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FRESH FOCUS

Implementing the Street Psychiatry Model in New Haven, CT: Community-Based Care for People Experiencing Unsheltered Homelessness

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Abstract
"Street psychiatry" is an innovative model that serves people experiencing unsheltered homelessness, a vulnerable population with increased rates of mental illness and substance use disorders. Through community-based delivery of mental health and addiction treatment, street psychiatry helps the street-dwelling population overcome barriers to accessing care through traditional routes. Throughout the United States, street psychiatry programs have arisen in multiple cities, often in partnership with street medicine programs. We discuss the philosophy of street psychiatry, document operational highlights involved in the development of a street psychiatry program in New Haven, CT, suggest key ingredients to implementing a street psychiatry program, and explore challenges and future frontiers. Street psychiatry is an effective person-centered model of service delivery with the potential to be applied in a variety of urban settings to serve people experiencing street homelessness.

Keywords Street psychiatry · Street medicine · Homeless · Unsheltered homelessness · Serious mental illness · Implementation

Introduction

Mental illness and substance use disorders are disproportionately prevalent among people experiencing homelessness. Estimates suggest that between one-quarter and one-half suffer from a serious mental illness or substance use disorder (The, 2010 *Annual Homeless Assessment Report to Congress*, 2010). They exhibit significantly higher prevalence of psychotic and mood disorders (Fazel et al., 2008), in addition to high rates of childhood trauma, family instability, and poverty (Sullivan, 2000). People experiencing unsheltered homelessness, also known as "street homeless" or "rough sleepers," bear a particularly heavy burden of mental illness and substance use disorders. They are 1.6 times more likely to suffer from a mental illness or substance use disorder than their sheltered counterparts (Levitt et al., 2009; Montgomery et al., 2016). Meanwhile, health care access for people experiencing homelessness and serious mental illness can be a challenge due to barriers like insurance, transportation, access to phones, mistrust and stigmatization, and prioritization of survival (Martins, 2008); these barriers are magnified for the unsheltered population. When accessing health care, people experiencing homelessness use emergency and hospital care over preventive or primary care; as a result, those who are unsheltered generate costs to the health care system that are more than three times those generated by the sheltered population (Folsom et al., 2005; K. A. Koh & Roncarati, 2019).Unmet mental health care needs are enormous for people experiencing homelessness—21% of respondents of one survey reported an unmet mental health care need (Baggett et al., 2010); though this may be an underestimate since many feel stigmatized if they admit to having a mental health problem. Despite best efforts to refer to mental health or substance use disorder treatment, follow-up does not always occur. While 37% of homeless individuals in one

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study agreed they had an emotional problem, and half of these people agreed to be referred to mental health services, only one-fourth of those referred actually received care (G. Morse et al., 1985).

Homelessness is a public health problem affecting cities across the United States and the world in increasing numbers. In the United States, approximately 568,000 people experienced homelessness on a given night in 2020 (Henry et al., 2020). In response to enormous health disparities and extreme care gaps, medical entities have strategized ways to reach people experiencing homelessness. One effective mechanism of reaching this group is through street outreach, which reaches some of the most difficult to engage individuals experiencing homelessness (Lam & Rosenheck, 1999), whose needs are often not met by traditional services (K. A. Koh, 2020). "Street medicine," the delivery of medical care directly to rough sleepers where they reside through street outreach, is practiced throughout the world and is recognized as an important—and often the only—way of reaching this population. It involves an assertive, compassionate, nonjudgmental approach and recognizes that health care is a human right (Withers, 2011).

The Argument for Street Psychiatry

An emerging field within street medicine is "street psychiatry," which is the delivery of mental health and addiction services to people experiencing unsheltered homelessness wherever they can be found; for example, under bridges, in parks, or in encampments. Street psychiatry recognizes that the unique needs of rough sleepers necessitate a different model of mental health and addiction care delivery. It is philosophically aligned with Assertive Community Treatment (ACT), an evidence-based, proactive approach to meeting people with serious mental illness "where they're at" both literally and figuratively in an interdisciplinary, holistic, and person-centered way (Bond & Drake, 2015). Street psychiatry differs from ACT, however, in that it seeks to engage new clients: people experiencing homelessness who have yet to be connected to treatment of any kind or who have not succeeded in accessing treatment.

