

## Feet First: Reflections on Primary Care for Homeless People with Serious Mental Illness

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*A 55-year-old homeless woman with untreated schizophrenia presents to a shelter clinic at the suggestion of shelter staff. She reports “molecular bubbles” on her teeth, tingling in her hands related to “lithium ion batteries,” and abdominal swelling due to “air pressure, water elements, and iron.” She has not seen a doctor in more than five years. On exam, her blood pressure is 180/110, her teeth are blackened and decayed, she has a 20-cm firm suprapubic mass, she has lice on her clothing, and her feet are macerated and foul smelling with elongated toenails that wrap underneath her toes. She declines imaging of her pelvic mass but accepts a foot soak, nail trimming, and new socks.*

**A**s the number of homeless individuals in the United States grew in the 1980s, some reports suggested that as many as 90% of homeless people had mental illness.<sup>1</sup> Although we now know this prevalence to be considerably lower, the burden of mental illness among homeless individuals is nonetheless substantial. An estimated 14% of homeless people have schizophrenia,<sup>2</sup> and more than 50% have a lifetime history of mental health problems.<sup>3</sup>

Homeless individuals with serious mental illness are arguably among the most vulnerable members of our society, and their complex needs are often not well met by traditional health care systems. In 2010, Boston Health Care for the Homeless Program partnered with the Massachusetts General Hospital Division of

Public and Community Psychiatry and the Massachusetts Department of Mental Health to create a novel medical clinic embedded within a shelter for homeless people with severe and persistent mental illness, including psychotic disorders. The clinic provides primary and preventive care on a weekly basis and includes psychiatry residents who assist in the evaluation and management of patients.

Despite lofty goals, the clinic had a humble beginning. For the first two years, we saw patients in the women’s bathroom because it was the only private location with a working sink. The pink walls proved to have a calming effect on both me and my patients. Like many internists, I had received no special training in psychiatric illness, much less psychotic disorders, during residency. Still, I was instantly drawn to this work and to the remarkable people I encountered doing it. What follows are my thoughts on some of the most salient things I’ve learned in taking care of homeless people with serious mental illness over the past three years:

**1. Go to them.** While a homeless person with psychiatric illness strikes many of us as the prototypical “high utilizer,” my experience has suggested that on average this group of people is much more likely to underutilize or avoid health care services. This usually isn’t because of self-destructive tendencies but rather because of disorganized thinking; delusional paranoia or even well-founded mistrust of medical institutions; lack of insight about their own health needs; or

inadequate knowledge about where, when, and how to seek health care. Locating our services in shelters and programs where our patients reside removes some of those barriers and allows them to approach us on more familiar terms without the need to navigate confusing hospital corridors, crowded waiting rooms, or requests for identification. Indeed, we’ve learned that if we wait for them to seek us out in a traditional medical setting, it’s much later in their course of illness, making it more difficult to alter their health trajectory.

### **2. Start with tangible needs.**

Many of the illnesses that comprise bread-and-butter primary care are often, at least early on, intangible disruptions of bodily homeostasis that bother physicians more than they bother patients. High blood pressure, high blood sugar, high cholesterol—these are usually not the issues that our patients are most concerned about. More commonly what brings them in the door and keeps them coming back is an issue with more tangible consequences, like dental pain, vision disturbances, skin rashes, or foot problems. Although these are often the issues we feel least prepared to treat, even a little effort to do so goes a long way. Since early in our clinical experience, foot care has been a cornerstone of our service model. We offer patients a foot soak at every visit, and oftentimes I dedicate entire visits

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to trimming toenails and shaving calluses. For a population with a heavy burden of trauma, this is a safe introduction to the concept of physical contact and a safe way to start health-oriented conversations outside the framework of traditional history-taking. Medically, the feet reveal a great deal about a person's overall health and self-care, but more importantly, the simple act of soaking feet inverts the traditional patient-physician power dynamic and conveys to patients that we are there to serve them. As the relationship evolves, we use these types of encounters to gradually link patients' tangible symptoms to less tangible conditions like diabetes and hypertension.

**3. *Understand the narrative.*** As internists, we're trained to diagnose illnesses and treat them. We make problem lists, prescribe meds, and fix abnormal numbers. In the midst of these efforts, it's easy to lose sight of the person in front of us and the story he/she has to tell. Engaging in a conversation with someone with a psychotic disorder is no easy task, and we're tempted to think that a disorganized historian renders the history obsolete. In my experience, this isn't true. Although a patient's story may be tangential, it often contains crucial details of life as he/she perceives it. Beyond being useful from a diagnostic perspective, these details often tell us what makes our patients happy, what worries them, and what their

priorities are—however delusional they may be. Without first understanding this narrative, making forward progress on anything else is impossible. This doesn't require that a clinician participate in patients' delusions, and it is certainly not useful to refute these delusions. When a patient expresses a distressing delusional idea (e.g. "The people who work here are spying on me."), usually a brief statement of empathy is sufficient (e.g. "That sounds really stressful."), followed by a conversational pivot that shifts the focus to the patient's strengths (e.g. "Tell me more about how you handle that."). At the core of these interviewing techniques is the goal of establishing, to the greatest extent possible, a trusting relationship as the foundation of healing and recovery.

**4. *Be patient.*** The case above illustrates a complex patient with numerous outstanding health issues. Our instinct is to try to fix all of these things at once. Sometimes this is appropriate, but it's rarely necessary, and in some cases it can be counterproductive. One of the most valuable skills I've learned in caring for this population is how to take a deep breath in the face of chaos. None of these issues started today, and none have to be fixed today. We don't ignore or give up on important issues like undiagnosed pelvic masses or untreated hypertension, but rather we allow for some flexibility in

pursuing these issues at a pace that's compatible with building trust and getting buy-in. In some cases this pace will be quick, and in other cases it will be glacial. I met with one patient every week for one year before she agreed to try an antipsychotic medication. Another patient wouldn't get on an exam table for the first year I saw her because "only bad things like mammograms and Pap smears happen there." In such cases, the usual metrics of primary care quality don't readily apply. According to many of these metrics, my clinical performance is an abject failure. I think this highlights the need to better incorporate patients' values and preferences, as well as their psychiatric and medical complexity, in the measurement of primary care quality; otherwise, there will never be a favorable incentive structure for making the long-term investment necessary to care for this population.

**5. *Collaborate.*** A single person cannot do this work alone. As physicians, we are often ill equipped to handle many of the challenges our patients bring to us. These challenges are bigger than any of us, and they require a skill set that extends far beyond our own. Because of this, multidisciplinary collaboration is an essential component of caring for this population. Each week, the shelter where I work hosts interdisciplinary case management rounds where key shelter staff, nurses, social

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workers, outreach workers, addiction specialists, mental health care providers, and primary care providers come together to discuss client-specific issues. We collaborate with community-based caseworkers and peer specialists who collectively weave a network of social support services to meet their clients' needs. These are the unsung heroes of the entire process, and very little can be accomplished without their input and assistance.

By now it should be clear that I'm not really peddling new knowledge. Taking care of a population with sometimes-specialized needs creates the impression that the

work itself requires specialized knowledge. For the most part it doesn't. The basic principles of taking care of homeless people with serious mental illness are the same as those underlying good primary care in any setting. We strive to put the patient at the center of the process and to build the agenda collaboratively. We tailor our goals to reflect our patients' values and preferences, and we exercise our best judgment in translating those values and preferences into shared decisions about testing or treatment. Sometimes that means we swiftly pursue five years of backlogged health maintenance tasks, but more often it means we soak their feet, listen, take deep breaths, and be present.

### References

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