Frontline Reports

A Mobile Buprenorphine Treatment Program for Homeless Patients With Opioid Use Disorder

National opioid-related overdose deaths have increased dramatically, from 2.9/100,000 people in 1999 to 13.3/100,000 people in 2016. Opioid overdose deaths are particularly high in homeless populations and are a leading contributor to the increased mortality rate among homeless versus housed individuals. Oakland, California, serves as a microcosm of these issues, in that homelessness has increased 21% in the past 2 years and opioid-related emergency visits are the highest in Alameda County. To address the barriers that prevent people experiencing homelessness from accessing office-based buprenorphine treatment, Alameda County Health Care for the Homeless developed a low-barrier, mobile buprenorphine program in 2018.

After conducting a literature review and stakeholder interviews, we reviewed the historical antecedents of homelessness to ensure nonjudgmental interactions with patients. Systemic racism and socioeconomic inequality—housing segregation, punitive drug policies, income inequality, and community violence, among other influences—have resulted in community trauma that is pervasive in homeless populations. In Oakland, homelessness disproportionately affects people who are African American. This background provided the foundation for all components of this program.

Flexible policies were key to addressing common barriers to buprenorphine treatment, such as physical constraints, strict inclusion criteria, medication diversion concerns (sharing of prescription medication), and financial concerns. We implemented street inductions to circumvent logistical brick-and-mortar clinic limitations and avoid creating transportation burdens. We excluded patients from buprenorphine treatment only if medically necessary. In those cases, we provided referrals and offered transportation to clinic appointments. Adolescents and pregnant women were immediately referred. Otherwise, we considered referrals only when concerned about liver disease or heavy, chaotic benzodiazepine and alcohol use. Patients experiencing homelessness are often deemed ineligible for buprenorphine treatment because of concern about medication diversion. While prescribers must consider this possibility when utilizing controlled substances, strict urinary toxicology screen requirements can act as a barrier to treatment. Rather than completing this screen in the field, patients completed one in the clinic at follow-up. We further prevented diversion by consulting the Controlled Substance Utilization Review Evaluation System (CURES). If diversion was suspected, we shortened the prescription duration and requested a count of remaining medication films rather than terminating treatment.

The next goal was to ensure medication access through insurance assistance and pharmacy partnerships. We either activated patients' Medicaid insurance or accessed a county emergency fund until insurance could be obtained. Even with insurance, patients experiencing homelessness often face discrimination and logistical barriers at pharmacies (e.g., lack of photo identification). Therefore, we partnered with community pharmacies to set up buprenorphine stocking and patient identification agreements, and we distributed transit passes or arranged direct transportation to the pharmacy.

Our patient engagement strategy was to meet patients where they were. We did this by employing clinicians who regularly visited homeless encampments, including a 0.4 full-time-equivalent (FTE) psychiatrist, a 1.0 FTE nurse care manager (NCM), and a 1.0 FTE outreach worker. The initial target population of this program included three stable encampments, two of which had known opioid use concentrations. One formidable barrier to providing buprenorphine to patients experiencing homelessness is the need for a reliable means of communication and follow-up, and scheduled visits to these encampments allowed us to meet clients where they live. Prescribers met and counseled interested patients and offered referrals to support groups and therapy. We followed up with patients within 1 week in the field or clinic, with the time frame determined by clinical need. The NCM also maintained cell phone availability for the follow-up interval. Whenever possible, we linked patients to brick-and-mortar clinics for follow-up and comprehensive services.

Finally, the harm reduction principles of reducing negative outcomes for and respecting the rights of people who use drugs are integral to the ethical foundation of this program. Overdose prevention was thus an important consideration in program design, and to this end we partnered with a harm reduction organization to provide naloxone and track its use. We also connected with emergency departments to help in the event of an overdose reversal.