Street outreach programs may be run by outreach workers and case managers without clinical staff, while street psychiatry programs have built-in clinical staff that can provide psychiatric diagnosis and treatment. It is not surprising that both community-based models have demonstrated positive impacts. Street outreach teams that provide mobile case management services have been found to significantly improve psychiatric illness, increase linkage to psychiatric and addiction treatment, and increase outpatient resource utilization for the sickest and most vulnerable unsheltered individuals (Fisk et al., 2006; Hwang et al., 2005; Lam & Rosenheck, 1999; G. A. Morse et al., 1992). There is growing evidence that street psychiatry teams (which may also be described as "mental health outreach" or "psychiatric street outreach") improve a number of outcomes as well. One study found that intensive outreach by a psychiatric social worker and availability of weekly psychiatrist visits at a homeless shelter increased engagement with outpatient psychiatric and substance use disorder treatment (Bradford, Gaynes, Kim, Kaufman, & Weinberger, 2005). In a study of a psychiatric outreach program in Sydney, the rate of psychiatric admissions for people with schizophrenia who received services from the program was significantly lower than those who did not receive services (Buhrich & Teesson, 1996). Street psychiatry teams are also well-equipped to respond to mental health crises, and can help meet the rising need for non-police responses to mobile crisis care (Hogan & Goldman, 2021). One mobile crisis team designed for people experiencing homelessness with severe mental illness demonstrated significant reduction in psychiatric symptoms and days homeless for participants (Morris & Warnock, 2001).

Street psychiatry programs have thrived in many cities, and include Project for Psychiatric Outreach to the Homeless (Janian Health) in New York, NY (APA Gold Award, 2013), Vanderbilt Street Psychiatry in Nashville, TN, House of Hope in Providence, RI, Mercy Care Street Medicine in Atlanta, GA, and the Sulzbacher Homeless Outreach Project Expansion in Jacksonville, FL (Christensen, 2009). Many other street medicine programs such as Boston Health Care for the Homeless in Boston, MA (H. K. Koh & O'Connell, 2016) and mobile crisis teams like CAHOOTS (Crisis Assistance Helping Out On The Streets) in Eugene, OR (Hecht, 2020) incorporate mental health providers into their interdisciplinary teams. We will discuss how a street psychiatry program was conceptualized and implemented in the U.S. city of New Haven, CT.

Process and Timeline of Implementation

In 2016, the year in which this project was first being explored, New Haven's Point-in-Time Count volunteers counted 625 people experiencing homelessness on a given night, with more than 100 of them unsheltered (*Connecticut Counts: 2016 Report on Homelessness in Connecticut. Connecticut Coalition to End Homelessness*, 2016). At that time, multiple organizations were already serving people experiencing homelessness by providing case management, housing, food, shelter, and clothing. Many primary care and mental health clinics also accepted patients experiencing homelessness, who were generally eligible for state Medicaid insurance. One street medicine team provided primary care through street-based outreach, and another operated a medical van and mobile syringe services program. However, there were no mental health providers doing street-based outreach at the time. A previous clinician-led outreach and

engagement team, run by the Connecticut Mental Health Center (CMHC), had lost funding many years ago and since scaled back to a smaller case manager-led team. Meanwhile, street medicine providers and outreach and engagement workers were identifying numerous individuals suspected to be experiencing mental illness, but they faced barriers in linking those patients to mental health treatment. Those clients would struggle to follow up through traditional clinics due to rigid requirements, such as mandatory group psychotherapy, strict no-show policies, and delays in seeing a prescriber, as well as chaotic lives that were poorly suited for clinic-based care. Ongoing street-based outreach alongside the existing teams continued to reinforce the need for an integrated mental health practitioner embedded within the teams. Established outreach organizations and treatment providers agreed that this network of medical and social services could be augmented with the addition of a street psychiatry component. Leaders of CMHC's long-dissolved clinical homeless outreach and engagement team supported the idea and helped inform the current project's logistics and sustainability (See Fig. 1 for timeline details).

