Community Based Progtrams For Chronic Inebriates As an Alternative To the Emergency Department

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Chronic inebriates repeatedly present to the **emergency department (ED)**.[1-7] Frequent use by these individuals, who are often homeless, unemployed and who have not been helped by numerous attempts at alcoholism treatment, further strains this already strained emergency system.[8] Repeated visits prolong ED bed utilization, require ED staff to monitor these patients, and contribute to existing ED crowding. Unfortunately, time in the ED is frequently not optimally utilized. The ED visit does not usually address their underlying dependency or social problems.

A few EDs have developed ED-based programs for referral of patients with substance abuse problems.[9-10] Though successful, these programs consume ED resources. Several communities have developed programs external to the ED that would prevent the ED visit from recurring. The objective would be for the chronic inebriate population to use these programs instead of the ED.

We performed a comprehensive literature review to identify non-ED based programs managing the ED use by chronic inebriates. These programs could serve as templates for others.

Methods

A literature review was performed in August and September of 2006. Search terms used, with syntactic variations used for different databases, included: chronic inebriate (alcohol*, drunk*, inebriat*, intoxicat*) and emergency department (emergency medical services, emergency department, emergency room).: MEDLINE (PubMed), Cochrane Libraries, Web of Science, CINAHL, LexixNexis Academic, CRISP, and Health Services Research Projects in Progress were queried.

All abstracts/papers identified were screened for population of interest, program (unique set of services provided to population) and goal of program (reduction in ED usage). All articles were searched for relevant citations of other programs. Additionally, the Web of Science database was searched using the ISI citation reference search for each program specific article identified. Program websites, if available, were also reviewed. Authors of program-specific articles and/or programs themselves were contacted via phone and/or email to confirm and review the description of services, goal, achievements and funding source. They were also asked if they were aware of any new or unique programs with a similar focus that had not been identified through the literature review. Lastly, programs were contacted in February 2009 to confirm continued operations.

Results

Eight programs were identified. All were contacted and provided with a copy of their program description; six of the eight responded, verifying their program description.

1. Glenwood Residence Program; Minneapolis, MN [8-11]

Goal: Hennepin County initiative to reduce ED overcrowding, admissions and emergency resource utilization while providing safe, acceptable living environment for men who would not accept or had failed traditional attempts at alcohol dependency treatment.

Program: Housing for men only; each resident has a private room; facility has congregate dining and bathrooms. Program does not require sobriety, but does not allow alcohol on site. Health care is provided by physician visits at residence, men receive ongoing education to reduce ED visits, and the program provides transportation to medical appointments including urgent care and ED.

Impact: Glenwood, Anishinabe and Street Case Management were assessed together and reported a reduction in health care utilization for most patients. Median health care expenditures declined, as did the median number of injury and alcohol-related visits, while median number of illness-related visits remained the same.

Funding: State/County funded through Group Residential Housing monies at a cost of $1,087 a month; residents contribute $136 a month from their General Assistance Medical Care or $441 from their Social Security Disability Insurance check (1999 dollars). Catholic Charities of St. Paul and Minneapolis contributes toward the cost.

2. "Street Case Management Project"; Minneapolis, MN [8,11]

Goal: Reducing inappropriate ED and detoxification services.

Program: Intensive street-based management for highest users of EMS related to intoxication (most were homeless and remained homeless while involved with the program). Clients were told goals of program (i.e. use ED less frequently) and were free to decide how to accomplish the goals with incentives directed by clients (i.e. carton of cigarettes if goals met for the week). Full-time nurse manager coordinates the program, working on the streets with clients. Street Case Management Project recently loss funding and is now part of a detox center program.

Impact: Glenwood, Anishinabe and Street Case Management were assessed together with a reduction in health care use for most patients. Median health care expenditures declined, as did the median number of injury and alcohol-related visits, while median number of illness-related visits remained the same.

