A Street Psychiatry Rotation for Medical Trainees: Humanizing the Care of People Experiencing Homelessness

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Despite an epidemic of homelessness in the USA, with approximately 568,000 people experiencing homelessness on a given night in 2019, medical trainees are often poorly equipped to address the needs of this population [1]. Trainees will inevitably encounter these individuals in their practice, but evidence shows that altruism decreases as trainees advance in their medical education and attitudes toward people experiencing homelessness become more cynical [2]. Only half of psychiatry residency programs offer clinical rotations with specific exposure to homelessness, and only 20% of residents actually participate in these [3]. A recent call to action frames the lack of medical training specific to homelessness [4]. Clinical electives offering community-based exposure to people experiencing homelessness are necessary to fill this important gap in medical education.

Educational experiences have the potential to improve trainee attitudes toward people experiencing homelessness. The Health Professionals Attitudes Toward the Homeless Inventory (HPATHI) assesses healthcare professionals' attitudes, interests, and confidence about working with individuals experiencing homelessness through a series of validated 5-point Likert scale questions. Family medicine residents demonstrated significant increases in the "social advocacy subscale" of the HPATHI after participation in clinical and enrichment activities related to homelessness [5]. Health professionals and trainees with more than 1 year of experience working with people experiencing homelessness had significantly higher HPATHI scores [6]. Physician assistant students who had worked previously with people experiencing homelessness scored higher on the HPATHI than those who did not

[7]. In another study, a larger proportion of residents in one program entered a public psychiatry fellowship after a rotation about homelessness was implemented, suggesting that trainees may even steer their careers toward community work after these rotations end [8].

"Street Psychiatry" is a model of mental health and addiction treatment delivery that brings services directly to those who make their homes on the street, who may lack access to mental health treatment through traditional routes. Mental health professionals have long understood the need to meet people with serious mental illness in the community, and Street Psychiatry aligns philosophically with the "Assertive Community Treatment (ACT)" model and other evidence-based community outreach models. Street Psychiatry specifically targets people experiencing unsheltered homelessness—those who sleep outdoors—due to their disproportionate vulnerabilities. This group suffers from mortality rates ten times higher than the general population, a high burden of serious mental illness and substance use disorders, and significant barriers to obtaining care [9–12]. Through regular engagement with a Street Psychiatry team, a trusting relationship creates a more welcoming, respectful, and collaborative space—both literally and figuratively on the patient's terms [13].

Street Psychiatry experiences have been implemented at several health professions training programs and existing educational offerings at Vanderbilt School of Medicine in Nashville, TN, Janian Medical Care in New York, NY, House of Hope in Providence, RI, and other programs were reviewed [14–17]. The Yale Street Psychiatry Elective, a rotation based at the Connecticut Mental Health Center in New Haven, CT, is a clinical experience for psychiatry residents, public psychiatry fellows, and other trainees. The learning objectives include developing familiarity with health systems, addressing social determinants of health, advocating for social justice, and enhancing empathy for marginalized peoples (see Table 1). We describe the Yale Street Psychiatry Elective's implementation and its evaluation through a pilot post-experience survey of early participants.

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Table 1 Learning domains, objectives, and corresponding Accreditation Council for Graduate Medical Education (ACGME) core competencies and curricular experiences

Domain	Learning objective of Street Psychiatry rotation	Corresponding ACGME core competencies and curricular experiences [18]
Integrated care and systems-based practice in a community setting	Navigate role on an interdisciplinary, integrated team; coordinate care across health settings and observe failures of traditional health and social service systems	<ol style="list-style-type: none"> 1. (Interpersonal and communication skills) Communicating effectively with physicians, other health professionals, and health-related agencies 2. (Interpersonal and communication skills) Working effectively as a member or leader of a healthcare team or other professional group 3. (Systems-based practice) Coordinating patient care across the healthcare continuum and beyond as relevant to their clinical specialty 4. (Systems-based practice) Working effectively in various healthcare delivery settings and systems relevant to their clinical specialty 5. (Curricular experience) Learning about and using community resources and services in planning patient care, as well as consulting and working collaboratively with case managers, crisis teams, and other mental health professionals
Structural and social determinants of health and health disparities	Develop clinical skills in non-traditional settings such as streets, park benches, and other public places that require an intimate understanding of the structural and social determinants of health as well as creative interviewing skills, diagnostic strategies, and reality-based solutions	<ol style="list-style-type: none"> 1. (Systems-based practice) Awareness of and responsiveness to the larger context and system of healthcare, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal healthcare 2. (Systems-based practice) Understanding healthcare finances and its impact on individual patients' health decisions 3. (Curricular experience) Resident experience in community psychiatry must provide residents with a cohort of persistently and chronically ill patients in the public sector, such as in community mental health centers, public hospitals and agencies, and other community-based settings
Advocacy and social justice	Advocate for social justice on individual and systemic levels to address disparities and empower marginalized communities	<ol style="list-style-type: none"> 1. (Systems-based practice) Advocating for quality patient care and optimal patient care systems 2. (Systems-based practice) Advocating for the promotion of mental health and the prevention of mental disorders 3. (Systems-based practice) Advocating for patients within the healthcare system to achieve the patient's and family's care goals, including, when appropriate, end-of-life goals 4. (Systems-based practice) Assisting patients in dealing with system complexities and disparities in mental healthcare resources
Empathy and engagement	Enhance empathic skills by witnessing, accompanying, and building relationships through outreach and engagement work with a challenging, diverse patient population	<ol style="list-style-type: none"> 1. (Professionalism) Compassion, integrity, and respect for others. 2. (Patient care and procedural skills) Forging a therapeutic alliance with patients and their families of all ages and genders, from diverse backgrounds and from a variety of ethnic, racial, sociocultural, and economic backgrounds