Psychiatry residents and public psychiatry fellows were the first unofficial staff who conducted mental health outreach, with support by Yale Psychiatry Residency and the Yale Public Psychiatry Fellowship. This flexibility allowed for the groundwork to be incorporated into trainees' dedicated research time, avoided incurring excess costs early on, and served as a valuable learning experience in public sector psychiatry and program implementation (Lo et al., 2021).

Meanwhile, model agencies around the country were contacted to inform the program's design and one program, Janian Health, provided a live consultation by meeting in depth with New Haven's multiple stakeholders as led by CMHC. Meetings proceeded to discuss where and how a street psychiatry team should form. Given its historic dedication to underserved populations including New Haven's homeless, flexibility in billing structure, and academic support through a partnership with Yale, CMHC emerged as a natural location and leader of the new team. However, integration of the existing services was important in order to create a functional network that provided complete yet unduplicated services. A collaborative network, Street Outreach Services, was formed, which included the existing New Haven Outreach and Engagement Network (composed of several non-clinical outreach and case management agencies), Cornell Scott-Hill Health Homeless Health Care Team, and the proposed CMHC Street Psychiatry Team. People with lived experience were also essential during this process. Formerly homeless individuals of the Homeless Advocacy Network introduced the team to encampments at the earliest stages, the Peer Support Specialist program at CMHC provided consultation about program design, and we collaborated with the Sex Workers and Allies Network (SWAN), a harm-reduction group run by people with lived experience, through street outreach early on and later in designing community-based psychotherapy groups.

A major public health event occurred in August 2018 on the New Haven Green, a public space where many people experiencing homelessness reside. A potent strain of K2, a synthetic cannabinoid, led to over 100 emergency department visits over a three-day period. Making national news, this event shed an unfortunate light upon a growing problem of drug use and homelessness, drawing attention from the City of New Haven, Yale University, and Connecticut's Department of Mental Health and Addiction Services (DMHAS), all of whom would later partner together to prevent future overdose events. The K2 crisis, though tragic, helped catalyze DMHAS' decision to fund the CMHC Street

