

Episode: *Ethics Talk: Street Health Care as Harm Reduction*

Guest: Jim Withers, MD and Dave Lettrich

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[mellow theme music]

[00:00:05] TIM HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. Harm reduction for people who use drugs has an image problem. Providing drug use supplies to people as a means of mitigating harmful health consequences of drug use sounds, to some, clinically and ethically counterintuitive. But the benefits of harm reduction strategies are clear and numerous. As a health care intervention, common strategies like syringe services and naloxone distribution programs help prevent infectious disease transmission and enable faster responses to potential overdoses. But regardless of whether these strategies mitigate harm, drug use is still deeply stigmatized as a characterological shortcoming that some view should not be within the purview of clinical concern. Dr Jim Withers describes the reaction he received upon bringing people who use drugs and who are experiencing homelessness into clinical spaces.

DR JIM WITHERS: And one of the staff who knew me just looked at me with disgust and said, "You're bringing them here?!"

HOFF: Health care professionals, so the thinking goes for some, should not be in the business of making drug use easier, regardless of harms mitigated, or regardless of how one's drug use is influenced by structural drivers of ill health, such as a lack of stable housing. Stigma is still so powerful that some people who use drugs who experience homelessness even avoid seeking needed care. Dr Withers again explains.

WITHERS: I remember early on desperately wanting people to go to health care and kind of being shocked at how they'd rather die than go to the hospital, the emergency room in particular. And for me, it became a desperate search for how to get someone to the ER for care that I couldn't do under a bridge.

[00:02:11] HOFF: In these cases, harm reduction strategies need to be implemented by clinicians who care for people in communities and on the streets, not in clinical settings. Street medicine can be a critical part of delivering harm reduction interventions to people who use drugs who are experiencing homelessness, and meeting people where they are and listening when they tell you what they need to be safe can help save lives.

DAVE LETTRICH: In the big picture, for us, harm reduction supplies are everything. A tent is harm reduction. Sleeping bag is harm reduction.

HOFF: That was Dave Lettrich, the founder and executive director of Bridge to the Mountains and the Bridge Outreach program. He joins us, along with Dr Jim Withers, medical director at Pittsburgh Mercy's Operation Safety Net and the medical director and founder of the Street Medicine Institute, to discuss how street medicine and street outreach programs help mitigate harms of drug use among people experiencing homelessness. Dr Withers, Dave, thank you so much for being on the podcast. [music fades out]

LETTRICH: Thank you.

WITHERS: Thank you.

[00:03:12] HOFF: Listeners might recall our November 2021 issue on health care for people who are experiencing homelessness, which features some discussion and an article by Dr Withers about street medicine. But for those unfamiliar with the concept, can you please reintroduce us to its key practice features?

WITHERS: Certainly. So, street medicine is a term that emerged in the early 2000s to recognize the delivery of medical care, health services, directly to the unsheltered homeless populations of communities around the United States, and in fact, globally, where health care workers walk under bridges, along the riverbanks, abandoned buildings, alleyways, and provide health care in those contexts. It's a subset of Health Care for the Homeless, but it requires that you actually go into the encampments and the places where people are living.

[00:04:17] HOFF: So who's actually doing this kind of street outreach? Is it mostly people affiliated with quote-unquote "official" street medicine programs, or do individual clinicians just identify a problem and take it upon themselves to go out to deliver care to people experiencing homelessness?

WITHERS: It's a changing landscape. When I started in 1992, there were very few health care workers going under bridges and on the streets. A notable exception is Jim O'Connell in Boston, Dr Greer in Miami, and a number of nurses Chicago, Toronto, and places. But for the most part, even Health Care for the Homeless was not going out to reach people, rather waiting for them to come to soup kitchens or shelter-based clinics or primary health centers. And I think that the reality gap between those two practice environments was really not appreciated. What happened, I think, over time is that academic physicians and practitioners began to embrace the idea of going into the streets, in what I would call the classroom of the streets, offering a radically different learning environment. That was certainly my impetus in 1992. And so, most of the clinicians I knew in the '90s were family medicine or internal medicine in academic medical centers that were combining it with medical education. Over time, federally qualified health centers, other organizations, community-based organizations, began adding street medicine to their existing work. And more recently, there's been a tremendous surge of health science students initiating street medicine programs at medical schools and such.

