

Notes from a Street Doctor

By Adam Nelson, MD

For many, the world is a difficult place in which to live. A glance through the newspaper will give notice of attacks, shootings, domestic assaults, rape—abuses of too many kinds to list completely. We read these stories and try not to become overwhelmed by the sheer number of them, counting ourselves among the lucky or the blessed, if we can. Still, the details snag at us. The names. The photos. Turning the page, we wonder how someone can survive such an experience.

There are some, however, who cannot simply turn the page. When they pick up the paper, they use it for warmth, for protection, for a bit of padding in the soles of worn-out shoes. And if the paper were simply something to read, what they saw would not surprise them. Their own traumas, too, are overwhelming and often repeated.

You see them everywhere—on the street, under the freeways, camped behind a warehouse. They are hungry and dirty. They trust few, if any. Many resort to using alcohol or drugs. They may behave in ways that you consider strange or bizarre. You may be disgusted or frightened at the sight of them. Policy makers and experts refer to them as “the homeless.”

I see many of them, too—every day—in my practice.

They are my patients, each with a name and almost always with a horrifying history. As the chief psychiatrist for the Brinton Homeless Project in San Francisco, I treat people who are mentally ill and living on the street. And I am frustrated that current policy regarding homelessness is increasingly disconnected from reality, seemingly driven more by concerns about public perception than by the actual problem.

A walk through almost any section of our City makes clear that we live side by side with many people simply unable to find or maintain adequate housing, people who are forced to seek unreliable and inadequate shelter. Our best estimate suggests that 14,000 such individuals live among us. Yet, there are just more than 1,000 shelter beds in all of San Francisco. For some—the “working poor,” for example—social and welfare policy reform, including increased access to affordable housing, job-training and support services programs, may offer a way out of homelessness.

But many others without housing—3,000 to 5,000 in San Francisco—also suffer from some form of severe mental illness. These conditions—including major depression, schizophrenia or bipolar disorder (manic-depressive illness)—are often hereditary in origin and are seen throughout all socioeconomic groups. Not surprisingly, however, they are seen more commonly in persons who are poor and/or homeless, prompting popular misconceptions of homeless persons as refugees from state hospitals. As psychiatrists, we are quite familiar with the assessment and management of these conditions, but when coping with mental illness on the streets, the problem of homelessness presents an added challenge for the patient in obtaining effective care and treatment.

Beyond those two segments of the homeless population, another exists that is not necessarily suffering from severe mental illness, but is still incapacitated and unable to get off the street. This group, in fact, constitutes the vast majority of the people with whom I work. Some have a substance abuse problem, but many do not. Regardless, they still find seemingly routine matters of daily living impossible to manage.

We recently surveyed people as we treated them on the street and gathered startling results. Every person we interviewed had experienced some type of severe and repeated trauma throughout his or her life. Not

surprisingly, much of the trauma was related to being homeless. But something even more dramatic also came to light: more than 90% reported some type of severe and repetitive trauma during childhood, typically before their 14th birthday! These traumatic events included beatings, sexual abuse, abandonment, neglect, or all of the above.

Our patients—and by implication a large proportion of the homeless population—continue to suffer the enduring after-effects of these severe and repeated traumas. For these individuals, homelessness is a compounding aggravator of much deeper and more difficult-to-manage problems. A typical story begins with abuse as a child, then abuse again as an adolescent, within the family or at the hands of welfare or criminal justice authorities. Sometimes the abuse is institutionalized in jails or juvenile facilities. Wherever it happens, the common historical thread for these patients is severe abuse with multiple occurrences.

We see the devastating results of these traumas on the street everyday. Drug and alcohol abuse. Social difficulties. Inability to go to work or keep appointments. Occasional violence. Laws are broken, requiring that the legal system become involved. Physical injuries require a visit to the emergency room or other urgent care facility. Depression and other difficulties lead to further withdrawal, avoidance, and undifferentiated anger.

One clinical consequence of severe trauma can be Post Traumatic Stress Disorder (PTSD). Originally described by the VA to explain the severe emotional difficulties of veterans returning from Vietnam, it has since been observed in participants from almost every armed conflict. And with the 4th revision of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV), the diagnosis has been expanded to encompass those who have survived other life-threatening traumas as well, such as natural disasters, horrific accidents, and ethnic violence. Yet, even this diagnosis fails to account for the experiences and symptoms of those whose traumas are both severe and repetitive, particularly when the onset of trauma occurs at an early age. Although not yet found in DSM-IV, the uniquely devastating problems associated with the traumas of chronic physical, sexual, and emotional abuse or neglect have been acknowledged by the profession. Research now suggests that such abuse or neglect in childhood can adversely affect the functioning of the brain later in adulthood.