Implementation of the Clinical Elective

The piloting of this rotation began in 2017, as the first resident began shadowing an existing “Street Medicine” team—an outreach team providing primary medical care to people experiencing unsheltered homelessness [18]. In 2018, the rotation was formalized for residents and in 2019 was opened to

public psychiatry fellows. Trainees then began accompanying the newly hired Attending Psychiatrist and Licensed Clinical Social Worker (LCSW) in the community. The rotation was expanded to include nurse practitioner, social work, medical and undergraduate students, and psychology pre-doctoral fellows. Their roles vary based on the level of training (see Table 2) and include engaging individuals and conducting

Table 2 Examples of trainee roles

Trainee Level	Roles
Student (pre-clinical and clinical)	<ul style="list-style-type: none"> • Outreach and engagement: build relationships by offering basic needs items like socks, food, and water, and through respectful listening • Patient navigator: help connect with social services and accompany when interfacing with medical system • Assistance with medical workflow: complete vital signs, triage, and take notes
Resident and fellow	<ul style="list-style-type: none"> • Consultant to primary care provider or outreach staff: psychiatric guidance for diagnostic clarity, medication management, or housing • Primary provider of treatment: complete psychiatric evaluations, prescribe medications, engage in psychotherapy • Emergency triage: activate an appropriate crisis intervention • Continuity: follow-up in resident clinic, emergency department, or inpatient hospital

triage evaluations. This longitudinal experience is offered for 6-month or 12-month blocks, in which trainees attend approximately one street outreach session per week. During each 2–4-h session, trainees visit sites including encampments, soup kitchens, and the town green. Trainees join an interdisciplinary team including street medicine providers, case managers, people with lived experience, clinical social workers, and nurses. Group supervision with the Attending Psychiatrist occurs weekly.

It was essential to have the support of the Yale Department of Psychiatry Residency Program, which facilitated participation of resident trainees and provided important feedback. For example, the clinic's existing safety protocol for outreach was adopted to ensure the safety of trainees. Clinical protocols were developed to prepare for a psychiatric emergency. The role of the resident was further defined, to craft an experience that was less overwhelming. Feedback indicated that supervision should begin as “direct” with an attending present, while more experienced trainees could benefit from the autonomy of more “indirect” supervision.

Interest grew quickly from two trainees in each of the rotation's first and second years to ten participants in year three and sixteen in 2020–2021. New roles, such as Patient Navigator, were added to accommodate more trainees and encourage a diversity of experiences. A telehealth “Wellness Calls” program was also created, in which trainees made supportive phone check-ins with individuals who were moved from shelters to hotels due to COVID-19 measures.

Evaluation of the Clinical Elective

A pilot survey was designed based on the HPATHI in order to evaluate the trainees' experiences. Some questions were modified, and open-ended questions were added to better assess the learning objectives and qualitative impacts of the experience. The anonymous survey was offered to 11 of the 12 trainees who had enrolled in a rotation with Street Psychiatry in 2018–2020, with one trainee excluded due to

participation in only one outreach session, when the inclusion criterion was five sessions.

The survey data was collected using Qualtrics (Qualtrics, Provo, Utah) [19]. Each of the questions scored on the Likert scale was correlated to numbers (e.g., 1, strongly disagree; 5, strongly agree), with the scale reverse-coded for certain questions. The HPATHI is scored by taking the mean of all answers given by each participant, for a numerical result between 1 and 5. Higher scores indicate positive overall attitudes toward people experiencing homelessness. Due to the small sample size, a statistical analysis was not completed. Each response to the open-ended questions was reviewed and tallied in order to generate themes.

Survey Results

Seven participants—3 residents or fellows and 4 students—completed the survey and met the inclusion criteria. Four had participated in 31 or more outreach sessions, 2 had completed 11–20, and 1 had done 5–10. The overall mean Likert scale score was 4.44 (range 4.00–4.76).

There was strong agreement in 7/7 participants with statements about doctors' responsibility to address both the physical and social problems of people experiencing homelessness, financial resources being directed to people experiencing homelessness, and a social justice framework of medicine. All participants felt comfortable being part of a team and providing care to different minority and cultural groups. All but one trainee planned to work with underserved individuals in their future careers.

Qualitative responses revealed overall positive perception of the experience. Several themes emerged, which are described below, followed by several points of critical feedback.

