STUCK ON THE STREET:

Lessons from Intensive Mobile Treatment

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Street Psychiatry Conference

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STEP BACK

Objectives

- What factors lead street clients to disengage totally or fall through the cracks?
- What is Intensive Mobile Treatment and how does it work to address the needs of this population?
- What IMT principles can be utilized in other street treatment settings?

Getting to know each other

Who is here today?

Where do we work?

Discussion Question

Think about a patient who has not been served by traditional models of care, who has been unwilling to accept the care you were offering, who feels stuck in an unsafe situation, or who has kept you up at night.

What factor(s) make that person so difficult?

Ways in which patients can fall through the cracks

- Unable to find them - transient
- Behavior that makes the individual unable to engage with teams or intolerable by teams
- Frequently jailed or hospitalized and thus lost among systems
- Aliases and other reasons for unclear medical history
- Medication non-adherence
- Standard medication treatments failed - “we don’t know what else to try”
- Diagnoses that don’t meet criteria for standard tx teams
- Unable to go inside due to paranoia
- Homeless but benign so they go undetected
- ID or DD with no suitable housing options
- Uninsured or Undocumented status
- Complicated Medical Comorbidities

Referral to IMT #1

43yo M, originally from Central America, undocumented, homeless for 15 years, level II registered sex offender, 8 state hospitalizations from 2002-2020, numerous other hospitalizations in civil hospitals, hx of schizophrenia, polysubstance use disorder, multiple arrests for violence including sexual violence in the community and in institutions. He did not take medications outside of institutions and his last team had great difficulty locating him.

Referral to IMT #2

42 year old man, living on the street for nearly a decade, and had been followed by a Manhattan Outreach team and a street medicine team. He had a history of complex PTSD related to childhood sexual and physical abuse, as well as carceral trauma, including history of solitary confinement. Pt has Crohn's disease with an ostomy, but was unable/unwilling to get proper medical care. He was noted to "weaponize" his ostomy when he felt threatened. Also significant substance use, including alcohol, K2, crack cocaine and opioids. There had been several attempts to get him into transitional residences, but he was unable to tolerate these settings and quickly dropped out each time.

WHY IMT?

New York City Initiative Aims to Help Mentally Ill People Who Get Violent

Advocates for homeless people praised the initiative but maintained that permanent housing should be addressed as well. Michael Appleton for The New York Times

By Nikita Stewart

Aug. 6, 2015

Mental health experts will fan out to New York City's homeless shelters, into the streets and to other places to treat mentally ill people who exhibit violent behavior, as part of an initiative announced on Thursday by Mayor Bill de Blasio.

The mayor said the goal of NYC Safe, a $22 million mental health initiative, was to aggressively reach mentally ill people prone to

sio, Facing Criticism, Is Taking melessness With $22 Million ve

n on Eighth Avenue in Manhattan in May. Spencer Platt/Getty Images

Grynbaum and Nikita Stewart

n has leapt from dinner parties to community boards to news, its implications echoing in the highest echelons of Why are there so many homeless people in New York?

y, Mayor Bill de Blasio is set to appear with his wife, Cray, to announce a $22 million mental health initiative inistration says will aid the homeless.

esident Kills Director of meless Shelter, Police Say

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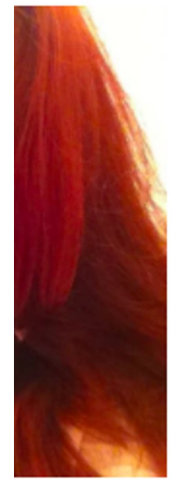

Ms. Charle in a photo from her Facebook page.

nt of a Bronx homeless shelter returned there bducted its director, forced her to undress in her s she tried to flee and then shot her in the street, officials said on Tuesday.

etectives that the victim, Ana Charle, 36, ran naked n the suspect, West Spruill, 39, who was also naked and opened fire.

ing but the shots," a police official, who spoke on anonymity to discuss a continuing investigation,

WHAT IS IMT?

