

## Frontline Reports

The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Materials submitted for the column should be 350 to 750 words long, with a maximum of three authors (one is preferred) and no references, acknowledgments, tables, or figures. Send material to Francine Cournos, M.D., at the New York State Psychiatric Institute (fc15@cumc.columbia.edu) or to Stephen M. Goldfinger, M.D., at SUNY Downstate Medical Center (smgoldfingermd@aol.com).

### Electronic Psychiatric Consultation in Primary Care in the Safety Net

In the U.S., most people with mental illness do not get adequate treatment, primarily because they lack access to care. Many primary care clinics within a safety-net setting (providing services to uninsured patients, Medicaid enrollees, or especially vulnerable patients) lack the resources to fully embed psychiatric specialists in their practice settings. To provide timely access and appropriate triage for a broad array of specialty services, Zuckerberg San Francisco General and the University of California, San Francisco, created eReferral, a Web-based referral and consultation system. The system facilitates communication and coordination among primary care practitioners (PCPs) and specialists, with the goals of enhancing primary care capacity and improving access to specialty care. PCPs initiate specialty referral and consultation requests through the eReferral portal (housed in the existing electronic medical record [EMR]). Specialists review and respond to each request. eReferral has decreased wait times for specialty care visits through increased comanagement of care with PCPs. Although similar models have been used effectively in dozens of specialty services across the country, these types of programs have yet to be described for psychiatric care.

We examined the feasibility and acceptability of implementing a psychiatric eReferral program in a publicly funded, community-based primary care clinic in San Francisco staffed by eight PCPs. This clinic is open to pilot projects and was an early adopter of a new EMR with embedded access to the eReferral platform. The consulting psychiatry team (a primary psychiatrist and assistant licensed therapist) reviewed the consultation requests and identified the patients who could benefit most from a psychiatric visit so they could be scheduled to see a part-time psychiatrist at the clinic. For patients who might benefit from comanagement with the eReferral specialist, PCPs received a response to the consultation request through the eReferral portal.

In the four-month evaluation period, >3,000 primary care visits occurred and 42 consultation requests were initiated. PCPs usually received a response within three business days. Patients' ages ranged from five to 69 years ( $M=45$ ). Diagnoses

included depression, anxiety, or both (50%), and a smaller portion (5%–10%) had insomnia, psychosis, substance abuse, attention-deficit hyperactivity disorder, a bipolar disorder, or other conditions (including eating disorders).

Most consultation requests (21 of 42) concerned medications: initiation of a new medication, contraindications, changing medication, or general medication questions. Of these consultations, most discussed antidepressants. Others concerned antipsychotics, benzodiazepines, stimulants, and other medications. Nonmedication-related consultation requests included questions about diagnostic clarification or psychosocial issues.

In about half of the consultations (23 of 42), PCPs requested that the patient be seen by the on-site psychiatrist. The psychiatry reviewers deemed most requests appropriate and recommended scheduling. The on-site psychiatrist saw most of those patients (some patients did not show, preferred to follow up with a PCP via telephone, or were never scheduled because they could not come on the day the psychiatrist was available). Some were referred to an outside provider (a crisis clinic, for example).

The psychiatry reviewers initially responded to the PCP without scheduling the patient in 71% of cases ( $N=30$  of 42). Half of these ( $N=15$  of 30) included a recommendation for the patient's treatment to be managed by the PCP, with detailed, supportive responses to PCPs' inquiries to promote learning and expansion of PCP capacity. The other 15 consultations were scheduled after iterative communication between the PCP and the specialist team. Nearly 30% ( $N=12$  of 42) of requests were recommended for scheduling by the psychiatrist without further discussion with the PCP.

PCPs found the service helpful for "improving understanding of psychotropic medication management" strategies. Most expressed satisfaction with the program, but for scheduling, some saw the eReferral system as an "extra step" compared with scheduling directly with an on-site psychiatrist.