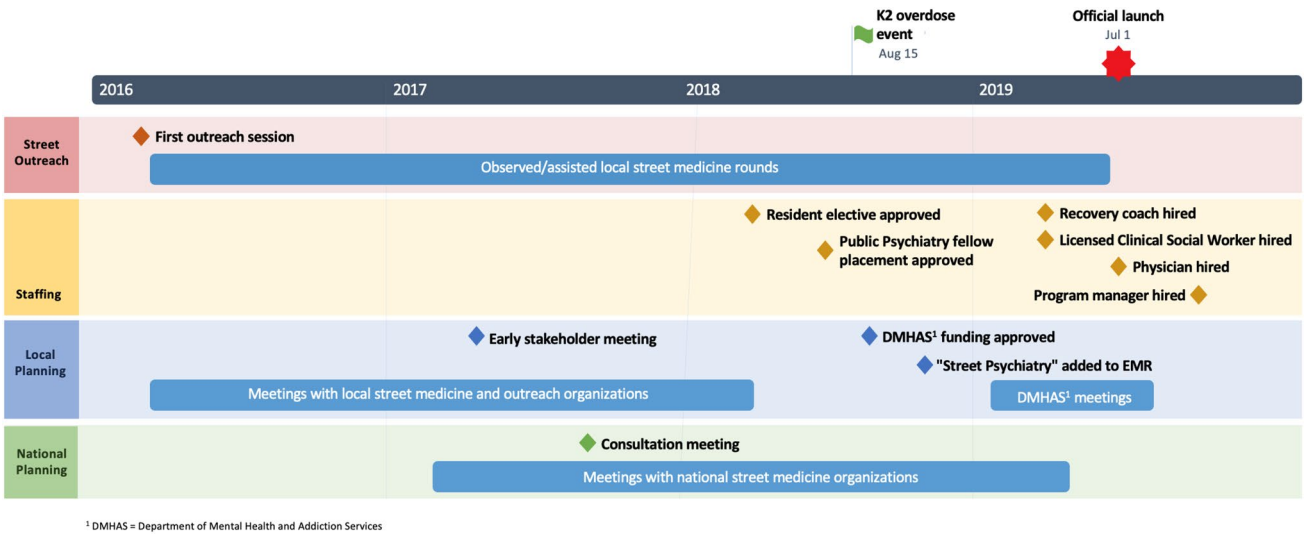

Fig. 1 Timeline of Connecticut Mental Health Center (CMHC) Street Psychiatry program implementation highlights and milestones

Psychiatry Team as a new community-based program tasked with responding and preventing these types of overdose events.

A program manager, recovery coach (with lived experience), clinical social worker, vocational specialist, and psychiatrist were expeditiously hired by DMHAS to create the team, which launched officially in 2019. Since that time, the team has been dispatching to various community locations such as encampments, the New Haven Green, soup kitchens, and public places such as libraries, bus stops, and train stations. Scheduled for outreach about four days per week, the team covers multiple neighborhoods of the Greater New Haven area. Referrals to the team have come from the inpatient hospital, outreach workers, and outpatient medical and mental health providers, but the majority of individuals are identified during outreach rounds on the street.

Workflow in the Community

A natural workflow emerged as the team encountered more and more individuals in the community from 2017 to 2019. The Street Psychiatry Team documented 650 encounters between July 2017 and January 2020 (constituting 239 unique individuals).

Dispositions were categorized based on the initial encounter; however, it should be noted that these categories were fluid and often changed after the first contact (See Fig. 2 for disposition workflow). Twenty (8.4%) individuals were already enrolled in CMHC's outpatient services, so their provider teams were contacted and a plan devised to improve engagement. Some were already registered patients of another community mental health agency; therefore, the CMHC Street Psychiatry team facilitated

