

Building a Sustainable Street Psychiatry Framework: The Sulzbacher Program in Jacksonville

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Short Report

Keywords: Street psychiatry, Street medicine, Homeless, Unsheltered homelessness, Serious mental illness, Implementation

Posted Date: September 30th, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-10988967/v1>

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Additional Declarations: No competing interests reported.

Abstract

Individuals experiencing unsheltered homelessness and severe mental illness face compounding systemic barriers, limiting the effectiveness of traditional clinic-based psychiatric models. This paper outlines the operational framework of the Sulzbacher Homeless Outreach Project Expansion (HOPE), a transdisciplinary street psychiatry program serving Northeast Florida for over two decades. Operating out of a Federally Qualified Health Center in Jacksonville, the HOPE team integrates direct psychiatric care, case management, basic needs provision, and medical trainee education directly in the field.

Despite systemic funding challenges, particularly in a state without Medicaid expansion, the program sustains itself through a hybrid financial model. This relies on municipal grants, continuous political advocacy, philanthropy, and specialized medication access programs. Continued funding depends heavily on rigorous data tracking to demonstrate program efficacy to local stakeholders.

Clinically, the program utilizes a trauma-informed methodology centered on three core objectives: Relationship, Reconnection, and Recovery. Emphasizing the need to overcome patients' prior negative experiences with healthcare and law enforcement, the model prioritizes building authentic trust and utilizing outreach workers with lived experience. Recovery is defined holistically, focusing on housing acquisition, community reintegration, and social empowerment rather than merely psychiatric symptom reduction. Ultimately, the HOPE framework demonstrates that effective street psychiatry must transcend traditional clinical boundaries to address profound isolation, prioritizing the humanity, dignity, and social reconnection of highly marginalized individuals.

Introduction

Untreated mental illness among the homeless population exists at the intersection of multiple systemic failures. A lack of affordable housing, low wages, and poverty have displaced vulnerable individuals with psychiatric conditions, pushing them into street homelessness where they face compounding health risks (Stern, 2026). The 2024 Supreme Court decision in *Grants Pass v. Johnson*, which effectively criminalized homelessness by allowing cities to penalize people for sleeping in public spaces, has further marginalized this population while leaving underlying mental health needs unaddressed (Hartung, 2026).

Individuals with severe mental illness (SMI) face a significantly higher risk of unsheltered homelessness. The prevalence of psychotic spectrum disorder among people experiencing homelessness is 14%, far exceeding 0.4% in the general population (Barry et al., 2024). Active symptoms of psychosis, such as paranoia or persecutory delusions, can precipitate the loss of permanent housing or lead to exclusion from shelter programs (Lewczyk, 2025). Other common mental health diagnoses in this population are substance use disorder, major depression, other mood disorders, and PTSD. Importantly, the experience of homelessness often encompasses chronic stress, exposure to violence, and the interruption of sleep and basic self-care- which all have negative effects on mental health (Padgett, 2020).

Traditional shelters are often ill-equipped to accommodate this population; the environments can be chaotic, lack secure storage for medications, and enforce strict behavioral or substance use policies that create insurmountable barriers to entry for the sickest individuals (Tsai et al., 2024). Individuals experiencing unsheltered homelessness with comorbid mental illness are subsequently cut off from relationships of care, accelerating the decline of both mental and physical health (Wang et al., 2023). The path to securing and maintaining housing requires adequate psychiatric care that meets them where they are (Rafla-Yuan et al., 2024).

Street psychiatry outreach programs serve this critical function through direct provision of mental health care to the unsheltered homeless where they live (Koh & Reilly, 2026) (Lo et al., 2021). This approach allows for consistent therapeutic relationships and medication management that improve treatment adherence, stabilize symptoms, and create pathways to housing (Christensen, 2009). These efforts aim to break the cycles of emergency department visits, incarceration, and premature mortality that too often characterize untreated mental illness in homeless populations.

The Sulzbacher Homeless Outreach Project Expansion project addresses these needs through a model that prioritizes building trust and reestablishing connection to a larger community. Despite the demonstrated need for street psychiatry, there remains a lack of literature on the operationalization of such programs. This framework details over 20 years of street psychiatry outreach in Northeast Florida and provides key takeaways on our approach to treatment and longevity.

Program Structure

The HOPE (Homeless Outreach Project Expansion) teams are transdisciplinary street outreach units working to engage and bring services to persons experiencing homelessness. Two teams operate out of the Sulzbacher service center, a shelter and FQHC in Jacksonville, Florida. One of these teams focuses on outreach in urban Jacksonville, while the other serves the communities of Jacksonville beach, Neptune beach, and Atlantic beach.

