No Angels Here
The Closing of the Pine Street Inn Nurses Clinic, 1972–2003

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The Pine Street Inn: An Abbreviated History

The Pine Street Inn (PSI) is a private nonprofit facility founded in 1969 by Paul Sullivan, who was himself a recovering alcoholic. The Inn was originally located on Pine Street in Boston's South End; the Inn served about two hundred homeless male alcoholics. Sullivan's mission was to provide a place for these men – called "guests" – to keep their bodies and souls together until they wanted and were able to do this for themselves (Ferguson 1989; Lenehan et al. 1985).

Nurses came to Pine Street at the urging of Paul Sullivan. Sullivan had observed that many of the guests suffered from untreated wounds, lacerations related to falling and fighting while they were intoxicated (Martin-Ashley 2002). The guests would end up in the Boston City Hospital (BCH) emergency room, only to be turned away or poorly treated by the hospital staff. Paul Sullivan realized that the men who used the shelter also needed health care that was accessible and health care providers who were compassionate (Ferguson 1989; Lenehan et al. 1985). As part of his advocacy for the homeless, Sullivan would visit the BCH emergency department, bringing donuts and fried chicken to entice the nurses to come to the Inn and provide nursing care (B. McInnis, personal communication). The common sentiment expressed by those nurses who visited PSI in the late 1960s was that the guests had an overwhelming need for continuity of health care. The guests were often treated in the emergency room and given prescriptions – which they couldn't pay for and had no place to store, and neither did they have access to clean water to take their medications or to wash and care for their wounds. Many of the guests suffered from pneumonia, tuberculosis, seizures, and mental illness.

In 1972 the men's clinic was opened for a month-long trial run. Nursing duties included: caring for wounds, removing sutures, assisting clients in obtaining, holding onto, and taking medications, and monitoring chronic health problems, such as diabetes and hypertension (Lenehan et al. 1985). Emergency response was also a vital service of the nursing clinic whose staff responded to guests who were unconscious, suffering from chest pain, or experiencing gastrointestinal bleeding.

Amazingly, women were not allowed to access shelter beds or other PSI services. Some women would disguise themselves as men to access PSI services (J. Gold, personal communication, August 2003). Sometimes women would show up to be seen by the nurses, but they could not store their medications or receive the same level of support as the men. As the Inn expanded its services, women were seen in the men's clinic until 1987, when the women's clinic was opened in the Women's Inn at 363 Albany Street (Martin-Ashley 2002).

The Women's Clinic

> I was thinking about the wonderful women's clinic . . . and I do want to offer that my philosophy when I was there was that the clinic be a place of refuge, a safe haven where women can come and be safe and loved for at least a few minutes out of their otherwise often chaotic day.

Homeless women face a host of challenges that impact their lives, including substance abuse, physical and mental illness, and sexual and physical violence. At a time in their lives when these women most need support, they find themselves isolated. The stigma of homelessness is often greater for women than for men, especially if they have children, as their homelessness is seen as the ultimate abandonment of their families and of their roles as women. Homeless women's lack of trust was much in evidence when the Women's Inn first opened. Staff relate the difficulties they experienced in getting the women to stay overnight. The women would come into the Inn during the day, stay for lunch and dinner, but when it was time for bed, they would leave (S. J. Hanson, personal communication, May 2003). The nursing staff was very sensitive to the needs of the female shelter guests, including that

of earning their trust. The first nurse manager was adamant that the clinic be a shelter within the shelter.

I remember when visitors would come in and say, 'ooh, isn't this lovely.' I would try gently to remind them that the worst stigma the women would tell us was being homeless. . . . no matter how pretty the mauve walls are . . . women were told when to go, when to come, when to shower, when to eat. . . . I didn't want an illusion to be created about pretty homelessness. It sucked, no matter how mauve the walls were.

One difficulty in working in a shelter-based clinic is that, as nice as the facility may look, the women visiting it are still homeless. Part of the nursing advocacy involves reminding shelter visitors, donors, and politicians that homeless women don't need a "nicer" shelter, but homes. This means nurses must advocate for low-cost, transitional, and supportive housing, as well as increased access to affordable health care.

As nurses in the women's clinic, we provided the same services as the nurses in the men's clinic. We assisted the women in obtaining, taking, and storing medications, with making and managing appointments with their primary care providers, and with wound care and immunizations. Where nurses in the women's clinic differed from those in the men's clinic was in the greater amounts of time we spent with the women: we served tea and cookies, listened to music and sang, and heard the stories of their children and grandchildren. We encouraged women to follow-up after sexual assaults, often sitting with them for hours in the emergency room at Boston Medical Center. The women who stayed in the shelter were of all ages and races and included siblings, grandmothers, aunts, and mothers and daughters. Guests also included pregnant women, elderly women, and disabled women.

