

Episode – Ethics Talk: Street Psychiatry for People Experiencing Homelessness

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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.

Primary care is typically defined as general internal medicine, family medicine, pediatrics, obstetrics and gynecology, and psychiatry. Each of those kinds of health care typically work with patients as inpatients, that is, in hospitals, or as outpatients in clinics. Street medicine isn't confined to either of those locations, or in fact, any of those categories. Street health clinicians move out of the clinic or hospital to meet patients where they are and on their own terms. Services are administered by cross-disciplinary teams of nurses, physicians, and social workers, for example, who coordinate patients' care. One kind of success in street health is following a patient from the streets over time, transitioning them to permanent housing, and supporting them in building skills and gaining the experiences many of us who have always been housed take for granted.

A woman we'll call CJ was in her early 50s, experiencing homelessness, and had a history of trauma, depression, asthma, and substance use disorder. For decades, CJ was many times an inpatient, often being transferred between general medical and psychiatric units when she wasn't unsheltered on the streets. She didn't trust most clinicians, she didn't have insurance, and she became more and more disabled by acute exacerbations of depression and asthma.

Fast forward to now: CJ no longer uses drugs or alcohol. She lives in permanent housing and manages her depression and asthma medically. Each year, she celebrates her hard-won stability with a few clinicians who supported and helped her and whom she eventually came to trust long enough to secure permanent housing. Securing permanent housing might sound like a neat and tidy single step to, quote, "solving homelessness," but obviously for most, it's not. CJ had to abandon long-term relationships she had forged with others experiencing homelessness who weren't as lucky or as supported as she was. Maintaining long-term safety, food, water, and access to hygiene opportunities was a major lifestyle shift for CJ. She also needed to learn how to adapt to her new stability and responsibilities, managing her illnesses, striving for decent encounters with law enforcement personnel, paying bills, and vetting new roommates.

Street health first seeks to remove barriers to care for people like CJ and then continues to try to build trust and maintain multidisciplinary support. If you ask her, she'll tell you that anyone could do what she did as long as they have a team to boost them up.

Joining us now is Dr Sheryl Fleisch. Dr Fleisch is an Associate Professor of Psychiatry at the University of Florida, Chief of Psychiatric Services at UF Health Shands Hospital, and Chief of Health Equity in the Department of Psychiatry. She's with us to talk about what it means to offer good mental health care to people experiencing homelessness. Dr Fleisch, thank you very much for being on the show. [music fades out]

DR SHERYL FLEISCH: Sure. It's my pleasure. Thank you so much for having me.

HOFF: To begin with, could you please give us a brief introduction to Homeless Health Services, the program that you developed when you were previously at Vanderbilt University Medical Center?

FLEISCH: Yeah, of course. So, Homeless Health Services was basically a comprehensive program. It had an infrastructure that essentially included in reach and outreach efforts with a social worker, employment specialist, housing navigator, outreach workers, fast track disability coordinators, psychiatrists, residents, medical students, and a psychiatric nurse practitioner. We basically collaborated with post-acute care programming and numerous nonprofits in the city. And our goal was to really improve discharge plans from our hospital.

We had essentially four major components of the program: We had inpatient homeless psychiatric consultation service, an outpatient street psychiatry clinic, a homeless housing navigation service, and a homeless disability service. And our goal was basically to provide psychiatric care to persons experiencing homelessness within an academic medical center, particularly to those people who are uninsured. And that in itself was pretty unique. But the program bridged an important gap beyond the hospital to really innovate social solutions like obtaining disability insurance and permanent housing, which hospitals traditionally haven't done before. And our goal was to really also impact the hospital's bottom line, by decreasing hospitalizations, improving the funding source, and also obviously, impacting the disease process. So, it was a really amazing program and something that we all really loved being a part of.

HOFF: Sure. And for our listeners who are unfamiliar, could you expand a little bit on the street psychiatry angle? I imagine that term is unfamiliar to most folks.