- 100% grant funded mobile team
- Serving New Yorkers with complex histories of SMI, violence, and intractable homelessness for who all other tx teams have failed
- No diagnostic eligibility requirement or strict number of hospitalizations, etc
- Higher provider to participant ratio – 9 providers : 27 participants
- Open-ended with no time limitation
- Goal: to help people build relationships and lead a satisfying life

Service Eligibility	Service Description
Intensive Mobile Treatment (IMT): • 18 years of age or older • Reside in NYC shelter, live on the street or experience other housing instability in the NYC area • Recent and frequent interaction with mental health (MH) and criminal justice (CJ) systems • Recent behavior that is unsafe, and which is escalating or occurring with greater frequency • Traditional forms of care and support have not met needs of client or engagement has been unsuccessful	• Provides MH and substance use treatment, including medication and support to people with significant behavioral health (BH) concerns, complex life situations, transient living situations and/or involvement with CJ systems who have been poorly served by traditional forms of care • Teams are staffed by BH clinicians and peers • Typically operates during business hours with on-call availability for clients • Teams have variable frequency and duration of contact with their clients, depending upon clients' current needs
Assertive Community Treatment (ACT)*: • 18 years of age or older; *and* • Serious mental illness (SMI) diagnosis; *and* • Extended functional impairment due to mental illness; *or* reliance on psychiatric treatment, rehabilitation and support • Prior authorization required for people with Medicaid Managed Care	• Provides MH and substance use treatment, including medication and support • Staffed by BH clinicians and sometimes peers • Typically operates during business hours with on-call availability for clients • Sees clients six times a month
Shelter Partnered ACT (SPACT): • Meet above ACT eligibility; *and* • Reside in designated NYC MH shelter	• Same services as ACT; *and* • Teams work closely with Department of Homeless Services assigned shelters and provide services on-site as well as in the community
Forensic ACT (FACT): • Meet above ACT eligibility; *and* • Current or recent involvement in CJ systems within the last 12 months and due to SMI or noncompliance with treatment	• Same service as ACT; *and* • Staff are specially trained to work with people who have had current or recent interactions with the CJ system
Care Coordination: • 18 years of age or older • For individuals who are not eligible for Medicaid** • SMI with functional impairment • Not eligible for Medicaid • Not successfully engaged in community-based services • Need for ongoing supportive services	• Provides clients with a worker who assists them in achieving goals related to health, MH and overall wellness • Care Coordination does not provide treatment

Increasing Intensity

https://www.nyc.gov/assets/doh/downloads/pdf/mh/mobile-behavioral-treatment-care-coordination.pdf

*For more information, see the State Guidelines for ACT by visiting **omh.ny.gov** and searching for **ACT program guidelines**.
**For individuals with or eligible for Medicaid, referrals are made directly to the Lead Health Home that services the borough in which the individual resides.

Teams

Psychiatrist/Medical	Social Work	Case Management	Peer Specialist
• 0.5 FTE psychiatric provider • 1 FTE nurse	• 0.5 FTE PD • 0.5 FTE APD • 1 FTE Clinical Supervisor • 1 FTE SW	• 2 FTE case managers	• 1 FTE peer specialist • 0.5 FTE peer specialist supervisor

Where IMT goes

- Macro - NYC
  - Wherever the participant goes
  - NYC 5 boroughs
  - Geographical limitations of outreach teams, ACT, AOT
- Micro - individual
  - Wherever participants want to meet
    - On the street
    - In the community
    - At the IMT office, shelters, restaurants, laundromats
    - At appointments for housing, medical, ID cards, benefits
    - At hospitals
    - Jail

https://www.cucs.org/wp-content/uploads/2024/03/Reaching-the-Unreachable-IMT-Whitepaper.pdf.pdf

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https://doi.org/10.1007/s10597-024-01243-0

FRESH FOCUS

Reaching the Unreachable: Intensive Mobile Treatment, an Innovative Model of Community Mental Health Engagement and Treatment

