TAKING ISSUE

Health Care and the Homeless

I had the opportunity last year to give a grand rounds presentation to our hospital's internal medicine department. I was asked to address the need for developing models of integrated health care—that is, the simultaneous delivery of primary care, addiction services, and psychiatric treatment—for homeless persons with mental illness. It was an ideal opportunity for a community psychiatrist to collaborate with primary care providers about the issues involved in caring for this highly vulnerable population. I suspected that much of what I had to offer would be a rehash of what most providers already knew. I was wrong.

As it happens, the week before I gave this presentation, I was on my weekly "ride along" with the street outreach team, which was attached to our city's shelter. On these rides we would scour the streets and nearby woods to engage homeless persons in need of medical care. If someone was interested in treatment, we would make arrangements for the person to be seen in our shelter-based primary care or psychiatry clinic. On this particular day we came across an elderly gentleman who was lying in a garbage-strewn alley. His legs were crudely wrapped in gauze dressings, and he was smeared with feces. On his wrist was a hospital identification band revealing his age to be 77 years. He said that he had been admitted to our local hospital for several days to receive treatment for recurring, oozing cellulitis on his legs. Upon discharge he had been put into a taxi with instructions to go to the nearest homeless shelter. Unfortunately, by the time he arrived, he had missed the admission curfew. When we saw him, he had spent the previous 18 hours lying in the dirt, unable to stand. Next to him was a large plastic bag filled with sterile gauze wrappings and unopened medical tape. Before his hospital discharge he had been instructed to change his bandages once a day, fill his antibiotic prescription, and elevate his feet as much as possible.

I related this humanly wrenching vignette at the grand rounds to underscore the need for the health care system to become more clinically responsive and morally responsible in its treatment of the homeless. Over the years it has become abundantly clear to me that community psychiatry has a rich tradition of caring and advocating for persons who lack entry and choice in a payer-driven health care system. Community psychiatrists who provide care to the homeless have learned that engagement practices can be unconventional, clinical settings oftentimes lack borders, and discharge plans usually need to be creative and always need to be compassionate. Although we admittedly still have a great deal to learn about how to better care for homeless persons, we may have an even greater obligation to share with our colleagues what we already know.—RICHARD CHRISTENSEN, M.D., *director, community psychiatry program, and associate professor, University of Florida College of Medicine, Jacksonville*

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