FLEISCH: Sure. Of course. So, provision of street psychiatry is something that continues to be fairly unique on a national scale. It's something where psychiatrists basically go out on the street and go to individuals where they are, so individuals who basically live in encampments, who live either at a shelter, who live under bridges. We basically met people wherever they were. And we would partner with a nonprofit, and we'd go out with their outreach worker. It was me, three residents, three psychiatry residents, and usually one or two medical students. We had partnered with our pharmacy so that we had psychiatric medications available to us if it was necessary. And then we actually were able to document in our electronic medical record. So, we were essentially an outpatient clinic, but we practiced in a nontraditional environment. And our patients knew that when they saw us, we would be able to provide not only psychiatric care, but basic medical care. And we really saw ourselves as just a traditional clinic, but just a clinic that essentially practiced in a nontraditional environment.

HOFF: Sure.

FLEISCH: So, again, it was something that was really unique and something that I had done actually in previous hospital systems as well, at University of Pittsburgh Medical Center and then also at The University of North Carolina when I was a Fellow. So, we were able to go in from those experiences and then bring it to Vanderbilt as well.

HOFF: Yeah, it's great that those kinds of efforts seem to be expanding in hospitals and getting more consistent access to mental health services to more people. Since that consistent treatment over time is so important for good mental health care, and since having any kind of consistent treatment is challenging for a lot of people, including people who are transient, what are some effective methods for delivering continuous care to people who are unsheltered?

FLEISCH: Sure. I mean, it's a great question. I think one of the most important things is that you must remember that standard of care remains standard of care.

HOFF: Mm.

FLEISCH: You know, just because somebody is experiencing homelessness doesn't mean that that person deserves anything less than that. There's no reason why we need to prescribe expired medications to somebody experiencing homelessness. Doesn't mean also that the best medicine is always the right medicine. We actually have to provide medications that somebody can access and that is affordable to that person. You also need to be willing to pivot, I guess would be the best way to put it.

HOFF: Mmhmm.

FLEISCH: Sometimes you have to be willing to change appointments, like times. You have to be willing to change locations quickly.

HOFF: Mmhmm.

FLEISCH: That's going to be critical if you're really dedicated to delivering continuous care. You also have to be willing to kind of work in a harm reduction framework. So, you can't have preconditions like, "You must be sober in order for me to see you." You kind of have to operate in an environment where you know that people are going to have really significant medical and mental health and substance use disorders.

And I guess the last thing I can think of is that you have to know about social status and social questions. I mean, you need to ask people about insurance status and their source of income and ability to afford medications and transportation and plan for follow-up care. You can't just assume that discharged to home means discharged to home.

HOFF: Sure.

FLEISCH: Discharged to home may, in fact, be that person's home, but it may be underneath an embankment or by a tree. And they may have to deal with significant rain or heat or snow. And that may go into how you're ultimately going to deliver care to that person.

HOFF: Street medicine clinicians often have to interact with other professionals, even outside of the health professions, such as law enforcement. What are some of the challenges of these interprofessional interactions, and what strategies do you recommend for building these relationships to best serve the people experiencing homelessness that you're trying to care for?

FLEISCH: You know, I think that law enforcement is in a really challenging situation.

HOFF: Mmhmm.

FLEISCH: Because their goal is to really keep the community safe. But often, the easiest solution for someone perceived as being unruly or breaking the law is to potentially arrest that person.

HOFF: Mmhmm.

FLEISCH: But individuals who have mental health problems are making up now a huge percentage of jails and prisons across the country. And they've longer incarceration times and higher rates of homelessness post-release and higher rates of recidivism. But there are a huge amount of challenges that street medicine clinicians are going to encounter with law enforcement when they're on the streets. A couple that I can think of off the top of my head would be, honestly, barriers to their own provision of care. So, oftentimes law enforcement will come up to us and tell us that we're trespassing.

HOFF: Mm.

FLEISCH: We won't be able to park in a specific location where we need to, to provide care. They will tell us that what we're doing is illegal and tell us that we're not allowed to practice on the streets. So, they won't necessarily be informed, and that will inhibit our ability to actually provide care. Also, sometimes we'll witness discrimination.

HOFF: Sure.

