I first worked with homeless people when I was a psychiatric resident and spent a couples months of elective time in Skid Row in Los Angeles. Skid Row is an amazing city dump for people. There are boxes lined up with people living in them, drug deals behind the police station, people yelling at their voices on the corner, and an average of two dead bodies per night. I split my time there between the county clinic there LA Men's Place, a drop-in center for homeless mentally ill men, both award winning programs. They were separated by a couple blocks. I was warned to be careful walking between them because a psychologist had gotten stabbed by a total stranger on that street the week before. For a white boy from the suburbs it was all pretty exciting.

I made my reputation in Skid Row one afternoon when an old man came into the clinic asking for help for his wife who was very paranoid and too terrified to leave their dilapidated SRO hotel room. He told us that she wanted help. She'd even be willing to take the shots she used to take, but she was too fearful to leave their room and come into the clinic. He begged us to help his wife. I asked him if he thought she would take the shot if I brought it to their room. He said he thought she would, so I grabbed the needle, a couple of alcohol swabs, the medicine vial, and a Band-Aid and stuffed them in my pocket. The case worker and I followed him down the street to his hotel. I'd actually been to that hotel before. Our social work students ran a bingo game in the lobby there to reach out to people who needed help, but wouldn't come into the clinic. Usually there were more psychotic people in that lobby than in the ER at the psychiatric hospital. But, I'd never been beyond the gates or ridden the ancient elevator before. When we got out at his floor the street hardened case manager gagged and almost passed out because of the stench from the rotting carpet that lined the hallway, but he staggered on. Fortunately, I have almost no sense of smell, a valuable trait for a homeless worker. When we entered their room, there she was, as advertised, lying petrified on the rusting metal bed. She didn't even have a blanket. The room was almost bare under the glare of the naked light bulb above her. She did agree to let me give her a shot there in her bed, and two weeks later when it was time for the next one, she was well enough to come into the clinic to get it. The story spread like wild fire.

After a while, I thought I figured out why all these people were on Skid Row. It was because none of them would follow any advice. I reasoned that if anywhere along the way as they descended into Skid Row, they'd followed even the slightest amount of good advice people tried to give them, they would've avoided ending up there. My supervisor more or less agreed. He said they were all unreachable.

Over the years, I've always worked at least one morning a week with homeless people, and over time I've gotten much better at it. Now I can reach out to people and connect with them. I can give advice that's worth following, and with startling regularity they do follow it and get off the streets.

As our Homeless Assistance Program became more successful, we became one of the leaders of the statewide AB2034 homeless and jail diversion programs, cited in the President's Commission Report on Mental Health, that are using an integrated service approach to help thousands of people. This paper was part of our training program for the staff of those programs.

Forming Treatment Relationships: Reach Out and Touch Someone

(2001)

I was taught in medical school that the foundation of a good treatment is a good diagnosis. I no longer agree. I now think that the foundation of good treatment is a good relationship. If I have a perfect diagnosis, but no relationship, the treatment will go nowhere. If, on the other hand, I have the wrong diagnosis, but a good relationship, I'll eventually figure it out. The person may even help me correct my diagnosis after a while, if they trust me, by telling me about the speed they shoot up, the boyfriend who's beating them, or the demons that are torturing them.

Almost every psychotherapy book begins by saying you need a treatment relationship. Then they go on to explain the details of their brand of psychotherapy, assuming we already know how to form a treatment relationship. Maybe we shouldn't go on so fast. After all, it's estimated that half of everyone with severe mental illnesses don't get any treatment and another quarter participates so irregularly it can hardly be called treatment.

Most of the people seen at the Village, whether "high utilizers" or homeless or jail diversion, have failed to form good treatment relationships in the past, often despite lots of contact with the mental health system. We have to focus on how to connect with them. I commonly use six approaches:

1) I give them something practical. Most people come asking for help, not treatment. If I maintain a good working knowledge of available resources, and the right forms, I can be very helpful. I can help with bus passes, GR work-crew excuses, SSI applications, disabled student forms, jury excuses. I can help them get a bag lunch, a shower, donated clothes, a locker, use of our washing machine. I also know where to find shelters, food banks, free medical care, sliding scale psychotherapy, sober living programs, Project Return groups, Board and Care homes, the Department of Vocational Rehabilitation and In Home Supportive Services. If I lead with these things, instead of diagnosis, they might decide I'm actually interested in helping them. I "meet them where they're at".

2) I give them pills. Some people actually want psychiatric medications. Some people actually want meds that aren't addictive, abuseable or sellable. The mental health system is set up such that you normally have to go through multiple assessments and waits to get medication. I try to use medication as an engagement tool. As long as I avoid Clozaril, Lithium, stimulants, and usually benzdiazapines, I'm not likely to do any harm. I'll probably give them what they think will be helpful, while I'm getting to know them. It might help and in any event I'm building the idea that I'm a person who will work with them with medications, listen to their ideas, and try to help. I'm building a relationship. After a while, they might even listen to my ideas.

3) I listen to their story. Not the story of their illnesses, the story of their lives. Most of us love telling our stories to an attentive audience. Yet most people hate going to a clinic or a hospital because "they'll just make me tell my whole story again." Our normal style of clinical interrogation makes an inherently enjoyable activity torture. I take time and listen to what they want to talk about.

4) I talk about street drugs. I'll ask how they use drugs ("Do you like shooting up the speed first and then the heroin so you don't get too irritable off the speed high, or the heroin first and then the speed so you don't nod off and waste the high, or just slam them both together and hope it works out?") I'll ask how drugs effect them (Are you a heavy weight or a lightweight? How many beers does it take to get you drunk?) This conversation is good for beginning a harm reduction or motivational interviewing approach (or more rarely for getting someone into active treatment.) However, I'm more concerned with impressing them with how much I know about drugs and how non-judgmental and pragmatic (while still clearly pro-sobriety) I am. I want them to think that I'm someone who can help them. I'm someone worth being honest with.

5) I try to connect emotionally. Most of the people we work with carry lots of emotional pain. Many of them have been abused or traumatized. Many have done things they're ashamed of. Many have suffered serious losses. I try to get them to share these things with me. If they say, "I haven't shared this stuff with anyone in such a long time", or cry while telling me their story, or if I can really feel their pain myself, I know we've connected. This is probably therapeutic, to share pain with someone caring, but at this point my focus is that it's relationship building. If I'm someone who can understand their feelings, maybe I'll be able to help.

6) I try to connect morally/spiritually. Most of the people we work with feel they've done bad things or have "lost their way." I'll tell people to spend a moment to quietly look into their heart (or pray) to find out what they need to be doing. Go beyond the automatic answers to find the deeper wisdom within them. "Are you really honoring your dead war buddies, but getting drunk every night?" "What would your old grandmother have told you if she were here now?" Out of the quiet invariably comes good "moral" advice. "I can give you pills trying to help with your sleep or nerves or anger or depression, but it's like putting on a Band-Aid. You know what you need to be doing to really heal these wounds." They're not used to the level of respect and valuing that comes from a truly moral/spiritual connection. They'll believe I'm someone who may be able to help deep down.

When I begin working with someone my main goal is to form a treatment relationship. It's nice if I can be helpful as well. But if after 6 months or even a year all I've done is form a good relationship, I'm not too disappointed. At least, now I have a chance to help.