The Cinderella van: runaways, street youth and public health in 1970s Boston

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INTRODUCTION

It was a humid evening in August 1975, as the young streetworker Steve Disenhof drove the Bridge Over Troubled Waters (Bridge) Medical Van to its next stop in Harvard Square. Long-haired and lanky with a kind demeanour, Steve was the ideal guide to navigating Boston.¹ That night, he was at the wheel of the van, a dilapidated Winnebago camper, with a nurse, a paediatrician and a new doctor volunteer in tow. Leaving Kenmore Square, the volunteer commented to the group that he did not understand how runaway youth survived day-to-day.^{1,2} The paediatrician concurred, but very firmly asserted, these were throwaways, not runaways. Meanwhile, the nurse inventoried supplies as the van rumbled through the streets, and a group of kids lined up to be seen.

The Bridge van was the beginning of a 1970s healthcare experiment, bringing what its founders called 'biosocial care' to Boston's street youth. Since the early 20th century, mobile health units had been deployed for public health surveillance in the USA, but this new usage paid attention to a growing problem. Bridge provided medical, social and psychological services, and the van and its parent organisation's social services continue, if not thrive, nearly 50 years later. Today, paediatricians and policy makers still explore the dilemma of homeless youth, an estimated 2.5 million people in the USA in 2018.³ These individuals face significant health challenges, both acute and chronic. By recounting the story of the Bridge programme, I describe a then-novel public health intervention and assess its limitations for serving a marginalised group.

BACKGROUND

Understanding the origins of the Bridge van requires situating it within Boston's history. By the early 1970s, numerous changes in urban healthcare delivery

were under way and new public health interventions abounded. While nationally there was a constellation of free clinics (eg, the Black Panthers and Haight-Ashbury), Boston was a site of pre-eminence with countless private and public hospitals, its own free clinics and community health centres, and a leader in the emerging clinical specialty of adolescent medicine. The latter was pioneered at the Children's Hospital of Boston in the mid-1950s, taking a radical approach to care for teenagers.⁴ On the other hand, the city was undergoing political and economic upheaval and growth, known as the 'New Boston'. In two decades, Boston transitioned from a declining manufacturing economy to a service-oriented one. Urban renewal initiatives were begun, including the decimation of the West End in the 1950s, the rise of the Boston Redevelopment Authority and the building of the Tufts-New England Medical Centre.

In 1968, alienated youth and runaways hit the streets of Boston, mirroring the scene in San Francisco and other urban centres.⁵ They were driven by the drug culture and political disenchantment of the mid-to-late 1960s and increasingly were escaping abusive home lives. These young adults were also plagued by health problems that were exacerbated by street life and were unable to obtain medical care due to the absence of parental consent. In this context, Dr Andrew Guthrie (1929–2016) arrived. An adolescent paediatrician at Massachusetts General Hospital (MGH), Guthrie was struck by the plight of the children and young adults. He partnered with a new organisation (Bridge Over Troubled Waters) founded by three Catholic nuns. Guthrie assembled a team of physicians, nurses and social workers and took to the streets.² Espousing principles of volunteerism, free care and advocacy, he wanted staff to reach youth on their 'own terms' without 'compromising' their beliefs.

'PEOPLE TO PEOPLE STUFF': VAN IN TRANSIT

Starting in summer 1970, the van roamed Boston and Cambridge on weekdays from 18:00 to 22:00.² After leaving the MGH garage, the van parked at one of several

prearranged locations, and streetworkers alerted kids of their presence.² The youth also learnt about the available services by word of mouth, shop window notices and the radio. Each night, approximately 30 patients were treated.² To avoid legal rigmarole, street youth used first names or pseudonyms while registering, such as 'Ms Bunny Rabbit' or 'Donald Duck'. The nurse or medical student would record a simple problem-oriented history, followed by a physical exam as needed.² Simple laboratory tests, such as urinalysis and pregnancy tests, were performed.² Healthcare providers addressed immediate medical problems on the van, or referred patients to local hospitals or clinics.²

The van was also distinguished by its 'biosocial' philosophy, integrating medical and social services.² Street workers, nurses, and medical students distributed clothing, food and beverages.² Staff had 'rap sessions' (informal meetings), pairing street youth with appropriate resources. Disenhof recalled chatting 'with them on their way out, but it really depended on what the situation was and who they were and what their needs were'. The July 1978 issue of the Bridge 'Street Survival Guide' listed phone numbers, addresses and services (eg, 'rape', 'legal' and 'food'), and made the key assurance 'Either way, we'll stay with you'. Finally, counselling occurred on the van, usually in the same location, and involved 'emotional support' or 'education and problem-solving'. Kids returned for sessions, and daylight office hours were held on the van. As Guthrie observed in a 31 May 1971 *Boston Globe* article, a youth's 'complaint' was their 'ticket on board'.

While the van provided invaluable services, its operations were constrained. Just as in free clinics past and present, there was a shortage of diagnostic tools and therapies.² Standard laboratory tests and pharmaceuticals were provided, but there were no narcotics on board, and more sophisticated tests necessitated referral to MGH and neighbouring hospitals,² nor was birth control dispensed, as a result of Bridge's funding and affiliation with Boston's archdiocese. Still, physicians and other health professionals continued reproductive counselling and referrals, in spite of their limitations. Additionally, by 1978, street youth advocated for 'health services seven nights a week', plus having the 'medical van go on a series of city-wide tours' with streetworkers and clients. Perhaps most important, Bridge workers and youth alike recognised the systemic nature of the crisis. Drs Guthrie and Mary C. Howell in a journal article noted: 'the

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van is merely a symptomatic remedy directed toward an increasingly significant social problem', or, as Larry, a 16-year-old West Coaster, memorably quipped in 1971: 'Shit, Doc, you know it's going to take a helluva lot more than any book to help most of these kids'.

SUBSEQUENT DEVELOPMENTS

In the decades to come, Bridge's purview would include transitional housing and longitudinal support. Mobile health services also dramatically expanded, some inspired by the Boston experiment. Initiatives occurred in New York, Seattle and Washington, DC. More broadly, the Mobile Health Map, which is run out of Harvard, records the activity of over 700 mobile clinics, nationwide, some of which target homeless youth. On the international scale, there are mobile clinics in Calgary, Canada, and dental clinics in Brisbane, Australia. Today, youth homelessness remains a public health priority, and its deleterious effects are well documented in the medical literature. However, it is

critical to recall that these programme are temporising measures, not long-term solutions. Homeless youth grapple with structural barriers to health, including physical and sexual abuse, homophobia, mass incarceration and, of course, lack of stable housing. With street medicine's ascendancy, the very persistence of these approaches emphasises that we have not yet tackled the root causes of youth homelessness.

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