FLEISCH: We will watch somebody be arrested for a petty crime, and it will feel very guilty because there's not much we can do about it in the acute circumstance. And then there are other times where we actually watch people be harassed for trespassing. But ironically, we are also trespassing.

BOTH: [chuckle]

FLEISCH: And we are actually not questioned.

HOFF: Sure.

FLEISCH: But the person who's experiencing homelessness is questioned.

HOFF: Mmhmm.

FLEISCH: And I think that results in us having to reflect on what it's like to be in our position in society and how that person experiencing homelessness is clearly treated differently than us.

HOFF: Mm.

FLEISCH: And we also, obviously, see a lack of education on how to literally address somebody who's experiencing homelessness, and those are challenges that we witness. But you also asked about how do we improve that? How do we build relationships with law enforcement?

HOFF: Mmhmm.

FLEISCH: And I think there are a lot of ways that we can do that. Previously, we've reached out to local police departments, and we've explained to them what we're going to be doing.

HOFF: Mmhmm.

FLEISCH: Like, "Hey, this is our program. We're going to be going out on the streets. We go to encampments weekly. We have the support of the Mayor's Office. We have the support of our hospital system. We'd appreciate the support from you."

HOFF: Mmhmm.

FLEISCH: We've also asked persons who experience homelessness about their interaction with law enforcement so we can better understand those barriers, so then we can better educate law enforcement.

And then we've also worked with law enforcement before to help in the development of what's called like a HOT program, Homeless Outreach Team. And sometimes those teams actually include law enforcement themselves.

HOFF: Mm.

FLEISCH: So, instead of having the first step be an arrest, law enforcement will actually be involved in the programming that can help with housing and disability access instead of, you know, so, basically being part of the solution instead of kind of being perceived as being part of the problem. I think that's very critical.

HOFF: Hmm. Similar to working with law enforcement, when confronted with a crisis, street medicine clinicians might also work closely with hospital-based clinicians. And while this kind of interprofessional work is standard for clinicians, persons experiencing homelessness have often had negative but numerous encounters with health care organizations and professionals. So, which strategies do you recommend for clinicians who are looking to acknowledge past traumas and distrust and express respect for the dignity and autonomy of people experiencing homelessness during crises that are scary or threatening for them?

FLEISCH: I mean, I think it's just so critical that we treat somebody who is experiencing homelessness just as we would any other person. We cannot combat stigma if we are part of the stigma ourselves.

HOFF: Mmhmm.

FLEISCH: And we cannot make assumptions about somebody else's story when we don't know the story. I think it's very easy for us to assume that we understand why somebody has fallen into homelessness. But the reasons why somebody is currently experiencing homelessness varies so greatly. The reasons can include anything from domestic violence, job loss, mental illness, a loss of family relationships. There are so many more that I haven't mentioned. But we really do not understand that person's story, and so it's critical for us to just treat that person like we would anybody else.

We also, as I mentioned before, when we supposedly are trying to acknowledge, as you said, their past traumas and distrust, one of the ways that we really struggle right now, kind of as kind of hospital-based clinicians is through our discharge processes.

HOFF: Mmhmm.

FLEISCH: We oftentimes discharge somebody to, quote, "their home," as I mentioned before. But when they don't have a traditional home, it honestly defies logic in many scenarios: so, people who've recently had surgical procedures or who under any normal circumstance would remain in the hospital for longer times or who need some form of an outpatient procedure, but they don't have insurance to pay for that procedure. We really have to be innovative and think of other ways to work with that person, because that's the exact way that that person is going to develop that distrust.

HOFF: Mmhmm.

FLEISCH: And so, in order to help that person develop autonomy and to treat them with dignity, we really have to develop a shared decision-making approach with that person. So, building trust is honestly like a two-way street.

HOFF: Mmhmm.

FLEISCH: And it's going to be hard fought, basically, just like any other relationship.

HOFF: Sure. I've got a sort of a practical question. So, let's say that you're out on a team doing the sort of street psychiatry or street medicine thing, and you are in a situation where it would be best for somebody if they had treatment in a hospital for whatever reason, what's the process of triaging that person to a different location or to a different kind of care?

FLEISCH: Sure. So, it's extremely rare that we would force treatment on somebody or force them into the hospital setting.