[00:06:23] HOFF: That's interesting, because much of this month's issue focuses on harm reduction efforts in clinic-based settings. But harm reduction strategies also need to be extended to settings, obviously, that are not clinic based. So how do harm reduction practices play out in street medicine?

WITHERS: I'm going to just say a couple words and then let Dave take it. I think the operative principle, and this is a transcendent principle for street medicine, is that you prepare a space and time to let people explain the reality that they're living in, and with respect to substance use, how that dictates their daily activities, their survival strategies. Many times we underestimate the degree to which substances are part of their self-medication. Withdrawal symptoms dictate the paths and the priorities that they make. And I think if you allow someone to tell you that in a non-judgmental way, in a way of curiosity, support, you'll get the kind of beginning of a relationship that you need to be effective and then ask them, "How do you meet those needs? What supports in the community do you know of?"

[00:07:44] HOFF: Dave?

LETTRICH: From my perspective, street medicine is harm reduction. Within the individuals that I serve and that I work with that we're engaged with on a regular basis and entering into relationships with and seeing regularly, street medicine, for us, is a harm reductive approach to be able to provide necessary care without having to introduce trauma to the individuals that we're serving by going to a hospital or by going to a clinical setting, right? So street medicine provides the ability to provide a level of medical care relative to substance use, most commonly IV substance use, in a place, in a space that is comfortable for those who need it. And the direct application of street medicine as it relates to harm reduction in the street, I think that's something that has evolved over time. Where we are right now in our substance environment, being one that is transitioning from a fentanyl based opioid IV drug market to a fentanyl based opioid drug market with xylazine cut into it has reshaped our harm reduction practices and our street medicine harm reduction practices just over the course of the past year and a half in our community. I know in other communities it's been longer. So not only is it wound care that can occur in the street, but it's also engaging in conversations about the ways to use safely to minimize the need for wound care and for antibiotics and additional medical needs associated with IV drug use that otherwise could end up in a clinic or in a hospital.

[00:10:04] And in that same conversation, hep C, for us, has been a major harm reduction drive. There was a tendency not very long at all ago for providers, medical providers, to want to defer hep C treatment until such time as somebody was no longer using IV drugs. And the belief was that if somebody's using IV drugs, it's no use treating them for hep C because the likelihood of reinfection is actually very high. I understood that. I was in a place where I was working with a large population of individuals who were hep C positive, and sometimes hep C positive for a very long time. So, even though they were only in their late 20s and early 30s, they had been hep C positive since they were in their late teens and starting to experience liver challenges associated with that. And so, a big drive for us over the past several years was finding ways to

bring hep C treatment to the street, getting as many people treated as we could. And it took a couple years, but we're now in a place where hep C is no longer an epidemic. We went from 90 percent to nearly zero and almost zero reinfection rate.

[00:11:42] HOFF: Wow. That's amazing. Jim, anything to add here?

WITHERS: The tagline of the Street Medicine Institute, which is now a practice on every continent, the tagline is "Go to the people." And I think that kind of says it all. The accompaniment and teachings that Paul Farmer had in terms of tuberculosis and AIDS are very applicable to the street medicine philosophy where we don't wait till someone is ready necessarily on our terms, but we go to them. And sometimes we affectionately call it "chase management."

HOFF: [chuckles]

WITHERS: But it really works.

[00:12:25] HOFF: So let's go to the other side of this equation. For clinicians who are clinic based, what should they know about harm reduction interventions for unhoused patients who do seek health care services in their clinics?

WITHERS: Well, I worked in the hospital and clinic before becoming a street doctor, so I experienced many interactions that went awry. At the beginning of my focus on the street was a patient who had alcohol use long term and insisted on leaving the hospital in the winter, and I learned that he froze to death. And I thought my communication skills were pretty good at that point, and so that inability to connect was what finally prompted me to begin sneaking out at night to do visits on the street. But I do think that it's important for a clinician to understand that when the person comes, it's often the climax of a very long story of overcoming barriers, of fear, of reluctance to face the trauma that Dave described. We don't see it as trauma, but when people come into our settings, they're carrying a lot of things that trauma-informed care requires us to be aware of. And so, you probably have a much shorter fuse than you expect when you see someone coming into your health center. It's well worth the investment to give that person a sense of respect and space to be themselves, and then they will begin to open up. And it's just a great investment because if you begin to shuffle people through your priorities before they're ready for that, most of the times, the patient will leave or not connect, and then they'll pass away.