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Abstract

In this paper we introduce the Intensive Mobile Treatment (IMT) model, which arose from a 2016 New York City initiative to engage individuals who were "falling through the cracks" of the mental health, housing, and criminal justice systems. People who are referred to IMT often have extensive histories of trauma. They experience structural racism and discrimination within systems and thus can present as distrustful of treatment teams. We detail the structure of the program as we practice it at our non-profit agency and outline the psychodynamic concepts that inform our work with challenging populations. We acknowledge IMT's role in engaging in advocacy and addressing social justice in our work. We also discuss how through this model we are able to both mitigate and tolerate risk in participants with difficult-to-manage behaviors. This is typically a long-term, non-linear process. We address how this impacts the team dynamic as a whole and explain how with long-term, trusting therapeutic relationships, participants can change and grow over time. We also explain the ways in which our non-billing model plays an integral role in the treatment we are able to provide and identify several challenges and areas

Teams: daily functioning

- Dynamic workflow, scheduling
- Safety
- Supervision
- 24-hour on-call line

CUCS IMT 2 Weekly Schedule

		On Call Staff:	Monday 10/17/2022 PD	Tuesday 10/18/2022 PD	Wednesday 10/19/2022 PD	Thursday 10/20/2022 PD	Friday 10/21/2022 PD
Last MD Appt	Last Name	First Name					
10/2/2022	Last Name 1	First Name 1			Field		Field
9/22/2022	Last Name 10	First Name 10	Office			Office	
9/26/2022	Last Name 11	First Name 11	Office / IM	Court (Man.)	Court (Man.)	Court (Man.)	Court (Man.)
9/7/2022	Last Name 12	First Name 12			Field		
10/5/2022	Last Name 13	First Name 13	Field (1pm or later)			Contact/plan tom.	Court (Bx)
10/6/2022	Last Name 14	First Name 14		Field	Field		
10/4/2022	Last Name 15	First Name 15	Contact				Field
8/16/2022	Last Name 16	First Name 16			Field	Office / Tru Link	
9/28/2022	Last Name 17	First Name 17		Field			
9/12/2022	Last Name 18	First Name 18	Field		Contact (invite to office)	Office / Contact	
10/11/2022	Last Name 19	First Name 19		IM			IM
10/6/2022	Last Name 2	First Name 2				VTC 10:30am	
9/22/2022	Last Name 20	First Name 20	Field (AM)		Field		
8/2/2022	Last Name 21	First Name 21			Field		
10/14/2022	Last Name 22	First Name 22	Field (AM)	Field			Field
9/8/2022	Last Name 23	First Name 23		Diligent Search / Canvass			
8/12/2022	Last Name 24	First Name 24		Field			Field
9/27/2022	Last Name 25	First Name 25	Field		Court (Bk)		Contact Mom
9/25/2022	Last Name 26	First Name 26		Field			
9/14/2022	Last Name 27	First Name 27					Field
10/13/2022	Last Name 3	First Name 3	Pick Up Call		Pick Up Call		Pick Up Call
9/28/2022	Last Name 4	First Name 4		Field			
10/6/2022	Last Name 5	First Name 5		Field		Contact	
9/8/2022	Last Name 6	First Name 6			Contact		Contact
9/15/2022	Last Name 7	First Name 7		Field (AM)		Office	
9/14/2022	Last Name 8	First Name 8	Lab Corps Appt 2:45pm				
9/8/2022	Last Name 9	First Name 9	Office? / IM	Field / IM back up		Office? / IM?	
		In Office	SW out 12pm-3pm SWI @ Training - TS 9:30-3:30pm	CS @ SIFI 11am-12pm	CS out 3pm-5pm		PSS @ Zoom Training 9:30-11:30am
		Supervision	CM	PSS, APD	SWI, PS, PD	SW, RN	CS, MD
		Notes	Team Meeting 3pm		SW in Training 3-5 Team Meeting 3:30PM	Team Meeting 3pm	

KEY
- Peer Supervisor (PSS)
- Nurse (RN)
- Program Director (PD)
- Case manager 2 (CM2)
- Psychiatrist (MD)
- Assistant Director (APD)
- Peer Specialist (PS)
- Social Worker (SW)
- Clinical Supervisor (CS)
- Social Work Intern (SWI)
- Case Manager 1 (CM1)

