The **Outreach Van** Project

BOSTON UNIVERSITY

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An Introduction to the Outreach Van Project

by Kenny Fan

Our History and Goals

Every Thursday night, Boston University School of Medicine (BUSM) students comprise a team that delivers basic needs and health awareness to an underserved population in East Boston. Our organization is called the Outreach Van Project (OVP) and our mission is three-fold:

1. To provide basic necessities to the underserved populations in the form of food, clothing, toiletries, dental supplies, and basic medical care supervised by a physician;
2. To make concerted efforts to connect people that are underserved to primary care and to other community services such as shelters and detoxification programs;
3. To give students an opportunity for hands-on involvement working with underserved populations in the Greater Boston areas.

At the time of its inception, OVP was simply a group of medical and public health students hoping to positively impact surrounding areas of Boston. This dream began in January 1997, when OVP began its mission at the Suffolk Downs Racetrack. OVP served this site for two years, during which time it helped a largely Latino migrant worker population. In 1999, OVP expanded its coverage to the Cambridge and Somerville communities. In 2000, OVP began reaching out to the more underserved area of East Boston, to which we are still delivering care today.

Our Current Events

OVP, comprised of approximately 30 students, travels to East Boston every week of the year, including Thanksgiving and Christmas. A team of 5-6 students and one physician serve the homeless community by delivering hot soup, clothing, groceries, and toiletries. During our outings, we engage the homeless population in conversation, inquiring about their lives, recent events, and any medical issues they might have. We also act as a referral service for detoxification programs and shelters, and can provide information concerning federal or state aid programs. In addition, our medical outreach committee has integrated education concerning common health conditions often seen in the homeless population, including frostbite and poor oral hygiene.

In the past academic year, OVP has exposed its team to many issues that surround homeless and community health. In the fall, Dr. Shunda McGahee, from the Boston Health Care for the Homeless Program (BHCHP), gave an overview about the challenges of mental health and its relationship to homelessness. She also spoke of the functions and purposes of BHCHP in serving this population of patients. More recently, a representative from REACH, a domestic violence awareness organization, educated students on her experiences with victims of domestic violence and its deep connections with homelessness. We have several other events scheduled for upcoming weeks, including tours of the Suffolk County House of Corrections and Pine Street Inn, a homeless shelter in the South End close to BMC.

If you are interested in learning more about OVP or have any questions, we can be reached at outreach@bu.edu and our website is http://blogs.bu.edu/outreach.

The Social Determinants of Homelessness

by Stephanie Shaw

Homelessness is clearly a complex issue that must be tackled from a number of different fronts.

Homelessness is a complex issue that does not have one clear cause. Boston Health Care for the Homeless estimates that there are approximately 25,000 people who are homeless in Boston for some amount of time each year. Between a shortage of affordable housing options and an increase in poverty, this number has been on the rise for the past 20-25 years.

In the difficult economic times that are upon us, foreclosures and eroding work opportunities have increased the number of people experiencing homelessness. According to the National Coalition for the Homeless, there was a 32% jump in the number of foreclosures between April 2008 and April 2009, and since the start of the recession, six million jobs have been lost. Many of the available jobs are offering fewer benefits, cutting back on hours, and seeing a decrease in pay. Without adequate resources to cover housing, food, childcare, health care, and education, choices must be made on where to spend money, and often housing is sacrificed.

This problem is amplified by a lack of affordable housing options and a decline in public assistance for housing. Cities all over the country have excessive waiting lists for public assistance, leaving people in shelters or substandard housing situations for longer periods of time.

A number of other major factors also can contribute to homelessness. For individuals and families who are uninsured or underinsured, a serious illness can result in a depletion of savings and an eviction from their home. Battered women living in poverty may have to decide whether to stay with their abuser or become homeless. In addition, roughly 16% of the adult homeless population suffers from mental illness, 38% are addicted to alcohol, and 26% are addicted to other drugs, all issues that can make accessing supportive housing and treatment services more difficult (National Coalition for the Homeless).

The National Alliance to End Homelessness also sites veterans as a group of people who experience homelessness. Between physical disability, post-traumatic stress, and other hardships, veterans may engage in unsafe behaviors like violence and addiction. The Departments of Veterans Affairs (VA) and Housing and Urban Development (HUD) released a report in 2010 that estimated 76,000 veterans experience homelessness on any given night. In addition, a report done by the advocacy group, 100,000 Homes Campaign, found that once homeless, veterans tend to stay homeless longer than non-veterans and have more serious health problems. They found that homeless veterans reported 5.7 years of being homeless, compared to 3.9 years reported by the non-veteran homeless population.

