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SERIAL INEBRIATE PROGRAMS: WHAT TO DO ABOUT HOMELESS ALCOHOLICS IN THE EMERGENCY DEPARTMENT

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Every inner-city emergency department (ED) has a core group of alcoholics—that sad collection of homeless addicts who come in seizing when they've run out of alcohol or comatose when they've had too much.

They have either failed or refused treatment many times over, yet they occupy beds for hours on end and consume massive amounts of health care resources. Many approaches to control these costs and treat the recidivists have failed for one reason or another, but one innovative effort in San Diego, CA, is gaining national attention.

After years of watching his ED's resources taken up by the small group of intractable alcoholics, Dr. James Dunford, an emergency physician at University of California, San Diego Medical Center, decided to find out just how much local EDs were spending on serial inebriates while their true, long term needs for treatment and housing were going ignored.

THE PRICE TAG

Dr. Dunford tallied up a total of \$1.5 million spent on just 15 randomly selected chronic drunks for their care in 2 local EDs and transport by emergency services during an 18-month period in 1997-98. They amassed 417 ED visits among them.

He gave his calculation to San Diego city officials, who responded with shock and soon adjusted the way they deal with the alcoholics who were regularly picked up by police or emergency medical crews. The San Diego Police Department worked with the local justice system to give escalating jail terms to chronic drunks but offered a 6-month treatment program with housing as an alternative.

That model, known as the Serial Inebriate Program (SIP), has been in effect since 2000. According to research published by Dr. Dunford and colleagues in this journal last year, the program reduced by 50% the amount of emergency response, ED and inpatient services required by a core group of San

Diego's chronic alcoholics in its first 4 years.¹ During that time, 308 of the core population amassed 3,318 ED visits, costing 2 EDs a total of \$2.5 million. The diversion into treatment of 156 patients in that time period helped save the 2 EDs \$12,000 per month, the savings beginning to accrue after they started treatment.

GARNERING NATIONAL ATTENTION

The numbers have been impressive enough that San Diego's Serial Inebriate Program officials are getting frequent visitors from other cities, including San Francisco, interested in duplicating the concept to provide a long-term solution to a key part of their core, chronic homeless population.

National officials on homelessness and housing are also enamored of the Serial Inebriate Program model and are promoting it as an innovation that works. In particular, the nation's "homelessness czar," Philip Mangano, cites the importance of Dr. Dunford's original research in pinning a dollar figure to the problem. While providing a long-term answer to this population's problems might be the right thing to do "morally and spiritually," Mangano says, it took the shocking numbers to provide government officials with the political cover—and clear cost-benefit calculation—to spend real money on treatment programs and housing.

"We're encouraging cities across the country to do the cost benefit analysis to look at how much the chronic homeless are costing the acute side, the behavioral side, emergency rooms, law enforcement interventions and incarceration, and let the cost study drive the political will," says Mangano, who is executive director of the US Interagency Council on Homelessness.

Federal officials have been trumpeting apparent successes in reducing the number of chronic homeless from the streets of many American cities. However, some homeless advocates

question whether the Bush administration's overall policies—including budget cuts in key housing programs—are appropriately addressing the problem, and wonder about the accuracy of homeless counts in individual cities.

In the research community, there is growing support for the idea of focusing on getting the core group of chronically homeless off the streets, citing research that suggests just 10% of the homeless use half the shelter resources. Specifically, the concept of "housing first" calls for a less judgmental approach to reducing the problem by providing a place for people to live without immediately requiring them to get over any mental health or substance abuse problems.

One of the most visible such programs is in Seattle, which in 2006 opened a building to house chronic alcoholics but did not require them to stop drinking. The project has been controversial, drawing fire from groups who believe the government is supporting the alcoholics' bad habits.

NO QUICK FIX

For chronic alcoholics who have been living on the street for decades, there is much more to moving back into mainstream society than brain chemistry. They have to learn the basics of how to live, and many may have long-term cognitive damage from their rough lifestyles, not to mention underlying mental illnesses.

The treatment program in San Diego, for instance, starts out with the basics: essential skills for living.

"It's not rehabilitation, it's habilitation," explains Deni McLagan, associate vice president of the alcohol and drug division of non-profit service provider Mental Health Systems. "The first 30 days we're modeling social behaviors with them such as hygiene, riding the bus, feeding themselves, taking medications. We're just trying to get the guy to shave and bathe in the first month. In the second or third, we'll get them employment."

It's a different model from substance abuse treatment for people in mainstream society, McLagan says. Someone who has been on the streets and drunk for 20 years doesn't react well to the structure of a purely residential program, she says.

They may need to go through the program multiple times to be successful, McLagan notes. She doesn't see that as an indication that treatment doesn't work, just that it takes a lot of time and effort to make such huge behavior changes.

"We anticipate seeing them 5 to 7 times before we get good outcomes," she says. "It gets better every time."