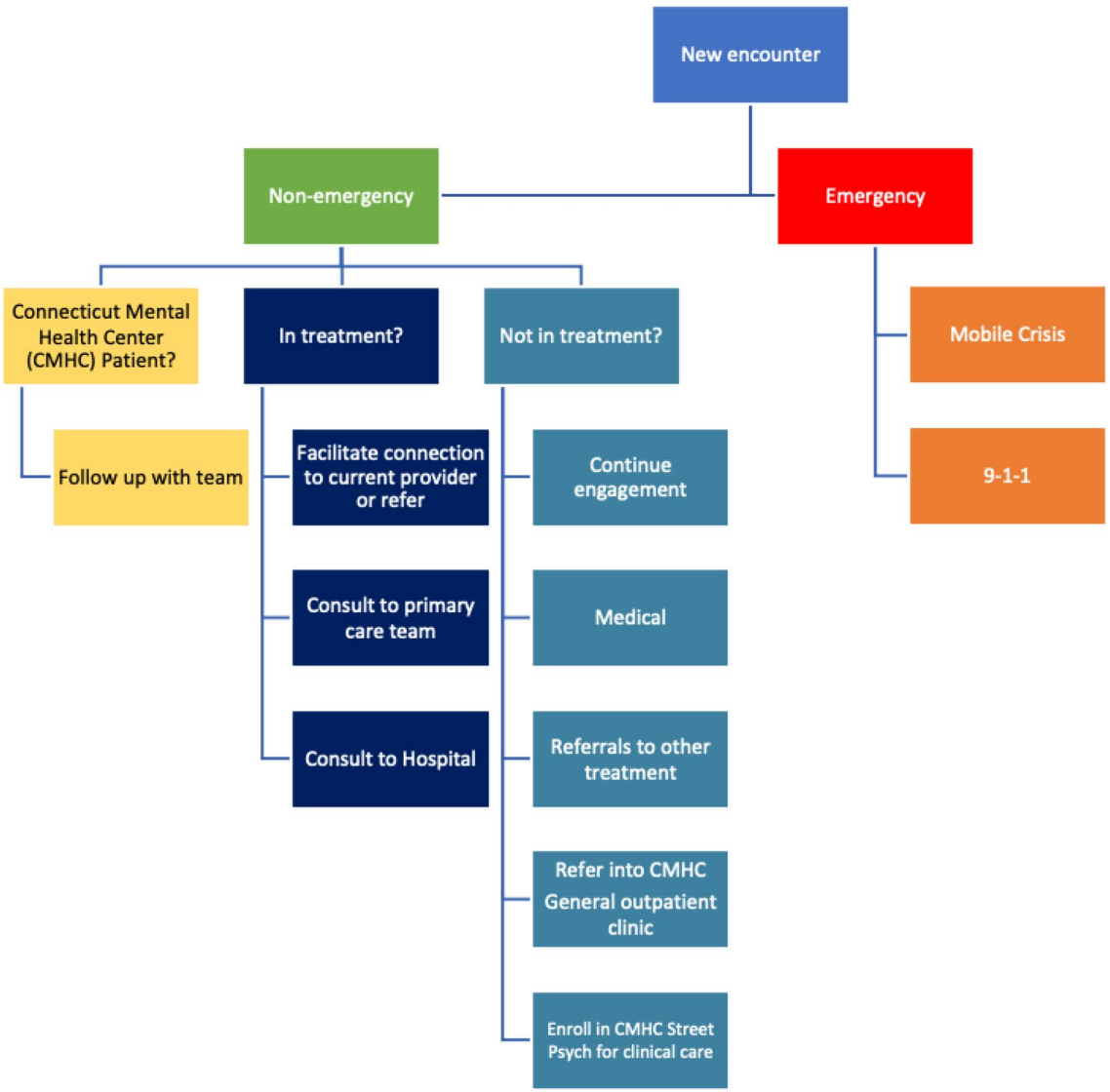

Fig. 2 Disposition workflow for initial encounters of newly engaged homeless individuals

connection to that provider for 27 individuals (11.3%). Occasionally, that existing care provider was actually a primary care provider or an inpatient hospital requesting consultation.

Most individuals (181 of 239) who were assessed by the team were not connected to any form of treatment on initial contact. A large proportion (85 or 35.6%) were not yet ready for treatment on first encounter and continued engagement was planned through the provision of basic resources like socks or food and getting to know the person's own goals. Thirty-six (15%) were deemed appropriate for referral to another community agency that would address their specific need (e.g. methadone program, free medical clinic, the street medicine team, or a previous mental health clinic with whom the person had a relationship). Of those yet to be connected to care, 34 (14.2%) were assisted in establishing care at CMHC's main or satellite clinics and 20 (8.3%) were deemed to require the intensive services of the CMHC Street Psychiatry Team and were enrolled under this team's clinical care, in which case intake paperwork, consent forms, and releases were signed in the community to enable psychiatric treatment by the team. This process often lasted several visits; however, the team was equipped to do immediate enrollment in certain cases, such as for the induction of buprenorphine. Insurance status, co-morbidities, homelessness duration, severity of illness, and logistical barriers to care were all considerations in deciding appropriateness for the Street Psychiatry Team, which would at times be the only entity able to accommodate patients facing barriers at traditional clinics. Basic first aid only or other non-emergent medical care was administered to several people as well (6 or 2.5%).

Occasionally (11 or 4.6% of the time) individuals required emergency medical or psychiatric evaluation by the team, for whom the mobile crisis team was called for backup or an ambulance was arranged, almost always with the consent of the individual. The team's experience in navigating mental health crises will play a key role in the city's new Community Crisis Response Team, an initiative to reduce police response to mental health crises in favor of care by trauma-informed, behavioral health-trained professionals.

Subsequent encounters often led to a variety of other voiced needs, which the street psychiatry team worked to address. In striving to be person-centered and recovery-oriented, those needs ranged from survival such as food, clothing, or hydration; to social service resources for needs like housing; to harm reduction supplies like syringe services; to therapy for exploring past trauma. The above numbers represent only initial encounters; longitudinal relationships built over time, working at the person's own pace, and working toward achieving their own goals are some of the core values of the street psychiatry team.