[00:14:32] The mortality rate of people experiencing homelessness from the Boston study is three times the population, but people living on the street, the mortality rate is ten times that of the normal population, the rest of the population. And so, it's almost like considering it an intensive care unit out there. I think the reason that we don't invest in the streets the way we do in intensive care units reflects the value we place on people who live out there. Some of that is internalized attitudes towards people who have the struggles, but I find a lot of it actually comes back to "you're not doing it my way." And so, there's a power dynamic that we cling to, and it subverts effectiveness. It

subverts good clinical outcomes, which really is something that we should be constantly pushing ourselves to improve and adapt to make those things improved.

[00:15:39] HOFF: Hmm. A few times you've made the distinction between somebody being homeless and somebody living on the street, and that might not be a distinction that's immediately clear to our audience. Can you just briefly clarify that?

WITHERS: Yeah. I mean, you have to spend some time on the street, I think, to really understand it. When you get out there, as I did in the early '90s, you realize the whole Escher inverts on you, and you realize you're looking into the system from the street level. You've gotten to know the people there. You've become fond of them. You see their foibles. And many times you begin to admire the strength of their survival strategies. And so, there's a different state of mind for the people that've been kind of ruled out, if you will, of the various resources. And they often go into a survival mentality. I saw the similar kind of mindset when I worked with domestic violence victims, long-term domestic violence victims, who are really in a state of just survival. And so, oftentimes, working with those two populations kind of was a cross-reference for me. Most people experiencing homelessness, 80 percent get off the street within a month or two. And they, but about 10 percent, is the work of Dennis Culhane, are longer term, much longer term. So, again, it's worth the curiosity to try to understand that segment and the dynamics that they're working with.

[00:17:22] HOFF: You mentioned sneaking out at night. Was that just a turn of phrase, or was your, you know, the institution you were working for really not supportive of this when you first started or what? What's the story there?

WITHERS: Well, I adopted the "it's better to apologize later" attitude.

HOFF: [chuckles]

WITHERS: I do think that it's important that we recognize that extending yourselves into uncooperative, if you will, populations is countercultural within our medical education and health care system. I think we can agree that that is true. I am in a health system that has always been supportive. The Sisters of Mercy had a mission that I was able to utilize [laughs] to keep my job. But at first, I really thought this was going pretty far outside of what a teaching attending would normally do. And in a way, I didn't want to bring students and a big plan into the streets and impose that on people. And I went out with a guy who used to be homeless and tagged along and didn't tell my malpractice carrier, didn't tell the hospital until I had spent some time just being Jim and getting to know people and understand. And then what really pushed me to bring it into the level of a program was when I saw the people that were dying, freezing to death, untreated wounds, levels of despair and disconnection, and it was impossible for me not to become an advocate at that point.

[00:19:15] HOFF: Both of you at various points have touched on the past trauma or distrust of clinicians in the health care system broadly as reasons that people who are homeless don't seek the health services that they might need. And some of the sources

of harm from drug use for unhoused adolescents especially come from sources of discrimination and stigma against people who are LGBTQ or racially minoritized. So how do clinicians respond to these broader sort of cultural-based, if I can use that phrase, problems?

LETTRICH: I think trauma is such an important conversation to have. And I will preface this by saying my perspective is shaped by those individuals who I have encountered who are homeless and living outside. So, this may not necessarily be the case with someone who has lost their place to live and is couch surfing with friends or whatever, and then resolves. But over the years, I've come to learn that the misconceptions of our society as to what leads to homelessness is somebody lost their job. You know, a big one is people become homeless because of their substance use, all these other things. My experience as I get to know more and more individuals is that overwhelmingly, those don't tend to be the root causes that led to someone's homelessness. Overwhelmingly, that root cause is found in trauma, and in most cases, compounding trauma. And so, the only safe assumption that you can make going into the street before you engage with someone is, this person has probably experienced some substantial traumas in their life, and the experience of homelessness is probably a clear and present trauma for this individual. So, as time goes on, that individual ends up finding a substance because it is the only way that they're able to continue to exist because of the weight of this trauma.