The San Diego program has housing for 15 people at a time, and pays for 10 beds in private residential treatment facilities. Clients are provided with communal living in 4 apartments and come to treatment 3 times a week on an outpatient basis. It is not uncommon for a first- or second-time offender to spend a few weeks there and go back out on the streets. It's not long before they've ended up back in the system and returned to treatment.

The program uses the threat of a long jail term to encourage homeless alcoholics who are frequently brought to the detox

center—5 times or more in a month—to finally go into treatment. San Diego officials believe their Serial Inebriate Program has substantially reduced their list of chronic drunks who are in and out of jail. They say the program has reduced hospital costs for this population by 80%.

While it's uncertain how many of those people have cleaned up and gotten jobs and conventional homes—and how many either died or moved out of San Diego—program leaders do know that some of their graduates are doing well. More than a dozen of them showed up at a dinner put on by the San Diego Police Department.

The San Diego model may not be for every city, Mangano acknowledges, because it calls for the police to make arrests for public drunkenness, something that is seen as inappropriate in some cities. In fact, San Diego's program was taken to court in 2002 by a man whose court-appointed attorney argued that he was mentally ill and arresting him constituted cruel and unusual punishment. Both a California district court and an appeals court disagreed, saying San Diego could continue to arrest drunks because of their potential threat to public safety.

Dunford's research indicates that the threat of jail is an important inducement for treatment. Only about half of those who enter the system choose treatment, but they choose it more often when the jail term they face is longer. Treatment was accepted by 20% of those who faced a sentence of 30 days or fewer but by 63 percent of those looking at 150 days or more in jail.

THE CARROT AND THE STICK

Just as important as encouraging this population into treatment is the other end of the program—housing. That piece got a small boost from the Department of Housing and Urban Development, which in 2005 gave \$10 million to 11 projects around the country to provide supportive housing for chronic homeless alcoholics. While those demonstration projects may help prove the concept, the project's numbers illustrate how expensive it is to find a fix: the \$10 million will provide housing for 555 people.

Advocates of the concept argue that doing nothing is even more expensive in terms of hospital, social service and legal system costs, not to mention the human suffering.

"Providing permanent supportive housing for this population is less expensive than people randomly ricocheting among primary behavioral health systems and legal systems," says Mangano, who spent many years managing homeless services in Boston before being tapped to head the federal program in 2002.

In San Diego, the Serial Inebriate Program runs on about \$200,000 of federal and local funding each year. Mental Health Systems, the San Diego non-profit contracted to run the treatment program, is seeking to expand to cover more local cities by working with its local governments one by one. For instance, the city of El Cajon is pitching in \$40,000 per year to pay for 3 of the treatment beds in San Diego. The program has

so far treated 5 clients from El Cajon whose hospital bills totaled \$75,000, McLagan said.

Emergency physicians are on the front lines witnessing the human cost, the suffering and the revolving door system that does little to change it. Like Dr. Dunford in San Diego, Dr. Sam Sliselman, an Albuquerque emergency physician, decided he needed to do something personally to find a better solution for the chronic alcoholics he saw on every shift at the University of New Mexico hospital ED.

"I saw how people were taken care of, and it really wore at me after a while," Dr. Sliselman commented by phone after climbing down from the roof of the transitional housing project he's helping to build. "It's really a ridiculous system. Just about every shift I work there is some inebriate handcuffed to a stretcher out cold with a police officer sitting next to him waiting for this nebulous concept of medical clearance."

He started a non-profit organization called Endorphin Power Company (named for the idea of using exercise to help addicts stay sober) that is providing support to local social services. Bernalillo County has developed a "social model" detox program lasting several days that diverts those inebriated people away from the ED. Dr. Sliselman's organization is working to provide minor medical services, such as laceration repair, and to develop a 30-day treatment program and transitional housing.

THE ED AS THE LAST RESORT

Fixing the homeless problem may not be in the job description of an emergency physician, but the ED definitely benefits when serial inebriates get diverted to more appropriate care.

"The ER is pretty much the catchment for everything that falls through the cracks," Dr. Sliselman says.

While the efforts in Albuquerque are still in the early stages, Dr. Sliselman already sees a difference in the ED, now that he has somewhere to send an inebriated patient who doesn't need medical care.

Dr. Dunford also sees a difference. "Yesterday we had one of these guys in all day; he was too drunk to go to detox," he relates. "That used to be an everyday occurrence, and we were all used to it, but now the nurses get kind of tweaked when one of these guys is here. We don't have 3 guys lying in the halls eating up beds for hours at a time."

As appreciative as he is that there are now services for those patients, Dr. Dunford would like to see the system work better with more case management and information sharing among providers and social service agencies to better track homeless clients. He'd like to see public health and emergency medical services work together more seamlessly.

As the medical director of emergency services in San Diego, Dr. Dunford sees it as his job to find fixes for the system.

"I'm in my 27th year at the UCSD ER, and there's only so much of this you can tolerate," he says. "I have only myself to blame if I don't do something about this issue."

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