Homelessness is clearly a complex issue that must be tackled from a number of different fronts. Jobs with adequate pay, support for people who cannot work, affordable housing options, and access to health care all need to be addressed to help those suffering from homelessness and prevent additional people from becoming homeless (National Coalition for the Homeless).

Reflections of a Homeless Healthcare Physician

by Laura Wong

The Outreach Van Project provides opportunities for students to learn about the issues behind caring for the homeless population of Boston not only through direct service, but also through monthly educational events. So far this year, these events have included an introductory talk on the causes of homelessness, a field trip tour of the Boston Health Care for the Homeless (BHCHP) and Barbara McInnis House respite and clinic center, and an event focusing on mental health and its relation to homelessness presented by one of the doctors at BHCHP.

Photo courtesy of Dr. Esther Valdez

I was particularly intrigued by this last talk on the mental health aspects of homelessness, and wanted explore this area further. What is it really like to be a mental health provider for one of the most challenging populations to treat? To discover the answer, I interviewed **Dr. Esther Valdez**, the Associate Medical Director for Psychiatry at BHCHP.

Where are you from?
I was born in Hong Kong and completed medical school in England. I moved here in 1992 for my Psychiatry Residency, and have been here ever since.

Where did you do your medical training?
I completed my initial studies at the University of London and my residency at BMC.

What is your current role/position at BHCHP? What is your typical schedule like?
I am the Associate Medical Director for Psychiatry, for which I oversee all psychiatrists in the program. My time is distributed between administrative and clinical obligations. I have three sessions of outpatient clinic and then see patient for consults in our medical respite unit approximately half the time.

Why did you choose to go into Psychiatry?
I enjoy working with challenging patients, and I especially like doing it in a medical setting with a multidisciplinary team approach.

What do you find most difficult about working with the patient population of BHCHP?

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Substance abuse and homelessness are huge issues impacting effective care. Community resources are also dwindling with time. Many patients also have long criminal histories and are being released to the street with few options. Providing care to these patients can be both challenging and potentially dangerous.

What do you find most rewarding about your work?
When I can make a difference in helping someone move forward in his/her life.

Can you comment on the common medical conditions you see and how housing status plays a role?
We see everything, from serious and life threatening illnesses, such as cancer and HIV, to orthopedic injuries and diabetes. Our medical respite unit has been crucial for the care of patients too sick to be in shelters or on the street but who do not qualify for acute inpatient care. Of course, many patients if housed would be able to be better managed at home. Being homeless impacts patients' abilities to maintain their medical and psychiatric care. Shelters provide poor nutrition; in addition, my patients are more at risk for substance abuse by being homeless, which further impacts health.

Can you comment on the overall trend of how health and health care for the homeless of Boston has been since you've started practicing medicine?
I am fortunate to work in a program that has been able to provide high quality comprehensive multidisciplinary care to patients throughout the last 15 years of my career with BHCHP. So far, Mass Health and Medicare cuts have not severely impacted this in Massachusetts to the same degree as they have in other states, but substance abuse and Department of Mental Health services have been severely impacted and the lack of affordable housing has remained the same if not worse. So overall, I feel that caring for this population remains ever challenging.

"I enjoy working with challenging patients, and I especially like doing it in a medical setting with a multidisciplinary team approach."

Any advice to medical students on how to provide better care for their homeless patients? Pitfalls to avoid? Thoughts to keep in mind?
Homeless patients struggle with many co-morbidities, including substance abuse, mental and medical illness, financial stress, trauma, frequent estrangement from family and support systems, and social bias. It is important not to have preconceived ideas and to understand that any one of us, given a slight shift in circumstances could also end up in this situation and to treat these patients with compassion and empathy.

Multidisciplinary care is key to giving people a chance to change their lives; without addressing the other complex and complicating factors that affect health, treating only their medical issues is unlikely to make a lasting impact.