TEAMS: core principles of team functioning

- Shared caseload
- Flattened hierarchy
- Every team member's participation is essential
- Awareness of and willingness to discuss team dynamics
- Core values alignment

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10/6/2022	Last Name 2	First Name 2				VTC (Dr. Khan)	
9/22/2022	Last Name 20	First Name 20	Field (AM)		Field		
8/2/2022	Last Name 21	First Name 21			Field		
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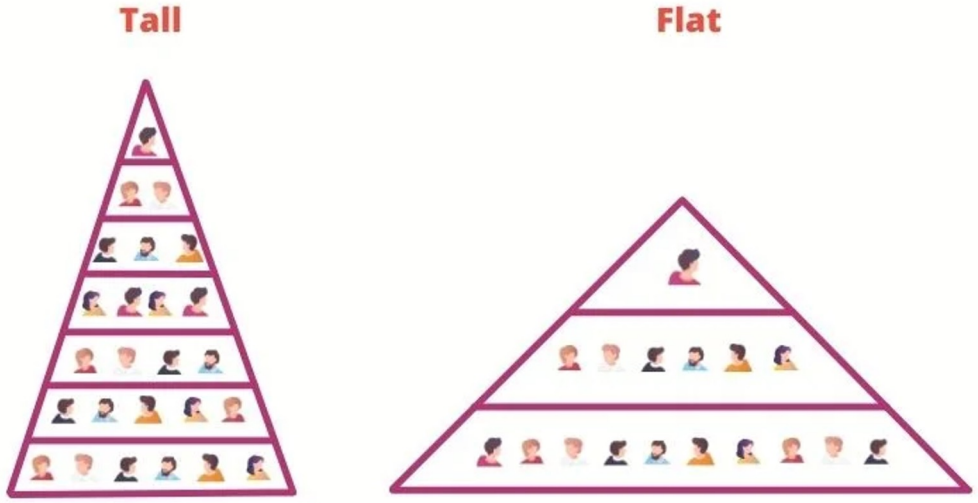


What can be learned from the IMT Model?

- Engagement takes time
- Core principles
- Role of the psychiatrist
- Object Relations approach

ENGAGEMENT

Patience

Autonomy

Dignity

Waiting for the right moment

Embracing social approaches

Core Principles of IMT

Treatment Principles

- The relationship is the Core of the treatment
- Treatment is for everyone
- Be practical, trauma-informed, person-centered and harm reducing
- Social Justice and Advocacy
- Risk tolerance

Team Principles

- Team integration
- Flattened hierarchy
- Psychiatrist fills varied roles
- Peers are critical team members

Harm reduction

- Motivational interviewing
- What does “any positive change” mean?
  - Expanding from the common approaches to reducing harm from substance use
  - Expanding this to other areas
    - medical care and prescribing
    - where people prefer to stay/live

Social Justice and Advocacy

Many staff, especially medical, come from identities of privilege

Maintain a perspective of humility and approach our work with curiosity, openness, and without judgment

Understanding Intersectionality but remembering the limits to how much we can understand

Multidisciplinary team provides a variety of perspectives

Address institutional inequality through advocacy and harnessing our privilege on behalf of our participants

Important to explicitly consider identity when making decisions (such as activating EMS)

Risk

1. Understanding threats as communication tools
    a. Responding in traditionally reactive ways, i.e. overreact, can break trust
    b. Pts who cause teams to underreact - ex: JC
2. Coordination of care and advocacy with crisis-based emergency service systems

1. Ongoing, dynamic risk assessment and **discussion** with the team
    b. fosters team unity
    c. allows all team members to feel safer
    d. risk shared among everyone on the team
    e. helps alleviate moral injury

Role of IMT Psychiatrist

Not just a prescriber!