Administrative data and medical record review was approved by the Yale Institutional Review Board with study protocol ID 2,000,026,342.

Aspects of Successful Implementation

A street psychiatry program is a novel way to address the mental health and substance use disorder needs of the unsheltered homeless population as well as address the crisis of homelessness in our urban communities. Street psychiatry models are becoming more prevalent around the country and world. However, there is no one template that applies to every community. Each community requires localized strategies due to differences in politics, financial and human resources, and intricacies of the homeless population itself. For example, New Haven has a street homeless population on the scale of hundreds; while larger cities must design programs able to address the needs of thousands. Our own successful methods may serve as a guide for others to consider when endeavoring to start a similar program on this scale.

Key Aspects of Successful Implementation

1. *Consistent Outreach*: Consistency in conducting regular street outreach was essential not only to building trust within an often mistrustful population, but also for the purpose of providing iterative feedback to inform the developing program. Because of early, regular outreach with partner organizations, conversations about program design could be contextualized in real-life experience. Furthermore, individuals engaged by providers early on and seen longitudinally benefited from the foundation of therapeutic rapport.
2. *Collaboration with Community and Stakeholders*: It was essential to gauge the needs and interests of community stakeholders such as the existing street medicine teams and homeless outreach teams due to the potential overlap of services. Frank discussions of logistics such as under what health care entity the Street Psychiatry Team should reside, were important early on to define what niche the new team would fill. Longstanding community providers gave important input about community gaps and program design. Relationships built with these stakeholders laid groundwork for future collaboration on mutual cases and sharing of resources. The interdisciplinary nature of these collaborations was a strength: many levels of training such as nurse and nurse practitioner, physician, Licensed Clinical Social Worker, Master in Business Administration, outreach worker/case manager, vocational specialist, and recovery coach were all important to the design of a community network that cares for people with complex needs. People with lived experience played an important role in the program's design,

as the team conducted early outreach with formerly homeless individuals, consulted with CMHC's Peer Support Specialists, and collaborated in the community with SWAN. Regrettably, early stakeholder meetings did not directly include people with lived experience; however, the team now employs, conducts outreach with, and relies upon the expertise of numerous people with past lived experience of homelessness who remain essential to the mission and function of the program. Design of street medicine programs should include people who are currently or formerly homeless; people with lived experience often have the most wisdom with regard to what their communities need and can serve as important allies in reaching a population largely mistrustful of medical systems.

3. *Integrated Care Model*: A team able to work seamlessly on medical and psychiatric issues on a continuum was very valuable in our program design. Historically, reduced access to basic medical care contributes to poorer health outcomes in individuals who experience serious mental illness (Lawrence & Kisley, 2010). Integrated care—the cohesive integration of mental health and primary care—is recognized as relieving access issues, improving communication, and treating patients holistically, which can be especially beneficial for those experiencing homelessness (Jego et al., 2018). In our model, the street psychiatry and street medicine teams are frequently co-located. While full primary care and mental health care integration would be ideal, differing medical records and medico-legal challenges limit the full integration of these two teams. However, by working closely together with frequent communication the teams can exchange information and coordinate easily. Our integrated model embraces person-centered care by offering a multitude of services like medical case management, recovery coaching, vocational counseling, harm reduction supplies, and connection to housing services, in addition to mental health and primary care. The teams' multifaceted roles allow for versatility in providing care despite a fragmented system.
4. *Response to Crisis*: The emergence of a crisis can be leveraged as an argument for resources. The K2 overdose on the New Haven Green event happened during the planning phase of our program, but before funding was yet secured to support it. Given the extensive attention received by the city, state, and academic institution in the area, there was public pressure for a rapid and specific solution. DMHAS recognized the potential of this program to serve the needs of this population, and applied existing funds toward this cause. Though its mission did not initially focus specifically on drug overdose, the Street Psychiatry Team was able to naturally incorporate overdose-prevention into its daily priorities and pivot needed attention toward prevention of mass-overdose events amidst the growing opioid epidemic.
5. *International Community*: The Street Medicine Institute was a wonderful resource for the team in networking with street psychiatry programs across the U.S. and world. Annual international symposia bring together providers on a multitude of topics related to the practice of street medicine. It was essential to have the expertise and best practices from these existing programs, which also provided legitimacy to our program by exemplifying successful models. This shared global community continues to inspire students, residents, and other medical practitioners to initiate their own street psychiatry programs, and our program has begun to assist others in their own implementation journeys.