Effects of Homelessness on Mental Health

by Nicole Economou

In the latest report from the National Alliance to End Homelessness, from 2008 to 2009 the homeless population in the United States jumped by 20,000 individuals to a total of 656,129 people, representing a 3% increase. Of note, this is a point-in-time estimate taken on any given night; many of these individuals are transiently homeless and may find housing within the year. Another estimate from the National Law Center on Homelessness and Poverty shows that in any given year, approximately 3.5 million people (including 1.3 million children) are likely to experience homelessness. In Massachusetts alone, it is estimated that 15,482 individuals are experiencing homelessness in shelters, transitional housing programs, and other places on any given night.

http://dmh.dc.gov/

Several studies have indicated that there is an increased prevalence of mental disorders and substance use (particularly multiple substance use) among the homeless population as compared to the age-matched general population. In particular, homeless individuals have a higher likelihood of having psychotic illness and personality disorders, as well as alcohol and drug dependence.

In the homeless population, the most common mental illness seems to be alcohol dependence, which has an estimated occurrence rate of 37.9% according to Fazel, et al. (2008). Drug dependence is also extremely common, occurring in approximately 24.4% of homeless individuals. Additionally, the prevalence of psychosis and depression was similar in this group at rates of 11-12%. In contrast, prisoners and refugees, other groups at risk for mental illness, have higher rates of depression versus psychotic illness (Fazel, et al 2008). These co-morbid disorders can make finding and sustaining housing extremely difficult for many individuals experiencing homelessness and mental illness.

In order to maximize the probability of homeless individuals with mental illness becoming and remaining housed, the combination of subsidized housing vouchers and intensive case management has been found to be effective for reducing the risk of discontinuous housing and maintaining stable housing. This combination was also shown to be effective for individuals with

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severe substance use problems. In fact, obtaining housing is in itself associated with a decrease in substance use and an increase in utilization of health services. For individuals with substance abuse problems, abstinence-based housing is associated with a greater increase in sustained abstinence than traditional housing.

Similarly, a study by Fitzpatrick-Lewis et al. found that specifically implementing health and social policies that include the provision of housing for homeless individuals are shown to be effective for improving health (2011). For optimal outcomes, housing provisions should be given within an integrated model with other support services including addiction counseling, case management, meal delivery or arrangement, and detoxification if needed.

Overall, research has indicated that subsidized housing vouchers combined with case management and other services are crucial in improving outcomes for homeless individuals with mental illness. This integrated, multidisciplinary model, which combines housing with other needed resources, seems to be the most effective in achieving and sustaining long term housing and improving health in the homeless population.

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Housing Solutions for the Homeless

by Abraham Khorasani

The ultimate goal for homeless individuals is, naturally, obtaining housing. The current status quo for transitioning out of homelessness is the "continuum of care" model. A continuum of care, as defined by the US Department of Housing and Urban Development, is "a community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximize self-efficiency." The continuum of care consists of four steps: outreach, emergency shelter, transitional housing, and permanent housing.

Shelters are a first resource for many homeless individuals. The City of Boston operates two emergency shelters – Long Island Shelter and Woods Mullen Shelter – totaling 577 beds. Additionally, the city has a number of private shelters, including Pine Street Inn and Rosie's place. Shelters are by no means a housing solution; guests must leave each morning and cannot store their belongings during the day. In addition, having a bed the previous night does not guarantee a place the following night; rather, one is required to again line up for a bed ticket the following day. The Boston Public Health Commission classifies the shelter system as a "safety net," citing a Pine Street Inn survey, which found that half of its guests came to the shelter within one week of discharge from hospitals, prisons, or other facilities.


http://www.ebcrp.org

Shelters provide a valuable respite from the rigors of living on the street, particularly in the at-times-hostile climate of Boston. In these shelters, guests can obtain a number of services, i.e. meals, medical and psychiatric care, case management, and substance abuse assessment, etc., that would otherwise be difficult to access. However, the conditions in the shelters are far from comfortable. Guests sleep in bunk beds mere feet away from each other, with no privacy or quiet. Disease, especially tuberculosis, can spread rapidly in these confines, and violence and crime can be commonplace. Moreover, guests have no private areas to store their belongings, leading to increased theft. These conditions make it very difficult to manage the common underlying issues that both result from homelessness and perpetuate its cyclical nature.