HOFF: Sure. I'm not even saying force.

FLEISCH: Yeah.

HOFF: But just if they agreed that they would prefer to go a hospital for whatever.

FLEISCH: And just for clarification, in very, very urgent situations, maybe once a year, we end up calling 911 or an ambulance for just extraordinarily acute situations on the street, either medical or psychiatric.

HOFF: Sure. Mmhmm.

FLEISCH: But for situations where it's our recommendation is that somebody would be seen in the hospital setting, one of two things happens, and it sounds really straightforward. The person either agrees or disagrees.

HOFF: [chuckles] Sure.

FLEISCH: [laughs] For lack of a better way to say it. If the person agrees, depending upon which nonprofit we work with, some of the nonprofits are allowed to drive the person to the hospital setting as long as the person is not in an acute crisis.

HOFF: Mmhmm.

FLEISCH: That is, in my experience, the most dignified way to bring the person to the hospital.

HOFF: Sure.

FLEISCH: It also saves so much money because you don't have to call an ambulance or anything else to get the person to the hospital setting. You're basically just, you know, I have an outreach worker who drives the person to the hospital. They are brought to the Emergency Room. And then with our previous programming, we had programming in the hospital, and one of either our psychiatrists or our psychiatric nurse practitioner could even meet that person in the Emergency Room.

HOFF: Mmhmm.

FLEISCH: And that was a way to sort of have a warm handoff.

HOFF: Right, right.

FLEISCH: If the person declined and basically refused to go to the hospital, and it didn't meet the need to call 911, we would work with them and try to provide care on the street.

HOFF: Mmhmm.

FLEISCH: If it was psychiatric, where we had more experience ourselves, we obviously felt more comfortable. If it required medical care, we developed relationships with many of our medical colleagues. And we were able to talk to them over HIPAA-appropriate Zoom, and we were able to show different wounds and different other things over Zoom. And then we were able to provide that person with the appropriate antibiotics. We were able to treat frostbite on the street. We were able to treat many different processes on the street, basically via those relationships that we had. So, we had a tremendous amount of success because of the rapport that we had built with individuals on the streets.

FLEISCH: Yeah. That's very interesting. And yeah, I was mainly focused on that warm handoff aspect because it seems like it'd be sort of a gap to say like, "Oh, well, you need hospital-based care. Good luck. You know, you're no longer with our team."

FLEISCH: Oh yeah. 100 percent. And I mean, even we had at one point, we had a big Hepatitis A outbreak in Nashville in around 2018. And even though we're psychiatrists, we actually partnered with our medical student free clinic, and they worked with us. And we had a gift from a family, and we were able to actually provide Hepatitis A vaccines on the street.

HOFF: Hmm, wow.

FLEISCH: And what was so interesting about that is that about 75 percent of individuals who were unvaccinated agreed to the vaccination on the street. If you think about that in

comparison to people who agree to vaccinations in general, even like the COVID vaccination, that's an extraordinarily high acceptance rate.

HOFF: Yeah.

FLEISCH: And these are sometimes individuals who had never been vaccinated in their entire lives.

HOFF: Hmm.

FLEISCH: And a lot of this was really due to, basically, the rapport that we had built with individuals over years; they basically trusted us.

HOFF: Yeah.

FLEISCH: And they were willing to receive a vaccine because they did not want to get Hepatitis A, and they were willing to listen to us and listen to us about the disease process and why they required that vaccine. And about 50 percent agreed to the flu vaccine.

HOFF: Wow.

FLEISCH: Which was higher than the general population, actually.

HOFF: Yeah, yeah.

FLEISCH: [laughs] So, that's kind of interesting how that worked out.

HOFF: Yeah, that just goes to show the importance of listening to people's concerns and treating them as valid.

FLEISCH: Yeah, exactly.

HOFF: That's been such a big thing with the COVID vaccine, as you point out.

FLEISCH: Totally.