Limitations and Challenges

While street psychiatry teams overcome many obstacles to providing quality care to people experiencing homelessness, the model has several limitations. A core feature of street psychiatry is the provision of care in unconventional settings including soup kitchens, train stations, encampments, and under freeway overpasses. Privacy can be difficult due to the public nature of these spaces and the presence of bystanders, but requiring individuals to come in to an office for privacy would create a significant barrier. The team often improvises with borrowed spaces and tactful distancing from nearby individuals. Acquiring bloodwork requires that the person come to a clinic, which is often not realistic given daily survival needs, and the team carries only limited medical equipment. Documentation remains an ongoing challenge. While the electronic health record allows for entry of patient information, it requires full name and date of birth as a minimum. Some people may feel comfortable providing only a first name or an alias. Therefore, secure spreadsheets and paper documentation are necessarily invoked in many cases, at the expense of pristine and accessible data sets.

Sustainability is an important challenge in the implementation of a street psychiatry program. Programs we researched were funded by a combination of grants, institutional support, government funding, fee-for-service payments, and charitable contributions. Several factors limit a fee-for-service model, including the slow work of engagement that results in more informal visits not meeting strict billing criteria and the traditional definition of a clinic having "four walls" for billable care. Only a minority of our street psychiatry visits result in enough information to document a billable encounter, so the program remains at the mercy of state budgetary discretion and political tides. Even for billable services, this population is often uninsured or under-insured depending on the state's decision to expand Medicaid.

Future Directions

It's heartening that the number of street psychiatry programs in the U.S. is increasing in response to well-documented needs. It is important to evaluate the impact of this model in order to achieve a level of evidence, as seen in data for ACT teams, that will bring more widespread recognition of its value. Programs addressing the mental health needs of individuals experiencing homelessness will need to adapt to a variety of factors within their communities such as changing funding streams, politics, opportunities for collaboration, and other local dynamics, but there are core elements of street psychiatry programs that might be adopted more uniformly as the evidence grows.

Typical indicators that are relatively easy to measure in studies of people experiencing homelessness include housing status, hospital utilization, and health status; though these may not be the most meaningful determinants of success of these programs. Ultimately, finding ways to hear the voices and perspectives of people who experience unsheltered homelessness should guide future research as well as continued program development. Programs should strongly consider participatory research methods including community engagement and focus groups with stakeholders to understand the specific needs, desires, and best practices that can be promulgated. Our services and continued advocacy to support them will be most effective when projects are designed, implemented, and analyzed by teams that include people with lived experience. In addition to pursuing research and program evaluation, we must continue to expand education and training opportunities on person-centered clinical care for people who experience homelessness.

Conclusion

While each community requires an individualized approach to program development, street psychiatry is an innovative model of delivery that can be applied in urban settings in which people experiencing unsheltered homelessness and serious mental illness do not have access to appropriate mental health care or substance use disorder treatment. Street psychiatry promotes the ideal that health care, including mental health care and addictions treatment, is a basic human right. The practice of delivering interdisciplinary mental health care directly in the community has been a bedrock of our field for decades, and this newer iteration of bringing care to people "where they are" is a fitting addition to Public Psychiatry's armamentarium. Street psychiatry programs have been successfully implemented in urban communities, leading to the delivery of humanistic, person-centered care to some of our most vulnerable citizens.

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Declarations

Conflict of interest The authors have no relevant financial or non-financial interests to disclose.

Ethical Approval This retrospective chart review study involving human participants was in accordance with the ethical standards of the institutional and national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The Human Investigation Committee (IRB) of Yale University approved this study.

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