at a hotel in Fremantle explaining COVID symptoms and taking temperatures for people who had been rough sleeping! Whilst being this ‘hands on’ may not be for everyone, there are other ways, and it powerfully conveys that we ‘walk the talk’ about public health and that we are grounded in the reality of the ways in which social determinants fuel health inequalities. Getting out to the coalface, even to contribute in small ways, can also be rewarding and affirming, as too often in public health, the benefits of what we do are long into the future or not seen.

Conclusion

So, to conclude this inaugural virtual Douglas Gordon oration: homelessness is both a driver and consequence of poor health. It exposes deep fault lines in our healthcare

system, and our housing, justice and welfare systems. But, one of the things I love about the public health fraternity is that we do not shy away from ‘wicked problems’. Like other intractable social issues, however, we can feel overwhelmed about we can do. So, I conclude today with three thoughts about what is possible for all of us:

Firstly, we need to ensure that our prevention and public health successes don’t further marginalise or leave people behind. People experiencing homelessness continue to be over-represented on nearly every health risk factor and morbidity statistics. This includes some of the public health issues where Australia has been enormously successful in the general population overall, such as smoking, treatment of hepatitis C and preventive cancer screenings.

Health equity means that we should ‘leave no one behind’. This doesn’t mean people experiencing homelessness have to be singled out as a priority group. But their unique barriers and challenges should not be overlooked when we frame our messaging and programs. Regardless of the area of public health or sector you work in, there are opportunities to make a difference. A recent example from my own state is seen in the practical support the Make Smoking History team provided in the form of quit resources and no-cost nicotine replacement products for rough sleepers who were being accommodated in a hotel as a result of COVID-19.

Secondly, it is crucial to be aware and responsive to the impact of trauma on health behaviours and choices. The impact of traumatic life experiences on brain development, on ways of thinking and behaving, and the body physiologically is profound. In Bessel van Der Kolk’s seminal book, *The Body Keeps the Score*,¹⁸ he shows how this plays out not only in addiction and mental health but on so many aspects of health and wellbeing. A growing body of evidence also shows that adverse childhood experiences (ACES) are strongly linked to higher risks of health-harming behaviours, including smoking, excessive drinking and drug use.¹⁹

In homeless and community services, and in some pockets of healthcare, the importance of trauma-informed practice is well established. It should be so also in public health. Being aware of the impact of trauma on health behaviours compels us to avoid

assumptions and judgement. It also adds further weight to distance ourselves from the proponents of ‘personal choice’ and reinforces the critical need to address structural and environmental determinants of health.

Thirdly, and to paraphrase public health’s much-missed hero, the late Professor Konrad Jamrozik, we need more than just ‘hand-wringing’ about the social determinants of health. Nearly every social determinant imaginable coalesces in homelessness. And yes, it is a complex problem, but there are countless ways we can tangibly do something. For me personally, it has been foremost about a mindset of just wanting to get on with it. And then of asking those at the coalface of homelessness (or whatever social determinant we are passionate about), what would make a difference, and how can I help. Public health skills here are invaluable – we know how to gather evidence to support advocacy, how to keep messaging clear and relevant to different audiences, how to think beyond silos, how to anticipate unintended consequences and how to do things on small or no budgets! And we are passionate about redressing health inequalities and injustice, and this can be infectious.

In closing, it has been said that the care of homeless patients in a hospital setting is in effect an ‘acid’ test for the whole health system.²⁰ I think that, similarly, homelessness is also a litmus test for the field of public health. We cannot ignore it if we are earnest about reducing health disparities and tangibly tackling the social determinants of health. And conversely, if we can play a role in ending homelessness, this will have ripple effects on other priority populations and issues with which homelessness intersects.

All of us, in whatever field or sector, have the potential to make a difference. And even small things contribute to the social change that Douglas Gordon¹ espoused as essential for preventing disease and promoting health.

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