The team has consisted of case managers, medically trained staff including nurses, MA's, or EMTs, and a psychiatrist (see Fig. 1 for timeline details). Currently, due to funding constraints, the HOPE team serving urban Jacksonville consists of one case manager and a psychiatrist. The model of care utilized by the team emphasizes shared responsibility in the assessment and treatment of individual clients. It also requires close communication between team members and integration with other community partners.

Since the first psychiatrist went out on HOPE in 2004, trainees have been present. Medical students and psychiatry residents rotate with the team and participate in street outreach. Prior research has shown that street-based clinical electives are effective in teaching trainees to address social determinants of health and improving empathy and structural competency (Lo et al., 2022). The incorporation of trainees into the HOPE team has long been a pillar of the program.

The HOPE team goes out on street psychiatry outreach trips one day per week. The case manager goes out 4 days a week, providing meals and consistent engagement with patients. Common initial items of engagement included packed lunches, cold water bottles, hygiene items, and clothing. For individuals open to staying in a shelter bed, we offer one of 10 beds at Sulzbacher reserved specifically for HOPE clients. Other social needs may include help obtaining identification documents, bus passes, and employment/education assistance.

Medication management is also a critical part of the services provided, although many individuals are not ready to engage in treatment on initial visits. Some are eventually able to be seen at the Duval Family Health Center (DFHC) ambulatory behavioral services clinic, the FQHC which is co-located with the Sulzbacher shelter, while others require continued treatment in the field by the mobile Street Psychiatry team.

Funding Structure

Securing and maintaining funding for this program requires a mix of government support, philanthropy, and ongoing advocacy (Gorman et al., 2026). The bulk of the HOPE program is funded by a grant from the City of Jacksonville. While this grant initially covered the costs of the program, it has not increased in amount even as program costs—primarily staff salaries and benefits, along with operational expenses—have grown over the years. The remainder of our funding is sourced through philanthropy, including fundraisers and direct mail campaigns. To make sure the program stays a priority to the city council and other decision-making bodies, Sulzbacher’s CEO meets with every member of City Council individually every year to discuss the importance of homeless initiatives and how critical it is that the City plays a role in addressing homelessness. She also serves on the Mayor’s Homeless Task Force and advocates as needed during City Council or Committee meetings. Furthermore, Sulzbacher distributes press releases for major events, stays active on social media, and invites the City Council to Sulzbacher every year to prepare and serve a meal to homeless clients as a team-building and volunteer activity.

The HOPE team does code for visits on the street so that if patients have insurance, it can be billed. However, the vast majority of our patients are uninsured. Most do not qualify for Medicaid, as Florida is one of the few remaining state legislatures who elected to deny Medicaid expansion. As such, reimbursement through public and private payers is not a significant source of funding. We rely on the city grant as well as overages collected from HRSA on all other clinic visits at DFHC. Regarding medications, in the unlikely case that patients are insured, we partner with a local pharmacy to get them ordered and delivered to the street team. The bulk of our medications come from Direct Relief or are ordered at a very discounted rate through HRSA’s 340B program. Another option if necessary is ordering medications directly through patient assistance programs with individual drug companies.

Critical in sustaining the program over the long term is the ability to consistently demonstrate measurable success. Government and philanthropic funding is contingent on proof of effectively meeting our proposed outcomes. Last year, the HOPE outreach team provided health outreach services

to 2,412 homeless persons. The team also facilitated client engagement by providing hygiene kits, water, socks, coats, blankets, and other necessities to 2,171 clients. For long-term sustainability, outreach programs must rigorously track impact in this manner. Figure 2 below provides more data on patients seen on HOPE outreach and illustrates the dip in engagement during the COVID-19 pandemic.

For programs looking to gather funding to start similar initiatives and begin grant writing, there are a few key places to start. First, engage with the local government to see what funding there may be available and to ascertain governmental interest in such activity. Second, contact the local Community Foundation. Community Foundations are tax-exempt public charities that pool donations from many funding sources (usually private individuals or family/small foundations) to support and improve the quality of life in a specific geographic area. Third, investigate what local agencies and non-profit organizations may already be engaging in homeless outreach or community mental health, or who may be interested in partnering due to a common interest.

Considerations for Psychiatric Treatment on the Street

Our approach to treatment was pioneered by the late Dr. Richard Christensen, whose sentiment for those most marginalized by society was embodied in the words “I see you, I hear you, you are not invisible” (Christensen, 2015). We conduct meaningful psychiatric street outreach founded on the interrelated objectives of relationship, reconnection, and recovery.

Relationship

Building a relationship of trust between outreach workers and individuals on the street requires a patient, open-minded, and flexible approach. First encounters and in many cases, repeated encounters, may be met with suspicion and distrust. In addition, in many municipalities, homeless encampments are sought out and swept by local law enforcement. As a result, individuals who stay in urban encampments may hesitate to reveal their location. Teams must also be mindful of their presence on street corners or at entrances to wooded areas, which may attract unwanted attention. To this point, smaller teams are often more effective and perceived as less intrusive.

