



HOPE team member Jackie Brown, a patient, and the author, with their van.
Photo courtesy of Dr. Christensen.



THE LANGUAGE OF CARE

Taking psychiatry to the streets

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The language of care is greater than the act of speaking. It is a language of sensitivity, patient presence, and gentle approach; a language of concern and mutual respect. It does not depend on our particular roles or the labels the world gives us. Healing words flow from our common humanness, our feel for a person's life condition, and our compassion for someone else's suffering.

—Craig Rennebohm^{1p182}

Over the years I have become increasingly reluctant to tell others that I am a psychiatrist. While getting my haircut, or on a long-distance flight, the inevitable question arises, “And what do you do?” When I finally come out with it, I just know my acquaintance has begun to mentally conjure those cartoon images from *The New Yorker* of the bearded, cigar-smoking psychiatrist, scribbling on a pad while “analyzing” the patient lying on a couch. I know those cartoons are playing a role in the questioning because I usually start fielding a string of queries about dream interpretation and long-smoldering conflicts with mother figures. In my most therapeutic way, I usually respond with, “Well, I don't actually practice *that type* of psychiatry.”

I then talk about my work with the mentally-ill homeless.

Individuals who suffer from serious and persistent mental illnesses comprise nearly one-third of the homeless population in this country.^{2p2} The most vulnerable are those who are both mentally ill and chronically unsheltered, who differ in a number of respects from homeless persons who are temporarily domiciled within a shelter system or service agency. The mentally ill who are chronically unsheltered are more functionally and socially impaired than their shelter-based counterparts and are less likely to pursue or accept basic services (e.g., food, shelter, appropriate clothing), case management assistance, and medical care.^{3p894}

Nearly a decade ago, Jacksonville's civic leaders and mental health advocates recognized the need to engage the segment of the homeless population in our city that appeared to be in greatest need for basic human services. These were the persons, it was argued, who were most difficult to engage because many cycled through the hospital emergency departments, jails, and psychiatric crisis units only to wind up back where they started: on the street. The city provided funding of several hundred thousand dollars per year, renewed annually for the past nine years, to implement a medical street outreach team comprised of two case managers, a nurse, and a part-time psychiatrist. A local car dealership donated a van modified to store medical supplies that could be used to transport the team. Through our academic department's community psychiatry program, I signed on as the "street" psychiatrist.

Most of my patients live in the urban niches provided by parking garages, or in scooped-out sand dunes alongside the beach walkways, or in the corners of a seldom-used bus stop shelter. Much of my clinical work over these years has been carried out, literally, on the street. My "office" is portable and my "patient follow-up" schedule varies dramatically depending upon who our outreach team can locate on any day. Most of the time we find the usual persons in the usual places, but tropical storms, relentless heat, or unannounced police sweeps of public spaces can wreak havoc on our search-and-find efforts.

Of course, our outreach team is always on the lookout for that new person navigating the street who has recently been released from jail, or discharged from the hospital without safe shelter, or cast out of an apartment by a rent-jilted landlord. Many times the outward signs of severe mental illness are obvious, but not always. As we roll up in our medical outreach van and introduce ourselves, I almost always experience that gnawing reluctance to reveal my professional identity. From experience, I know well that persons with chronic mental disorders living on the street seldom have images and memories of psychiatrists framed in comical Freudian stereotypes. For most, interactions with the public mental health care system—overcrowded crisis units, detoxification facilities, forensic hospitals and jails—have left them with painful recollections of involuntary hospitalizations, coercive treatment and less than compassionate recovery-oriented care. Rarely does the

person say, "Wow, am I glad to see you, Doc!" In fact, after introducing myself, the usual reactions are shot through with a glaring suspiciousness: "Why do you think I need to see you?" or "Ya gonna lock me up?" Hostility and flat-out rejection occasionally occur: "I don't want nothin' from you!"

I have over the years learned to take nothing personally during those initial encounters because I now have a different perspective. When I first began doing street outreach my approach was still shaped by my experience of interacting with patients who willingly came to my clinic: patients came for treatment and I provided it. That is not the case when conducting street outreach. On one of our team's initial forays years ago I made contact with a woman living on the street who was floridly psychotic, malodorous, filthy from head to toe, and fairly agitated. After telling her who I was and what I did, she totally and completely ignored me. Staring off into the distance, she pressed on with a monologue that made sense only to her. I was flustered because I was unable to interrupt or otherwise get her attention. Looking for any hook to engage her, I said something along the lines of, "You know, Ms. Virginia, I could give you medications that would make you feel better." At that moment, she stopped her psychotic soliloquy in mid-sentence, looked me full in the eyes, and replied, "Hmmm . . . Ya think? Well, I think giving me medication would make you feel better, but it sure as hell won't make me feel better!"

Since that time I have come to more fully recognize that meaningful psychiatric street outreach is not based on developing a diagnosis, formulating a treatment plan, or dispensing medication. Although our street outreach efforts yield over 120 contacts per month, providing shelter and/or medical care to approximately fifty percent of this population, our work is not only about producing measurable clinical outcomes. Rather, it is all about cultivating relationships. Those "first meetings" are given to making sure at least two things happen: first, I acknowledge the essential worth and dignity of the person, and second, I ensure that he or she is willing to see me again. Nothing else matters. Indeed, no truly meaningful medical treatment can begin until some semblance of a healing partnership has been established.

Four years after the initial encounter with Ms. Virginia, and after many, many street "appointments" during which medications were never mentioned again, she agreed to move into





Carlos Luna

safe housing. Today she fully participates in her recovery from devastating mental illness and actively directs her own care.

In reaching out to those who endure harrowing, isolated existences on our city streets because of confused minds and crushing fear, compassionate acts of human recognition and deep listening carry far greater transformative power than do initial offers of medication and treatment. If nothing else, my work on the streets as a psychiatrist has taught me that the slow dance of healing always begins with a “language of care” that speaks of presence rather than analysis, invitation instead of interpretation.

References

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