[00:21:52] LETTRICH: That individual goes to an emergency room probably multiple times, goes to a clinic probably multiple times because of the ill effects of living in the environment and using substances in need. And overwhelmingly, that's going to be a traumatic experience, especially if it's an emergency room. So, from a clinician standpoint, anticipate that this individual is going to have institutional trauma associated with health care facilities and that those health care facilities need not necessarily be an emergency room in a Level I trauma center. Those health care facilities can be a family practice clinic, right? And it's so important to know that because when it comes to street medicine professionals moving into the street, one of the first things that I suggest is make sure you leave your lab coat in the car, right? And when I'm saying that, I'm not saying your actual lab coat. Leave your clinic in the car. Leave your mindset in the car. If you walk into somebody's, a place where somebody feels safe, and you walk up to that with the mentality of a clinician, the way that you present yourself, the way that you respond to that individual, the way you begin to approach that individual from a clinical perspective can very easily trigger a traumatic response, because that's going to bring back memories of that traumatic medical experience.

[00:23:33] HOFF: Briefly, before we continue the interview, I wanted to offer a content warning for two upcoming stories that Jim and Dave share. These stories contain depictions of suicide. If you're not interested in listening to those, please skip ahead to about 29 minutes.

WITHERS: In reference to the some of the groups that you were talking about and their trauma, there was a Boston study years ago that showed virtually 100 percent of the women had been abused in some form. Rape is very, very common. Some studies

show 40 percent of the homeless youth are from the LGBT community. So, there's these unrecognized antecedents. As far as not sometimes understanding the depth of someone's trauma, I've got an example of a patient from the '90s. His name was George, and George was a Vietnam vet. He had depression, he had an alcohol use that was pretty heavy, and had suffered the effects of racism and had some thoughts and feelings about that. So I was getting to know him down by the riverbank, and I thought I'd checked all my boxes, and I had George figured out, was gaining his trust. And then one night he took me aside, and he said, "Doc, I just want to tell you something. When I was a kid, our mother took us into the living room, and she put a gun in her mouth, and she blew her head off. And we didn't know what to do, so we put her in a bed, and we tried to make her look okay until a grownup came." And I was stunned, and I recognized the depth at which George was letting me into his life. And then we start talking about something else. But I think these layers and layers cannot, you cannot underestimate that.

[00:25:50] LETTRICH: The very similar story, one of the greatest lessons that I learned early on, back in 2019, when we were in the beginnings of an initiative to bring low-barrier Suboxone to the street, one of the very first individuals that we encountered that said he wanted to get over onto Suboxone, the clinician that was working with me at the time, we worked really hard and jumped through some pretty crazy hoops to be able to create a situation for him to be able to easily and be supported. And we did all of that, and we actually moved him into our medical respite to be able to get induced. And he was induced, and he was doing great. He was on 16mg of Suboxone a day.

And a week later, suddenly things started going south, and he called me crying. And he's like, "I can't do this." I'm like, "Yes, you can. You got through the hard part of it. You got, you're induced. Now it's going to take a little." And he said, "No, you don't understand. I just realized I'm coming up on the two-year anniversary of when my teenage son blew his head off with a large caliber handgun." And I think that was the fundamental moment when my understanding of trauma and substances changed forever. Because I recognized that that—and substances are different; in this case we're talking about an opioid—that opioid had numbed the pain of that experience for such a long time, allowed him to exist within that horrific pain and trauma. And by not recognizing that that trauma was there in his past—in his past, but still immensely present—by not recognizing that while he's still using opioids, he is emotionally safe to be able to start unpacking that trauma and healing from it. That is the first step before we look to pull the opioid away. It literally flipped everything upside down for me because prior to that, the whole idea was you have someone with a traumatic history and a traumatic past, that's in the past, right? You need to take the substance away, and then after a long enough period of time, when it's safe, then you can start digging up the past. I just don't see that. Something that occurred years ago can still be in the very present moment for someone who is a long-term opioid user or a long-term benzo user, for that matter. So yeah, trauma is such an integral part of every single thing that we do.

[00:28:53] HOFF: Wow. Yeah. Thank you both very much for sharing those stories. They highlight, I think, in part, among other things, the importance of interdisciplinary

efforts. Can you speak a little bit more to which health professionals, besides physicians, are needed to care for people experiencing homelessness?