Housing is the end-goal of the continuum of care. Several avenues exist through which the homeless can obtain affordable housing, including Section 8, tenant-based rent vouchers, and private and public affordable housing. However, many significant obstacles stand between homeless individuals and these opportunities. First and foremost, the waiting lists for these programs are formidable– for example, the centralized waiting list for Section 8 housing is approximately five years – and some

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programs have ceased taking applicants altogether due to funding cuts. The number of programs and their eligibility requirements can also be confusing to navigate and difficult to follow. A "centralized" intake system exists only for families, so individuals must apply separately for different opportunities. Once on the waiting list, strict requirements must often be met, ranging from corresponding with the program on a regular basis to abstaining from substance abuse. Clearly, for many homeless individuals who are struggling with substance abuse issues, these requirements can be very difficult to follow.

Living on the street makes it extremely challenging to manage substance abuse and other chronic health conditions such as diabetes. To that end, many leaders in the fields of homeless advocacy and healthcare are now supporting "housing-first" solutions. "Housing-first" rests on the idea that if people can be brought in off the streets and given a stable place to live, it will be easier for them to get the help they need and make changes in their lives.

In fiscal year 2007, the Massachusetts state legislature created a line item in the state budget for a pilot program called "Home and Healthy for Good," initiated by the Massachusetts Housing and Shelter Alliance. As of December 2011, the program has housed 543 people who were once chronically homeless. Of these people, 64% had mentally disabling conditions and 52% had medically disabling conditions, with 47% suffering from multiple conditions. Not only are these situations difficult to manage, they also make it challenging to find employment and housing.

Although still relatively new, early data indicates that the program has been successful. Sixty-one percent of the clients have moved on to other permanent housing, while only 5% have returned to homelessness and 7% have been incarcerated. In addition, people in the program have been found to use public emergency systems, such as emergency departments, ambulances and detoxification programs, dramatically less than people who are not housed, and thus concurrently cutting state medical costs. Shelter usage is also almost completely eliminated in these individuals – in the six months prior to entry into housing, the 543 clients reported using the shelter system 48,861 times, or almost 90 times each. In addition, the public spends less money per person on housed versus un-housed individuals. According to analysis by Public Service Economics in the most recent "Home and Healthy for Good" report, an annual savings of roughly $4,000 per person was observed. An internal study, meanwhile, found that even after the $15,468 annual cost per person for housing, there was an estimated annual savings of over $9,000 per person due to drastically decreased uses of Medicaid and shelters and significantly reduced incarceration. From both studies, it seems that "housing first" represents a desirable solution, both to the individuals being helped and to the public who is funding it.

However, the conditions in the shelter are far from comfortable. Guests sleep in bunk beds mere feet away from each other, with no privacy or quiet. Disease can spread rapidly in these confines, and violence and crime can be commonplace.

While "housing first" programs cannot, by themselves, end homelessness – they can only house a small fraction of those who are homeless – they represent a new approach to thinking about ending homelessness. More creative solutions will be needed to ease the burden on shelters and housing programs, and concurrently bring more stability to the lives of their patrons, which as currently designed and funded, cannot adequately serve those who so desperately need them.

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Biography of a Homeless Man

by Kyle Cyr

Every Thursday evening, members of BUSM's Outreach Van Project travel to East Boston to serve a homeless and low-income population through a food and clothing distribution, as well as just to provide an ear for someone who needs to talk. I have the opportunity to go about once a month and in my time there, I have had many conversations concerning our clients' current activities or their past lives. Due to one man's openness and generosity, I have been able to forge a deeper connection with him. For the sake of this article, we will call him Lou. Lou shares his story with the hope that someone might be able to learn something from it, or that it could help someone in some way. In this article, we reflect on his childhood and what it was like for him to grow up, in a way looking at what led to his adult self becoming homeless.

Lou is originally from Boston. He was born in the late 1950s at Boston City Hospital, now Boston Medical Center, and was then raised in Roxbury Crossing.

Lou's home was attached to a traditionally African-American church. His father completed much of the church's maintenance, in addition to preparing for the worship services. As Lou aged, some of these responsibilities fell to him. He had a relatively normal home life; both of his parents worked, and he was able to attend good schools and camps.

Growing up, Lou was teased a great deal for many reasons; he was very tall for his age, had very big feet, had a dark spot on his skin, and was one of the few Caucasian people at his school and church. All of these things, among others, were sources of derision, sometimes verbal, sometimes physical.