Another element of successful outreach is the recruitment of outreach specialists with lived experience of homelessness and housing instability. Having walked a similar path, these individuals can build authentic trust and navigate complex emotional barriers that traditional staff might struggle to overcome (Mangan et al., 2024). Furthermore, employees with lived experience often demonstrate higher long-term retention rates (Aykanian et al., 2026). A deep personal commitment to the mission and realistic understanding of the outreach environment helps to reduce turnover. This allows for longitudinal engagement with individuals on the street.

Outreach workers must also take a trauma-informed approach. Many individuals with chronic severe mental illness have negative experiences with psychiatry, not limited to involuntary hospitalization and

coercive treatments. Traditional mental health services may even be perceived as retraumatizing due to a narrow focus on psychopathology and biological treatment, and a minimization of the impacts of trauma and an individual's lived experience (Mihelicova et al., 2018). This is compounded by damage caused by incarceration and encounters with law enforcement, as individuals displaying signs of mental illness are disproportionately more likely to encounter violence from law enforcement individuals (Saleh et al., 2018).

We must keep in mind that psychiatric staff and outreach workers may be perceived by the people we want to help as agents of incarceration and the loss of their autonomy. Just as individuals experiencing homelessness and mental illness face social stigma from many in the community, psychiatric street providers must be aware they may be viewed through a lens of prior negative experiences. In this unique context, initial street encounters should focus exclusively on building a relationship. The primary goal is to ensure an individual will be open to reengaging with the treatment team by listening deeply and emphasizing a partnership on equal footing. Only then is psychiatric treatment planning discussed.

Reconnection

Chronically homeless and mentally ill individuals living on the street are estranged in many ways from the community. They experience rejection and ostracization daily. Unmet basic needs, a need for constant vigilance, exposure to environmental hazards, and physical and sexual victimization all further traumatize these individuals and make it harder to reform connections to others (Omerov et al., 2020). Our approach prioritizes reconnection into social networks, starting with the treatment team and a larger community of care at the shelter/clinic. People experiencing homelessness describe supportive relationships with care professionals as essentially social interactions, involving shared vulnerability, laughing together, and attention to the details of their lives (J. Biederman et al., 2013). This step of re-establishing a tether to a welcoming and compassionate community is essential for beginning to heal the effects of extreme ostracization.

Recovery

Recovery for our patients involves maximizing self-efficacy, growth potential, dignity, and facilitating the return of meaningful social roles and relationships (O'Shaughnessy et al., 2024). To this end, an integrated and holistic treatment approach is necessary. For the typical patient encountered by our street psychiatry team, mental health recovery is dependent more on attaining housing, gaining control over substance use, and building positive social ties than purely achieving psychiatric symptom reduction.

Conclusion

Over the past 22 years of work, we have found that effective street psychiatry must extend far beyond traditional clinical boundaries to address the profound isolation and trauma experienced by the

unsheltered community. By grounding our approach in relationship, reconnection, and holistic recovery, we prioritize the humanity and dignity of every individual we encounter. In addition to a reduction in psychiatric symptoms, street outreach must emphasize the restoration of trust, the rebuilding of community tethers, and the empowerment of marginalized individuals to reclaim meaningful, visible lives.

Declarations

Funding Statement:

This research received no specific grant from any funding agency.

Author Contribution

P.P. wrote the main manuscript text and prepared figures. A.T. led the project, provided analysis, and reviewed the manuscript.