Obviously, the impact of such abuse is felt throughout a lifetime, especially for those who now find themselves living on the street, where additional trauma is an ongoing risk—24/7. Every day, those without housing face possible assault in a back alley or a crowded shelter. They may be rousted from an isolated encampment with all their belongings confiscated or risk having their vehicle and all possessions seized. Begging, or even finding a working bathroom, can become an opportunity for verbal or physical abuse. It's a small wonder that some will prostitute themselves to pay for a mind-numbing heroin fix. Or simply drown the day in beer or liquor. Life for those on the street is a series of traumatic events—major events earlier in life and now the ongoing pounding they take on the street.

I am hardly the only one to see this pattern. Last Spring I co-chaired a panel of colleagues at the American Psychiatric Association meeting here in San Francisco. Our panel brought together psychiatrists and other professionals who treat the homeless across the nation in VA facilities and a variety of community clinics. It quickly became clear that we see patients with the same symptoms, the same multi-trauma backgrounds. Several studies done in the past 10 years have offered similar findings.

Unfortunately, such a realization does not extend to everyone. Instead, I see the continuation of long held misperceptions: "Substance abuse causes homelessness." "They were better off in a state mental hospital." "Why can't they get a job instead of just begging for handouts?" This is what I hear about my patients and those are the views I see coloring much of the so-called public policy debate. Sadly, these misperceptions lead to "solutions" that actually make the problem worse. How can taking away someone's monthly payments to fund alternative clinical and social services possibly succeed? The proposed alternative services do not currently exist and are poorly planned at best. The current public health research convincingly shows that people who are homeless and/or substance abusing actually do worse when their government payments are cut.

So what will work?

I wish the answers were simple. Unfortunately, they are not, though I do believe that the ideas listed below can be helpful, especially if utilized in combination.

WELCOMING SHELTERS. While the most obvious need for someone who is homeless is housing, a parallel need is for human interaction—the opportunity to reestablish contact with others and perhaps rebuild the trust shattered for so many we see on the street.

In the City, we are fortunate that a number of religious organizations have taken on the task of providing welcoming shelter. Some are well known—such as St Anthony's and Glide Memorial Church—while others are much smaller and less visible to the public. Their common characteristic, beyond the distribution of food and/or clothing, is a sheltered environment that makes the poor actually feel welcome. Many of these organizations provide vital links to other needed services, offering a critical first step in stabilizing badly damaged lives. This is in sharp contrast to the regimented structure often adapted by other institutions that serve the poor and argues against large, state-sponsored institutions with a heavy-handed air about them.

HOUSING AND COMMUNITY. Beyond shelters must be the establishment of affordable housing. Local housing policy also needs to support the growth and strengthening of communities. Individuals with life-shattering experiences are more likely to choose isolation as a means of protecting themselves from further trauma. In fact, this pattern of isolation often becomes part of their problem.

Here too we have working examples that offer a solution. Innovative programs like those at Caduceus, Mission Neighborhood Resource Center, Martin de Porres, and Continuum, plus residential treatment communities, such as Baker Places and Walden House, prove that many who are homeless, if given the opportunity, are able to take part in a community environment, to build and trust.

HUMAN-SCALE CAREGIVING. At the Brinton Homeless Project, we have found success by adapting our program to fit the needs of our patients, not the needs of an institution or of local government. As have other health-care providers, we work with established organizations already serving the homeless. Our patients are seen in an atmosphere that they consider safe and friendly. I keep regular hours at Glide, the Haight Ashbury Free Clinic, the Mission Neighborhood Resource Center and elsewhere. But for people who cannot make or keep regular appointments, we also offer drop-in hours.

Because of my work, I have had an in-depth look at homelessness in San Francisco. And it is time, I believe, that policy makers deal with the full depth and breadth of the problem before we embark on another solution destined for failure. From my position beyond the political arena, I do not pretend to offer comprehensive solutions. I can offer only my knowledge and experience in working with people who are homeless and either mentally ill or mentally suffering. I can share what I have seen work. In the meantime, as the best policy is developed, I urge that we—as a community—recognize poorly-conceived solutions for what they are.

When we read news accounts of people who have survived and succeeded despite extremely challenging circumstances, we share their sense of pride and gratitude. But all around us, we continue to see people who simply cannot overcome the challenges of their lives. With these people in mind, we need to recognize that the solution to homelessness in San Francisco waits at the end of a long, complicated, and difficult road. It is a road that we must travel together—and with clear sight.

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