. . . most memorable guest of current times is M. M could woo a watermelon and has the best sense of humor around, very dedicated to punning . . . stubborn and persistent, an asset when you are old and homeless, practically blind, almost deaf and use up to 10 'die-a-pers' a day.

The three major functions of the shelter nurses were home health care, public health, and addressing emergent health issues (Martin-Ashley 2002). Nurses assessed and treated chronic and acute common health problems, such as pregnancy, diabetes, hypertension, asthma, and pneumonia. Care at the clinic was free and was provided in a manner that allowed for a guest to have as much attention and time as she needed. Medical care and treatment were still viewed as an integral and complementary aspect of the individual's health care. Collaboration with doctors, psychiatric clinicians, and substance counselors was a critical component of nursing care plans (Martin-Ashley 2002; Lenehan et al. 1985). While maintaining a central role in the guest's health, nurses referred patients to other health care providers as needed.

This goal was contingent upon building therapeutic relationships with the female guests of the Women's Inn. Unlike with their male counterparts, creating therapeutic relationships with the women required a longer period of trust building. However, nurses used creativity, commitment, and patience to build relationships with women and gain their trust (Martin-Ashley 2002). As relationships grew over time, the level of intimacy shared between guest and nurse was amazing.

A harm reduction model was central to the work of the nurses in the women's clinic. Expecting someone to stop using heroin was not as realistic as providing that guest with a bleach kit and educating her on how to avoid abscesses and how to decrease her risk of contacting hepatitis and HIV.

Staff in the Women's Inn estimated that 90 percent or more of the women who access the services of the Inn suffered from mental illness, including schizophrenia, bipolar disorder, borderline personality disorder, and major depression. These women are often untreated or undertreated, because they face significant barriers to accessing mental health care services, including their own paranoia, personal disorganization secondary to homelessness, and mental illness, the lack of continuity of mental health care providers, the limited number of mental health visits, and the long wait for appointments. Nurses connected with these guests who otherwise might not have entered the health care system.

My Story: How I Ended Up Spending Three Years of My Life Working in a Homeless Shelter

In 1998, while I was a student at the MGH Institute of Health Professions, a classmate invited me to hear three nurses discuss their experiences working with the homeless. The most memorable of the three speakers was Barbara McInnis, a public health nurse who specialized in the prevention, detection, and treatment of tuberculosis in the homeless population of Boston and who maintained a presence at the Pine Street Inn Nurses Clinic until her unexpected death in the summer of 2003.

It is the mission of the nurses clinic to provide community healthcare to the women and men who seek the services of the Pine Street Inn. We are united in the belief that

the healing process begins with caring relationships based on respect and dignity. (PSI Nurses Clinics Mission Statement)

Barbara addressed those issues nurses face working in a shelter-based clinic: lack of access to primary care for the guests; the difficulty in getting local area hospitals to address discharge plans which incorporate the patient's lack of housing; even something as simple as prescribing medicines on a twice- or once-a-day dosing schedule, which is much easier for the PSI nurses to monitor and for the guests to take. The most intriguing comments she made concerned foot care; while her descriptions alternated between extremely clinical and gross (i.e., how to monitor for diabetic foot ulcers, wound care, gangrene), something about the way she described giving foot soaks to and doing foot care for homeless guys, who seemed like the bottom of the barrel, intrigued me.

This coincided with the lowest point in my nursing education. I was beaten down by how competitive my class was, by the apparent lack of desire to care for others, especially marginalized populations, by the enthusiasm to be technically proficient while having little or no regard for patient care. I left Barbara McInnis's lecture energized; I wanted to check out this Pine Street Inn. Slowly, however, I gave into the demands of graduate work, and my desire to go to PSI faded.

Fortunately, I had a seminar with a woman who was working part-time in the women's clinic at Pine. Around the time of graduation, my classmate informed me that the women's clinic was looking for per diem nurses; she gave me the name and number of the nurse manager, as she thought I might like working in the clinic.

The women's shelter is located in an industrialized section of Boston's South End. An elevated freeway runs so near to the windows of the third floor of the shelter that one day a car is just going to drive right on in. That first day, it was hot and humid; I was sticky with sweat, anxiety, and exhaust fumes. As cars whizzed by me, I started to wonder if I was making the right decision. The closer I got to the shelter, the more I began to worry that the people speeding by in their cars would think I was a shelter client – a thought which horrified me.

A small crowd of women and their male friends, partners, and acquaintances were hanging out in front of the entrance to the shelter, drinking and smoking and laughing. I went in and identified myself as a nurse and was directed back to the women's clinic. I met with the nurse manager, who showed me around, introducing me as a nurse she was thinking of hiring. She talked about the uniqueness of working at Pine and the importance of meeting the guests at whatever place they are, mentally and spiritually, as well as the need to reserve judgment. She discussed how important the spiritual nature of the work was for her. Listening to her talk, I wanted to have that feeling, too. I wanted my work to have meaning and to be fulfilling. I was also interested in working in a nurse-run clinic. By the end of the interview, as she walked me out into the lobby and up the stairs to the entrance of the Women's Inn, she introduced me to guests and staff as the nurse she had just hired to work in the women's clinic.