Psychiatric Care	- Assessment, Psychotherapy & Psychopharmacology - Harm Reduction (MAT, FTS, Prep, birth control) - FLEXIBLE and CREATIVE - Work-arounds for Imperfect Adherence - Psychotherapy Modifications: low fidelity psychotherapy is better than no psychotherapy at all!
Clinical Leadership	- Partnership with IMT program directors - Promoting evidence-based practices on the team - Managing clinical crises - continuing education & clinical trainings
Clinical Coordination & Advocacy	- Coordination with outside providers - ”glue” during Care Transitions - leveraging our role and network to help participants access appropriate care - Identifying barriers and advocating when systems are unfair, racist, outdated, or simply too complicated
Medical and Psychiatric Co-Integration **”Primary Care Psychiatry”**	- Holistic approach - Limited access traditional medical care - Partnership with the IMT nurse and community providers Care might encompass: - Triaging medical concerns - Administering medical treatments (GLP-1s) - First aid and wound care - Bridging prescriptions

Psychiatric care

- Can deviate from usual standards of care since they haven't worked

- Harm Reduction (MAT, Fentanyl Strips, prophylaxis)

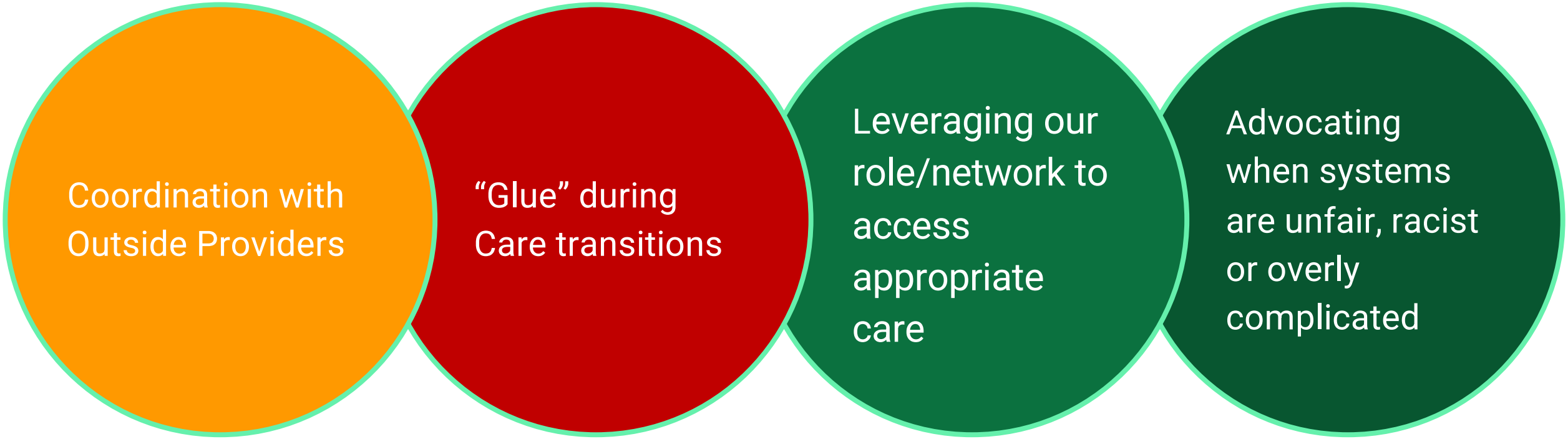
- FLEXIBLE and CREATIVE

- Work-arounds for Imperfect Adherence

- Psychotherapy Modifications: low fidelity psychotherapy is better than no psychotherapy at all!