Systems-Based Care on an Interdisciplinary Team

Several trainees commented on the value of the integrated and team-based care that was provided. One trainee learned “how

psychiatry and medicine in general are integrated with other social services.” Another reflected on the benefit of “Understanding how important it would be to connect them to a homeless team while they are in the inpatient or emergency setting, how important it would be to work with them to understand how they could possibly take medication safely, how important it would be to arrange for follow up the next day, [and] to see about supportive services like case management.”

Structural and Social Determinants

Trainees bore witness to the strained realities, harsh environments, and disparities experienced by those living on the street. They demonstrated a broad appreciation of the structural and social determinants of health. One observed that “Difficulty with transportation, lack of access to cell phones or other technology, difficulty in obtaining identification documents ..., stigma, [and] healthcare systems that are not flexible” were common barriers. Another felt they would be more likely to “ask more about the social determinants of health” when encountering individuals experiencing homelessness.

Social Justice and Career Direction

Several trainees commented on themes of social justice and expressed a desire to continue advocating for underserved populations in their careers. One trainee described, “The lack of universal healthcare system, means that individuals can’t just walk into any mental health provider or clinic for care. This means that the organizations that are meant to serve those that are on public health insurance are often overwhelmed and under-resourced to provide the intensive care that homeless experienced adults are facing.” Several trainees commented that they were interested in working with people experiencing homelessness when their training ends.

Empathy

Trainees were asked to work on the patients’ own terms rather than on the traditional terms of a clinic. They reported a better understanding of street-dwelling realities. One reflected upon “the helplessness that many of the patients likely feel.” Another summarized, “the biggest principle I will take forward is to meet people where they’re at, which means listening. It’s really easy in any sort of care provision to assume you know best.” Many had cultivated empathy for people experiencing homelessness, with one stating: “I’m sure I will be more compassionate, try to hear their stories.”

Critical Feedback

The post-experience survey also provided negative feedback that was essential to improving the rotation experience. Some respondents commented on a lack of direction or role clarity, desire for exposure to a greater variety of community sites, and a need for skills about working with specific populations, e.g., patients with history of trauma. One trainee suggested that “more formal ways of providing opportunities for assessment and follow up” would make the learning experience more focused. The program subsequently clarified roles and expectations for participants through a standardized orientation and implemented more opportunities for direct supervision. A potential drawback of direct supervision has been reduced clinical autonomy for the trainees, but the initial Attending presence appears to help orient trainees to the nuanced experience. Trainees are now encouraged to experience multiple outreach sites and are expected to follow patients longitudinally throughout the rotation. A seminar was created that teaches skills about engaging various sub-populations of people experiencing homelessness.

Discussion

The quantitative data from this pilot survey has limited ability to be compared with other HPATHI data due to both our small sample size and the fact that only 12 of the questions on our survey were taken from the HPATHI’s 19 questions. Our overall mean of 4.44 is slightly higher than the mean from first-year physician assistant students before exposure to any curriculum, which was 3.97 [7]. As a comparison, another study’s average HPATHI score for students and residents with more than 1 year working with people experiencing homelessness was 4.01 [6].

Our qualitative results demonstrate a positive overall experience and success in meeting the stated learning objectives. This rotation can be viewed as a valuable contribution to medical education by meeting several important Accreditation Council for Graduate Medical Education (ACGME) requirements specific to psychiatry resident education (see Table 1). Our qualitative results indicate fulfillment of our learning objectives and several core competencies and curricular experiences outlined by the ACGME, for instance, team- and systems-based care, social determinants of health, advocacy, and developing a therapeutic alliance [20].

Compared with other clinical rotations with exposure to people experiencing homelessness, this elective is unique because of its street-based approach in which all clinical encounters take place outdoors or in community settings. A lack of existing clinical experiences about homelessness in medical training makes this rotation timely and relevant. Our results

suggest that participating trainees are both prepared for and interested in entering careers dedicated to this population.

Limitations and Next Steps

This pilot study assessed the reflections of a small sample of trainees after completion of the rotation; future iterations will collect pre- and post-experience data with a larger sample. Selection bias may have played a role in the positive results, since those with a desire to work with people experiencing homelessness chose to participate in the elective. Not all participants in the rotation completed the survey. Additionally, participants who completed fewer than five outreach sessions were excluded from the study, but it would be important to understand reasons for early dropout. Future studies may help determine how many outreach sessions are minimally necessary to positively influence attitudes. Understanding the perspectives of those with lived experience will also be essential to optimize person-centered care.

Street Psychiatry is an innovative way to incorporate community-based mental healthcare for people experiencing homelessness into medical curricula. Through participation on integrated teams within complex systems, trainees are challenged to advocate at individual and community levels, develop an understanding of the structural and social determinants of health, and cultivate empathy while often being inspired to continue working with underserved populations. Now more than ever, it is critical that clinician-educators teach trainees about how to address the structural and social determinants of health in clinical settings and attract trainees into fields that target underserved communities. Transformative experiences like this one are imperative to creating a generation of empathic and structurally competent providers, who are empowered to eradicate healthcare disparity among people experiencing homelessness.

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Declarations

Disclosures On behalf of all authors, the corresponding author states that there is no conflict of interest.

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