Funding: $250 per client per month, paid by Hennepin County.

3. Anishinabe Wakiagun Residence; Minneapolis, MN [8-11]

Goal: Hennepin County initiative to reduce ED overcrowding, admissions and emergency resource utilization while providing safe, acceptable living environment for Native Americans who would not accept/had already failed traditional attempts at chemical dependency treatment.

Program: Provides single occupancy rooms. Residence is located next to the American Indian Center in south Min-

neapolis and across the street from a health clinic. Program allows alcohol within residence.

Impact: Glenwood, Anishinabe and Street Case Management were assessed together with a reduction in health care use for most patients. Median health care expenditures declined, as did the median number of injury and alcohol-related visits, while median number of illness-related visits remained the same.

Funding: State/County funded through Group Residential Housing monies at a cost of $1,087 a month; residents contributed $136 a month from their General Assistance Medical Care or $441 from their Social Security Disability Insurance check (1999 dollars) in association with the American Indian Housing and Community Development Corporation.

4. San Diego Serial Inebriate Program (SIP); San Diego, CA [12,13]

Goal: To provide patients who have exhausted traditional therapeutic options with a sober living alternative while reducing their adverse community impact.

Program: Aligns the judicial system with treatment to create incentive for individuals' participation in outpatient recovery program. San Diego Police Department in partnership with a treatment provider, the City Attorney, the Superior Court, the Public Defender, the regional Detox Center and City Emergency Medical Services, tailored the program to the predominantly homeless individuals who consistently failed traditional therapy. In association with new booking and sentencing procedures, individuals are offered 6 month outpatient treatment program instead of progressive sentences of up to 180 days in jail. Clients who accept treatment are driven from jail directly to St. Vincent de Paul Village Medical Clinic for initial medical evaluation by Combined Family Med-Psychiatry residents. Clients receive supportive housing, case management and introduction to a new "medical home" and are instructed to not return to ED for routine care. The program provides medications and health care.

Impact: There was a 50% decline in the use of ED, inpatient and EMS resources noted in individuals who chose the 6-month outpatient treatment program in lieu of custody, compared to no change in consumption by those who did not enter treatment.

Funding: The City and County of San Diego fund this program.

5. Seaton House Annex Harm Reduction Program; Toronto, Canada [14]

Goal: Seaton House shelters and supports men with diverse social needs through client-centered service, grounded in the principles of acceptance, respect and understanding, partnerships among staff, clients and community, and advocacy for community living alternatives.

Program: Provides housing to clients with alcohol or mental health diagnoses. A client's alcohol use is managed with a harm reduction approach that focuses on modifying harmful conditions and behaviors, restoring health and providing holistic options for up to 140 men at a time. Palliative care is available.

Impact: No published data

Funding: City of Toronto through emergency services, shelter and housing.

6. Shelter-based Managed Alcohol Project (MAP); Ottawa, Canada [15]

Goal: Following harm reduction policy, managed alcohol program was developed for people with long-term homelessness and refractory alcoholism within the shelter system; looking specifically at reduction of crisis services and consumption of alcohol while improving health care.

Program: Participants were housed at a shelter designated by MAP and provided with meals; a worker supervised the participants, assisted with ADLs, helped fill out applications for social benefits, accompanied clients to appointments and dispensed medications. Participants were given up to a max of 5 ounces or wine or 3 ounces of sherry hourly, on demand from 0700-2200, 7 days a week; medical care was provided 24hrs a day by nursing staff; a physician visited weekly.

Impact: Participants consumed less alcohol, visited EDs less often and had fewer police encounters. Staff and clients reported improved hygiene, general health and compliance with medical care.

Funding: Supported by a grant from Human Resources Development Corporation, Government of Canada, for the Inner City Health Project.

7. McMillan Stabilization Project; San Francisco, CA [16,17]

Goal: To reduce ED visits and improve health outcomes for chronic public inebriates.