Clearly, traditional buprenorphine delivery models do not reach some patients who are most in need. This program was designed to address the barriers preventing buprenorphine access for patients using opioids and experiencing homelessness. We have prescribed buprenorphine for 21 such patients through this program. We are in the process of formally evaluating the preliminary reach and efficacy of this program to ensure the highest-quality care for these homeless individuals with opioid use disorders.

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Psychiatric Services 2019; 70:635–636; doi: 10.1176/appi.ps.70701

A Justice and Mental Health Collaborative in Lubbock County, Texas

There is a tremendous need for coordinated, accessible mental health services for people with serious mental illness who are in contact, or at high risk of involvement, with the criminal justice system. Despite inadequate equipment and personnel, the Texas criminal justice system increasingly provides care for individuals with serious mental illness. Lubbock County Detention Center (LCDC) serves as a regional hub for inmate detention in rural west Texas, providing criminal justice and mental health services across a 250-mile radius. Nearly 50% of LCDC inmates have a history of mental illness. To address gaps in care for justice-involved individuals with serious mental illness, LCDC, Texas Tech University, Texas Tech University Health Sciences Center, and Starcare (a mental health regional provider) formed a justice and mental health collaborative (JMHC). JMHC first identified community organizations and collaborators who could contribute to a continuum of mental health care and services. In October 2017, JMHC received a U.S. Department of Justice (DOJ) grant to evaluate efforts to reduce recidivism, divert individuals with serious mental illness from jail into treatment, and establish continuity of care.

JMHC goals are to build a collaborative infrastructure, develop analytic capacity for mental health data, and reduce the number of people with serious mental illness in the criminal justice system. JMHC has formalized existing connections between the criminal justice and mental health systems. Collaborators are from the police department, local courts, the district attorney's office, the probation system, the private defender's office, the veterans' mental health agency, emergency medical services, and local inpatient mental health and medical facilities. Initial meetings encouraged collaborators to discuss their organizational capacity to manage individuals with serious mental illness and how each organization fits into the larger criminal justice and mental health systems. A system map was developed to identify gaps in definitions, network structure, and information sharing. Mental health definitions varied widely by organization, including a gap between the legal definitions of mental health competency and clinical mental diagnosis criteria. JMHC established a common serious mental illness definition for DOJ grant reporting. Organizations will report information to JMHC based on the common serious mental illness definition yet maintain autonomy to provide client services according to their internal mental health definitions.

With JMHC, organizations are working together for the first time, using networks they've established to address issues formerly handled by informal individual contacts. For example, 911 emergency dispatchers and first responders noted training and process gaps for handling mental health calls, identifying the appropriate responding agency, and deciding where to transport individuals with serious mental illness (medical emergency room, mental health crisis facility, or jail). JMHC is organizing first-responder training conducted by clinical professionals to bridge this gap.

Obtaining valid data about individuals with serious mental illness was problematic because of issues with data reliability, varying data structures produced by different agencies, and poor technical support for data acquisition. The data infrastructure was not built for research and lacks capacity to track individuals with serious mental illness. A major gap in records was a separately held diagnosis file. The booking system now includes a flag for individuals with serious mental illness that will aid long-term tracking and analysis of trends for that population. Many detained individuals have co-occurring substance use disorders, but lack of screening has prevented a full understanding of the clinical picture. As a result, LCDC implemented substance use disorder screening for all individuals who disclose substance use. When the county data vendor unexpectedly changed in 2018, JMHC began creating a historical data warehouse and will collaborate with the new software vendor to establish a data infrastructure conducive to analyzing and tracking at-risk populations.

Because of barriers in data acquisition, academic partners have prioritized formalization of JMHC across agencies and creation of a shared serious mental illness definition. Efforts toward development of a more robust data infrastructure will also facilitate better tracking of the population of individuals with serious mental illness.

Through communitywide collaboration, JMHC identified system gaps and proposed practical solutions for improving system integration between criminal justice and mental health care. We continue to qualitatively and quantitatively evaluate these systems in Lubbock County and look forward to reporting on future progress toward our goals.

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Psychiatric Services 2019; 70:636; doi: 10.1176/appi.ps.70702