About the time of the first grade, Lou had a life-altering experience. While he was playing outside with a little girl friend of his, an older boy rode up on a bicycle and told the girl to get on and come with him. Lou immediately knew something was wrong and tearfully begged the boy to let him take her place. The boy consented. He took Lou away and sexually molested him. Adults eventually found him and questioned him about what happened. Lou, overwhelmed by the gathering of adults asking questions and scared that he might be in trouble, denied that the boy touched him. He refused to tell anyone about the incident for over 30 years. From then on, he was never able to trust anyone, especially adults. He felt like no one could understand him.

Lou had been a normal child prior to that experience, but afterward, his personality changed. He started hating himself, not always sure why. Crying, Lou would yell at himself in the mirror, "I hate you! I hate you! I hate you!" He began having problems sleeping and in school. His family started treating him differently. They tried to help, although they did not know how. They sent him to a psychiatrist, but Lou never told her what happened to him.

Lou continued to have difficulties as he grew older. He had started scratching himself with paper clips at around age 4 or 5, continuing with sewing needles, and by the time he was 30, he was using razor blades. He now knows this to be a sign of having been molested or hurt. He was never trying to kill himself; rather, cutting was something that he could control. It was a way of coping.

Lou had his first beer when he was about 4 years old. He liked it. He started sneaking beers. Soon,

he found friends that drank, which made the habit worse. By the age of 15 he was going to bars. He enjoyed the social aspect of drinking, but he also became sucked into the violence.

Lou was in and out of schools for a few years and sometimes was abused by the teachers. With his drinking, he became involved with even more destructive habits and started stealing coins and cigarettes from his father. He was eventually kicked out of his house and sent to a boarding academy in New Hampshire. A judge eventually evicted him from of the state of New Hampshire.

Among the rough times that Lou talks about concerning his childhood, there is one moment in particular upon which he reflects with great joy and happiness. As a child, Lou had the privilege of meeting Dr. Martin Luther King, Jr. At the time, Lou did not know much about who this man was, or much about differences in race and skin color, other than getting called "Cracker" or "Whitey" by some of the kids in the neighborhood and at school. Dr. King occasionally came to town, preaching at the church next to Lou's home. In one particular instance, Dr. King came to Lou's room to comfort him on the recent loss of his pet fish. He could tell something deeper was wrong. As Lou tells the story, Dr. King gently prodded, "People pick on you, huh? What do they pick on you for?" Lou mentioned a few things: hair color, eye color, being tall, being skinny, his ears, the patch of dark skin, and many others. Dr. King said, "Wow they pick on you for that, huh? That brown spot? Well you see how that brown spot is similar to the color of my skin?" Lou looked at him and he extended his arm, which Lou touched and held. Dr. King said, "Imagine they pick on you for that, for that small spot, and how that hurts you. There are hundreds of thousands of people that don't like me for the color of my skin, and I'm completely covered in that color." Lou leaned into Dr. King's chest and started crying. This was the first time that Lou felt that someone understood him, that he wasn't alone. Lou says he still searches for that bond today, that humanness, that contact; that bond is what every human being needs.

Some of the Outreach Van clients on a rainy night

How to Support the Outreach Van Project

Ways that You Can Help Support OVP:

1. Send a tax-deductible donation for any amount to the address below (check payable to Outreach Van Project)
2. Volunteer to work with OVP (see below)
3. Share your skills as a physician, nurse, dentist, or health care worker, in treating the underserved.
4. Organize a food or clothing drive in your community. For donations of food and clothing, please email outreach@bu.edu for more details.
5. Send the necessary documents to the address below if your company has a matching gift program.
6. Tell others about our work.
7. Shop iGive.com and support the Outreach Van Project. It's free, private, & easy. Shop the Mall at iGive.com. You'll see familiar stores like Best Buy, Lands' End, JCPenney, Neiman Marcus, Expedia, Barnes & Noble, Sephora, and eBay to mention just a few. Up to 26% of each purchase gets donated to OVP. Plus, if you shop within 45 days of joining, OVP will get an extra $5 donation, free. To start, visit: http://www.iGive.com/html/refer.cfm?memberid=352000&causeid=32338

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Volunteering on the Van

If you are a BUMC student and are interested in volunteering on the van, you are invited to join the Outreach Van Project elective. The elective is already underway for the 2011-12 academic year, but you are welcome to join in the fall of 2012. To find out more contact outreach@bu.edu.

We need volunteers to go out on the van during school holidays (winter break, spring break, and the summer). If you are interested in volunteering during these times, email outreach@bu.edu.