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Figures

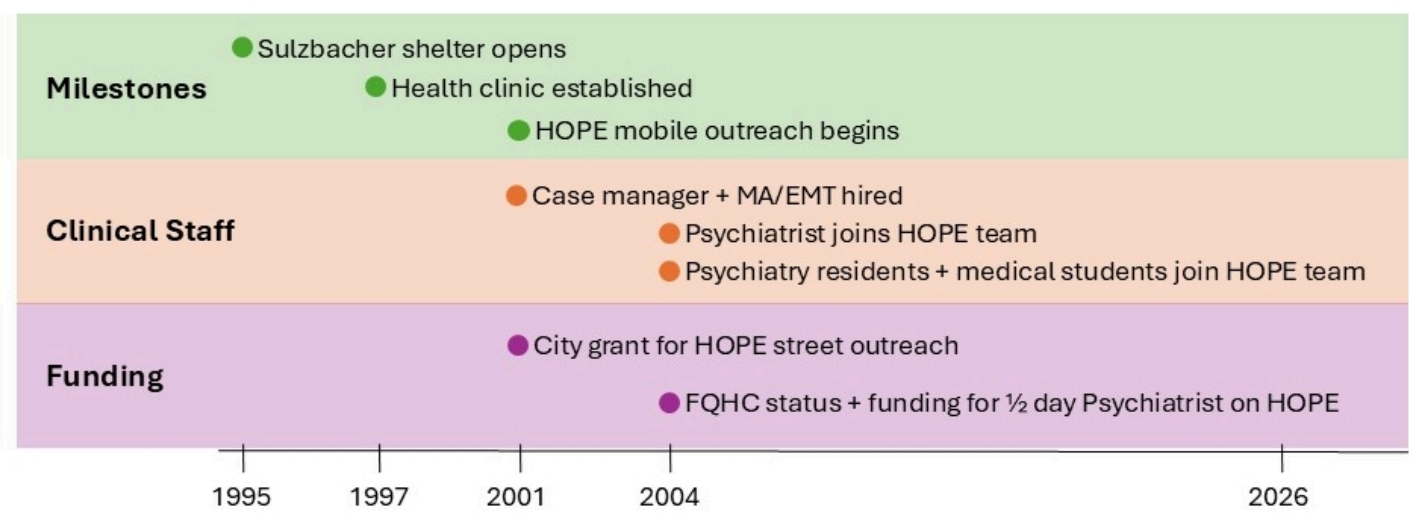


Figure 1

Timeline of HOPE Street Psychiatry program operations

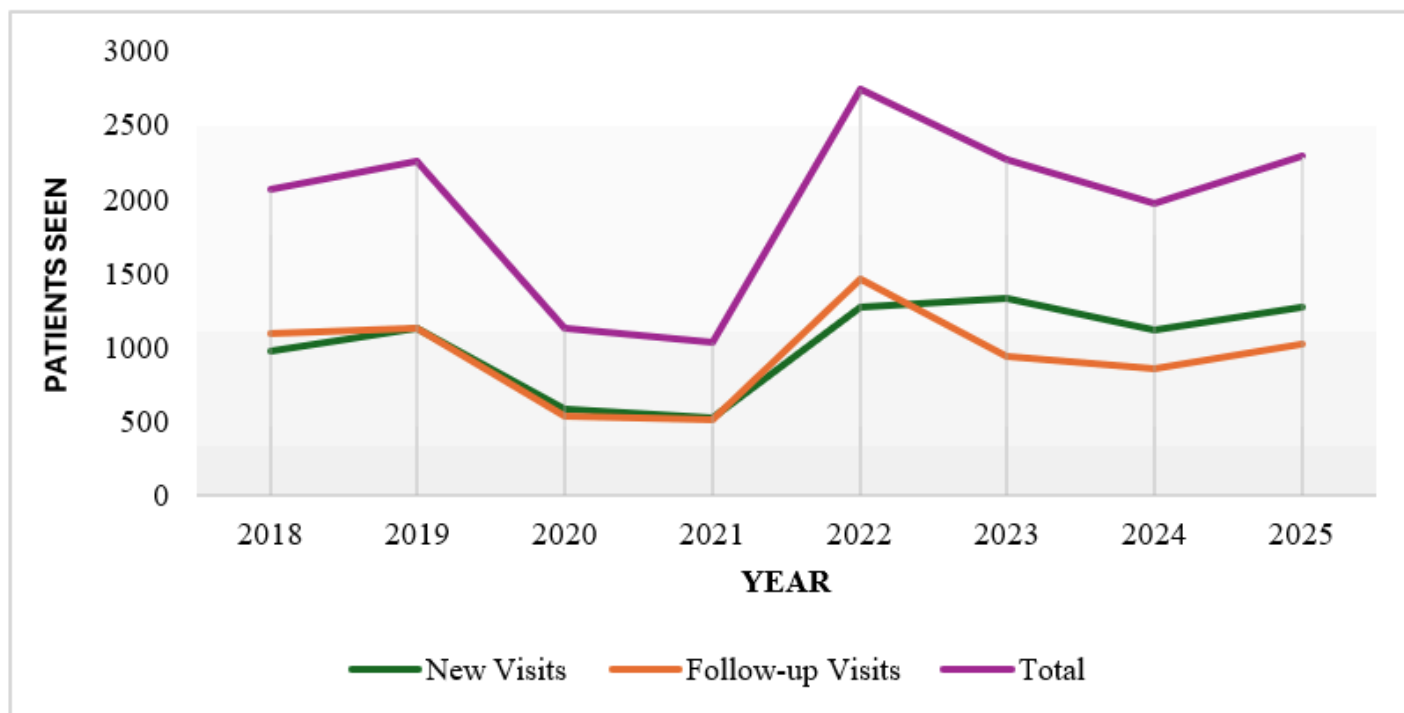


Figure 2

Patients seen on HOPE Outreach