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This is just a big FUCK YOU to the nurses. . . . If you think we're here for the money you're crazy . . . any of us could leave this building and walk in either direction and get jobs making five times the money we make here . . . for any nurse who works here this is a labor of love.

Of my memories of that day in March, when the staff was informed the clinics would be closing June 30, 2003, and that we were all being laid off, some are strong and fresh and others are vague and blurry. I remember standing by a wall in the second-floor conference room flooded with emotions and crying and thinking, this is just unbelievable. As I write these words, I realize I'm still in shock. If you've ever had a job that you loved and which you knew, deep inside, was your calling, and someone snatched that away from you, the feeling of powerlessness is unbelievable. At the same time, I had an epiphany (as Oprah calls it, an Aha! moment): this must be what the women in the shelter feel like on a daily basis. I spin back and think of every woman I said "no" to, every time I told a woman, "no, you can't have anymore underwear," "no, you can't take another shower in the clinic," "no, you already got five chapsticks this month." Power is relative, and so is control.

Lessons Learned

. . . the nursing clinics have provided care using an innovative nursing, rather than medical, model which promotes self care while attending to homeless men and women's acute and chronic health and emotional needs. While it may be difficult to explain a nursing model of care on paper, for anyone who has spent time visiting or as a guest of our clinics, it is easy to understand; We have sought and mostly succeeded for over 31 years to treat each guest as a person worthy of respect, to advocate for our guests with other agencies and hospitals, to encourage via outreach and education, the highest possible level of functioning and self determination that each individual may reach.

. . . The nursing staff was aware that Pine Street Inn management was in talks with the Boston Health Care for the Homeless program in the first half of 2001, long before the economic events which are being blamed for these cuts. Our director of clinics was not allowed to be present in these negotiations until it had already been determined that Healthcare for the Homeless was definitely taking over the clinics, and she could only try to advocate for us to be allowed to continue with our vital nursing services to the guests of the Inn as a partner with the other agency.

. . . since the layoffs . . . one member of our nursing staff has been told she is in danger of losing her severance package if she went to the media . . . our director of clinics is afraid to speak up about the situation as she cannot at this time lose her benefits . . . she would be "walked off the property" for speaking out. . . .

The nursing staff had decided, with limited support from the Inn's upper management, to hire a consultant to evaluate the number of patients seen and the possible amount of nursing care that was reimbursable. The clinics were found to generate about 120,000 reimbursable visits a year. Nursing management moved to increase the clinics' ability to generate income by hiring three nurse practitioners, of which I was one, to provide primary care to the guests of the Inn. The nursing staff was also moving toward a case management model, in which individual nurses would manage the care of five to six guests who were deemed at risk based on chronic illness, inability to follow-up/follow through with medical appointments, and age. As a group, we had multiple meetings within each clinic and, as a larger nursing staff, we decided how best to maintain the standard of care the nurses clinics had developed over a thirty-year period and still take into account the Inn's need to locate new funding streams because of the increasingly limited funding climate. Once it became clear that the clinics would be able to generate a substantial amount of money, nursing management found itself shut out of PSI management and board meetings, including those in which the clinics' futures were being discussed.

As a group we had worked to create institutionalized relationships with local area nursing schools—for example, providing clinical training and lecturing in community health and public health classes. We also worked with schools of social work and with public health and medical schools to share with their students our experiences and our expertise in working with the homeless and our best practices for providing services.

We had developed press packets and assigned specific nurses to serve as media point people to provide the nursing "spin" on issues of homelessness, public health care, access to care, housing, and mental health care. We had developed a training center, which would have been able to provide training to a number of institutions on how best to work with the homeless.

I believe that, as a group primarily of women, we served in silence, believing that our good deeds would be acknowledged and that we would be rewarded for being silent and doing our job. Boston Health Care for the Homeless Program (BHCHP), a male-dominated organization, saw an opportunity, and they took it.

It is still hard to comprehend the clinics' closure. I dream about guests and my nursing colleagues on a regular basis. I'm working now as a nurse case manager with individuals with HIV/AIDS, but not a day goes by that I don't wish I could return to Boston to work with the women at Pine Street Inn, but I know it will be a long time, if ever, before that might be a possibility, especially now that BHCHP has a monopoly on homeless health care in Boston.

I believe I will always grieve for the end of the nursing clinics. However, I now feel driven to create sustainable nursing clinics, and I am learning to be an advocate for nursing.

References

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