HOFF: A previous colleague of yours, Michelle Southard, describes an unhoused patient who actually declined a transitional housing arrangement that she found for them. She said she was surprised at the time, but that experience helped her realize that people experiencing homelessness face many more obstacles than simply not having a house. They might lack a place to wash or reliable access to food or might simply not feel safe sleeping in a new environment. So, how do you and the people you work with ensure that the care that you offer aligns with the actual needs and wants of the people that you serve?

FLEISCH: That's a really good question. I think in medicine, we often think about metrics like mortality and safety and efficiency, and these metrics matter. And they continue to matter when we provide direct health care on the street. However, I think that success is often defined by metrics on the streets, at least, that will likely never come to the attention of a hospital's CEO.

HOFF: Mm.

FLEISCH: So like, for example, we had a man in Nashville who, after two years, finally looked up and gave me a head nod. And—

HOFF: [chuckles]

FLEISCH: Yeah. And then he accepted a pair of socks.

HOFF: Mmhmm.

FLEISCH: And then he allowed me to examine his feet.

HOFF: Mm.

FLEISCH: And then after seven years, he spoke in full sentences to me. And then he would refer my team to other individuals on the street who he was concerned about.

HOFF: Wow.

FLEISCH: And I would argue that we did offer the care that he needed, and we offered it at the pace that he needed it.

HOFF: Mmhmm.

FLEISCH: And so, I guess I think that we learned that some of the greatest obstacles on the street logistically are probably related to vision impairment or lack of dental care, hygiene needs.

HOFF: Mmhmm.

FLEISCH: But really, there is this constant competing choice of like, should I get my medicine or my food or my transportation or my housing or my health care? And for us, we did our street rounds in the morning, and we set aside two hours at the encampments. And when we did appointments, we had one-hour slots, no matter whether they were new appointments or follow-up appointments. And I guess while time spent doesn't necessarily correlate with good care, it was really important to us that we provided an adequate space to listen and to understand what our patients needed.

HOFF: Mmhmm.

FLEISCH: So, in that sense, I guess that's how I would say that it was how me and my team worked with our patients to ensure that the care that we offered actually aligned with the care that they needed.

HOFF: Mmhmm. Yeah, and I like the pointing out that it's not only the care that they need, but at the pace that they need it—

FLEISCH: Correct.

HOFF: —since developing that trust and that relationship is just as much a part of providing good care as actually handing out antibiotics or something like that.

FLEISCH: Mmhmm.

HOFF: That's very interesting. Finally, what should the health professions students or trainees who are interested in caring for people experiencing homelessness know?

FLEISCH: I think they should know that homelessness is not a short-term problem. It is a long-term problem, and it requires significant investment and long-term solutions. And we have to learn how to manage our own expectations. And I think particularly for medical students, we are basically training students to, in my opinion, to provide this really up-to-date, evidence-based care. But when it comes to income and insurance status and housing status, oftentimes that is actually what dictates the level of care or type of care that hospitals can logistically provide.

HOFF: Hmm.

FLEISCH: And so, when you're a student or a resident or even an attending physician, it can oftentimes feel like it's essentially counteracting this basic ethical principle of health care provision. So, I would encourage students who are interested in caring for persons experiencing homelessness to be creative when they're providing health care to resource-poor patients and that they need to be very thoughtful and considerate when they're thinking about medication cost and follow-up appointments. So like, does a clinic even take uninsured patients or Medicaid-only patients? Does that person have access to transportation? And if they're having a bad day themselves, they cannot let that bad day affect the person that they are treating because those five minutes or 10 minutes or 15 minutes that they spend with somebody may be the most important 10 minutes of that person's life.

FLEISCH: Hmm. [chill music returns] Well, Dr Fleisch, thank you very much for your time and for the work that you do.

FLEISCH: Thank you so much for having me. I really appreciate it.

FLEISCH: That's our episode for the month. Thanks to Dr Fleisch for joining us. Music was by the Blue Dot Sessions. To read our full issue on homelessness and health care, visit our site, JournalofEthics.org. And for all of our latest news and updates, follow us on [Twitter](#) and [Facebook @Journal of Ethics](#). We'll be back next month with an episode on diversity and justice in medical school admissions. Thanks for listening to *Ethics Talk* from the *American Medical Association Journal of Ethics*.