Findings highlight feasibility and acceptability of implementing an integrated electronic psychiatry consultation and referral service in a community-based primary care clinic. This pilot program can inform future trials designed to examine the impact of this type of service on the delivery of high-quality mental health care and its cost-effectiveness in a safety-net health care system.

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## **Opening More Doors to End Homelessness Through a Shared Housing Approach**

Permanent supportive housing (PSH) for chronically homeless individuals has proliferated in recent years. However, availability of PSH remains limited by costs associated with rental subsidies, resulting in extensive waiting lists for individuals with urgent housing needs. Fortunately, homelessness service providers are focusing efforts on enhancing individuals' economic stability, thereby expanding housing options to both PSH and the mainstream market. One such service model was the Pathways to Independence (PTI) program, funded by the Substance Abuse and Mental Health Services Administration and delivered by a homelessness service provider in New Haven, Connecticut, to chronically homeless individuals. Of the 203 participants housed during the 2011–2014 grant period, 144 received subsidies and 59 were housed by their own income.

PTI involved staff specialists in three primary areas: housing, employment, and Social Security income entitlements. Their education and experience were akin to generalist case managers. However, the specialist positions allowed staff to achieve a depth of expertise in their area and stimulated creativity to solve housing barriers among program participants. One such barrier was the limited availability of both PSH and affordable housing options, which prevented participants from rapidly exiting homelessness. Even those in competitive employment and recipients of disability benefits did not have adequate income to afford most mainstream apartments. The fair market rent for a one-bedroom apartment in New Haven was \$980, whereas the average monthly income of PTI participants was \$853. The PTI team sought to address this barrier by developing a shared housing approach. Shared housing was pursued only for those expressing interest; the remainder were supported in exploring other housing options.

The PTI housing specialist fostered the transition into multibedroom apartments with others with lived experience of homelessness. Meetings were facilitated so participants could choose roommates. Participants engaged in six weekly group meetings: housing search and finances, establishing house rules and expectations, community building skills (communication and problem solving), addressing individual concerns, addressing communal concerns, and empowerment (lessor-lessee laws and self-advocacy). Rental property owners often had difficulty renting multibedroom apartments,

giving the housing specialist leverage to negotiate rent, utilities, and lease terms. Tenants were provided six-month leases to limit chance of eviction or loss of security deposit if the living arrangement was unsuccessful.

Eleven PTI participants housed without a subsidy were housed with roommates. Seven received disability income, and four earned income from employment. Participants in shared housing had an average monthly income of \$797, and the average rent was \$366. Nine participants were housed within six months of PTI enrollment, including the four who were connected with employment through the PTI employment specialist. The remaining two participants were housed 15–18 months after enrollment, delayed partly to await approval of disability benefits. Tenants described positive experiences of mutual support and felt they could share resources (cleaning supplies and food staples) with roommates to reduce financial stress.

Participants maintained PTI support services until program completion and continued to receive case management through the homelessness service provider—a level of support similar to that in PSH. Indeed, the necessity for support services for individuals with disabling conditions who have been homeless cannot be understated. Providers must be capable of helping individuals navigate the challenges of shared mainstream housing, including roommate dynamics and disruptions in employment or other sources of income that may increase one's risk of homelessness.

Although the approach described here occurred in the context of a grant-funded, integrated program, it is likely replicable in a range of homelessness service settings. The structure of the PTI team was innovative, but the PTI housing specialist used skills and resources that housing specialists and case managers generally possess, such as housing search and placement and cultivating a network of rental property owners—all of which were central to this approach. Thus implementation without a housing specialist or integrated employment or entitlement services may be possible. For example, case management teams could collaborate to identify and engage participants with incomes who may be interested in shared living. The housing effort could be divided among case managers, one managing lessor-lessee negotiations and another delivering a curriculum.

Shared housing is not necessarily a novel concept in homelessness services. Despite the promise of shared housing as an independently affordable rapid rehousing option, there is a dearth of discussion in the homelessness services literature on its implementation and effectiveness. Ongoing development of roommate models accompanied by rigorous research is merited to expand housing options and promote housing choice among individuals with extensive homelessness histories.

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