Clinical Leadership

Clinical Coordination & Advocacy



Primary Care Psychiatry

Principles

- Holistic approach
- Reducing Barriers
- Filling in when access to traditional medical care is limited
- Partnership with the IMT nurse and community providers

Care Might Encompass

- Triaging medical concerns
- Administering medical treatments (GLP-1s)
- First aid and wound care
- Prophylaxis (PrEP, birth control)
- Bridging prescriptions
- Seeing the “big picture” when many specialists are involved

Object-relations and the psychodynamic frame of IMT

- Participants – disenfranchisement, rejection, difficult relationships, including therapeutic relationships
- IMT: building deep, long-term relationships
  - Can practice reciprocity, build interpersonal skills, have corrective attachment experiences
    - This ripples out into other areas of their lives
  - Therapeutic alliance
    - Unconditional positive regard
  - IMT becomes a safe holding environment
    - Where psychological phenomena can be experienced and resolved
    - Transferences are shared and processed among all team members
      - Positive regard can be maintained, burnout reduced

Building Treatment Relationships

- Initial interactions focus on building a treatment relationship, establishing trust, and addressing immediate survival needs
  - Beginning relationship may be transactional in nature,
    - still allows to align around “what is important”
  - Reliability and consistency are key
  - Staying non-judgmental while maintaining boundaries
- Staff practice compassion and flexibility
  - Don’t take things personally

Boundaries And Limit Setting

Individualized, consistent boundaries on a team level

- No racist, sexist, or discriminatory language
- No violent or threatening language or actions
- No physical or sexual aggression

When boundaries are broken, we work towards repair

- Team consistency in upholding limits around infractions
- Ways of finding a road back to reconciliation while maintaining safety
- Natural consequences for infractions

Boundaries & Limit Setting Principles

- **Transparency** – limits are most successful when participants understand why we are setting them
- **Consistency** – limits will not be effective if they are not enforced by the entire team
- **Collaboration** – limits will be most effective when the participant has input into their application (such as coming up with a list of agreements)

What principles can be applied?

- Treatment is for anyone
- The relationship is the core of the treatment
- Accountability and longitudinal care
- Social Justice and Advocacy
- Risk tolerance
- Treatment is flexible, practical, person-centered, and harm-reducing
- Psychiatrists can step out of traditional roles to improve overall care

Revisiting Referral #1

43yo M, originally from Central America, undocumented, homeless for 15 years, level II registered sex offender, 8 state hospitalizations from 2002-2020, numerous other hospitalizations in civil hospitals, hx of schizophrenia, polysubstance use disorder, multiple arrests for violence including sexual violence in the community and in institutions. Referred to IMT due to inability to engage, medication non-adherence, high-risk status, and transience.

- **three years in and out of jail and hospitals, absconds from TLR**
- **ongoing med non-adherence, ends up hospitalized and offends again, sent to state hospital**
- **state hospital wants to dc to TLR but team expresses concern given hx**
- **team calls OMH high-risk case conference, leading to assignment to Aurora House, AOT, mandated sex offender therapy, weekly meetings w residence, IMT, AOT**
- **Pt flourishes and maintains meds, comes to office twice a week**

Revisiting Referral #2

42 year old man, living on the street for nearly a decade, and had been followed by a Manhattan Outreach team and a street medicine team. Mr. K had a history of complex PTSD related to childhood sexual and physical abuse, as well as carceral trauma, including history of solitary confinement. Pt has Crohn's disease with an ostomy, but was unable/unwilling to get proper medical care. He was noted to "weaponize" his ostomy when he felt threatened. Also significant substance use, including alcohol, K2, crack cocaine and opioids. There had been several attempts to get him into transitional residences, but he was unable to tolerate these settings and quickly dropped out each time.

- **initial attempts at MAT (suboxone) were challenging**
- **more traction when team started to help pt access ostomy bags**
- **pt arrested in for attempted murder, then pandemic**
- **psych and team advocated for patient at Rikers to get MAT and proper medical care**
- **pt released with ankle monitor, team helped with court appearances**
- **pt was acquitted**
- **accepted housing**
- **started Brixadi**

Takeaways

- Building trust takes time and is highly individualized
- Using our positions with humility and also asserting ourselves to advocate
- Bringing flexibility, creativity, practicality, and patience to our work
- Expanding the scope of harm reduction and psychiatrist roles
- Building team unity through non-hierarchical, collaborative team dynamics
  - assuming risk and understand object relations functions together

Discussion

Questions? Comments? Thoughts?

Thank you

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Reaching the Unreachable: https://pubmed.ncbi.nlm.nih.gov/38485797/