Program: Includes a sobering unit as opposed to ED. A Mobile Assistance Patrol van can provide transportation to clients. The client has access to medical, behavioral health, nursing, housing and case management services.

Impact: Since implementation of the project in 2003, several hospitals have reported a significant reduction in the number of inebriates seen and their length of stay in the ED. In addition, a number of high-profile homeless inebriates have been housed.

Funding: The support of multiple stakeholders (i.e., the Hospital Council of Northern and Central California, the San Francisco Fire Department, Emergency Communications Department, citywide emergency departments and Baker Places). The project is operated through a partnership between the department's Tom Waddell Health Center and Community Awareness and Treatment Services (CATS), a nonprofit agency that manages the McMillan Drop-In Center (MDIC).

8. 1811 Eastlake Project; Seattle, WA [18,19]

Goal: To improve the lives of residents through reduced alcohol consumption, better heath care, and increased stability. It will also reduce residents' use of the community's crisis response system, reduce public nuisances and encourage residents to undertake and follow through with treatment.

Program: Project provides supportive housing for 75 formerly homeless men and women with chronic alcohol addiction. Residents receive 24-hour, seven day a week supportive services including: state-licensed mental health and chemical dependency treatment; on-site health care services; daily meals and weekly outings to food banks; Case management and payee services; medication monitoring; weekly community building activities

Impact: Preliminary findings from an evaluation of the program demonstrated an estimated decrease in costs of $2.5 million for that emergency health services and crisis services.

Funding: Various government agencies; the largest amount comes from the federal McKinney homeless assistance program.

Discussion

Some individuals who have not benefited from traditional substance abuse treatment frequently enter EDs, or are brought there by police and Emergency Medical Technicians. Many community have ordinances that publicly intoxicated people be taken to the ED.

Through our literature review and personal communications with program staff, we identified eight programs in five US and Canadian cities that address chronic inebriates who frequent the ED. All the programs appear to serve their designated populations. All established case management, which has shown promise with reduction of health care utilization for this population previously.[20] Many of the programs accept that this group has failed sobriety and do not require it for participation. Others allow alcohol on the premises; a minority even provides alcohol to clients. Although all offer assistance with addictions and mental health services, it is a newer and more controversial approach to accept failure of treatment and focus on harm reduction.

Chronic inebriates frequently have a low priority in the busy ED. However, their long length of stay can have the same impact as four to five non-urgent patients in terms of provider time and bed utilization. The programs identified appear to offer health care services more efficiently than traditional ED treatment for this population. For example, the SIP showed a 50% decline in the use of ED, inpatient and EMS resources for those who were a part of the 6-month outpatient treatment program.[12] The three Minnesota programs showed a reduction in median health care expenditures and median number of injury and alcohol related visits but no change in illness related visits.[8]

Although all programs identified cater to the chronic inebriate population who frequent the ED, each operates within a unique framework of state and local ordinances and laws. The SIP relies upon the fact that public inebriation is a crime and that punishment becomes additive for repeated offenses which is not true in many of the other programs.

Funding is crucial. The cost of each program has been underwritten by differing mechanisms; however, the ED treatment of the chronic inebriate population has considerable costs as well. This cost can be measured by the community resources needed for assessment and transport to the ED, the human resources to attend to this group while in the ED, and the institutional resources needed to accommodate them. The financial capital to acquire and utilize such resources could be redirected toward a program that would provide more comprehensive service for the chronic inebriate population external to the ED. The programs cited here have demonstrated that it is possible to reduce EMS and police utilization and ED visits.

Limitations

Our protocol for finding programs relied on the medical and popular press. Although we asked programs their knowledge of similar programs, they too may have been limited by publication bias. Similar programs could exist without having any published references.

Conclusions

Communities which seek to address the excessive emergency department utilization by chronic inebriates have models to learn from in designing a program that has sustainable funding and serves the needs of this population.

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