LETTRICH: Street-based psychotherapy. Greatest scarcity that exists. Not even street-based, but just accessible psychotherapy. And I'm sure that it's different in different areas of the country depending on what your state laws are and insurances and everything else. In our state, one of the greatest challenges that we have is it's very hard for a new therapist to be able to start taking Medicaid insurance. You can take all the private insurances, but they control it. It's a very tight window. We have an immense need not for substance-related therapy but for trauma-related therapy, for true psychotherapy, and we just don't have those resources available to us.

WITHERS: So, the Street Medicine Institute is something that I and some of the others who were engaged early on in the annual Street Medicine Symposium pulled together to be the home of this new field of medicine. And through it, we are trying to develop the field of street medicine, assist communities that are interested in starting street medicine programs, encourage standards of care and medical education among a number of things. But one of the arenas that we are working on is the field of street psychiatry and street psychology. And there are few street medicine practitioners in those fields, but it's growing, and we're trying to encourage that as well.

[00:31:02] HOFF: Hmm, yeah. If you recall, obviously, the issue that you worked on back in November 2021, the episode of the podcast that aired with that issue was about this exact thing. *Street Psychiatry for People Experiencing Homelessness* was the title, for interested listeners. And I talked with Dr Sheryl Fleisch. I don't know if either of you are familiar with.

WITHERS: I'm very.

HOFF: Sorry?

WITHERS: She was my first psychiatry resident that worked with me here in Pittsburgh.

HOFF: Oh, is that right? What a small world. But yeah, she, in that episode, stressed many of the same points that both of you are making here, which unfortunately seem to be as relevant now as they were then.

But I wanted to turn to the future to wrap up here and ask about expanding the reach and scope of the work that community-based organizations do, groups like Bridge Outreach, which are well situated to respond to the needs of people who are homeless, specifically because they are community oriented and community based, and they spend a lot of time doing that relationship building that's so important to building trust between health care professionals and people experiencing homelessness. But the additional resources that come with federal support might help carry out the mission of these organizations more effectively, although they might introduce some barriers, as you both have already mentioned briefly. So, to get to the question, which support roles should federal government agencies play to contribute to these kinds of community-based harm reduction programs?



LETTRICH: We've seen such a positive evolution and acceptance of harm reduction just in the past few years nationally and in our communities. One thing that still exists, though, when it comes to federal funding, there is still no direct funding source that can fund the purchase of harm reduction supplies. [00:32:55] All of the federal funding streams that are out there right now will not allow federal funds to be used for what they deem as drug paraphernalia. So, as effective and as robust as our health departments have become, and our community-based organizations like Prevention Point have become, we are still always at risk of catastrophic loss of funding streams to be able to supply the paraphernalia, as it's deemed by the federal government. So a big change there from the fed aspect would be huge. And more than anything else, just that terminology in itself is discriminatory, as far as I'm concerned. So, drive down barriers and provide access to funding for the necessary supplies to be able to support harm reduction across the country and do something about the federal laws to make it legal, regardless of what state you're in, to possess those supplies. And take a good hard look at the regulations that we have in place around administering the methadone and consider what it might look like to give greater access to addiction medicine professionals to have regular access and the ability to oversee methadone without having to bring a clinic into the picture.

[00:34:36] HOFF: Jim, anything to add?

WITHERS: No. I think in general, options for recovery, harm reduction at the level at which folks on the street can actually engage them is an area that we have to look at more. [theme music returns] There's just this gap. It looks like not much, but it could be an ocean from the encampment to recovery. And we have to begin investing in looking at how to cross that gap for people.

[00:35:08] HOFF: Dr Withers, Dave, thank you so much for your time on the podcast, and thanks for the work that you both continue to do.

WITHERS: Same.

LETTRICH: Yeah, thanks. It's great discussion. Thanks for inviting us.

WITHERS: And highlighting it, yeah.

HOFF: That's all for this month's episode. Thanks to Dr Jim Withers and Dave Lettrich for joining us. Music was by the Blue Dot Sessions. To read the full issue on [Harm Reduction and Opioid Use Disorder](#) interventions for free, head to our site, [journalofethics.org](http://journalofethics.org). Find us on X [@journalofethics](#) for all of our latest news and updates, and we'll be back next month with an episode on Medical Legal Partnerships. Talk to you then.