

# Impact of the San Diego Serial Inebriate Program on Use of Emergency Medical Resources

**James V. Dunford, MD**  
**Edward M. Castillo, PhD, MPH**  
**Theodore C. Chan, MD**  
**Gary M. Vilke, MD**  
**Peter Jenson, MD**  
**Suzanne P. Lindsay, PhD,**  
**MSW, MPH**

From the Department of Emergency Medicine, University of California, San Diego Medical Center, San Diego, CA (Dunford, Chan, Vilke); the Institute for Public Health, Graduate School of Public Health, San Diego State University, San Diego, CA (Castillo, Lindsay); and the Long Beach Memorial Family Medicine Residence Program, Long Beach, CA (Jenson).

**Study objective:** We determine the impact of a treatment strategy called the San Diego Serial Inebriate Program on the use of emergency medical services (EMS) and emergency department (ED) and inpatient services by individuals repeatedly arrested for public intoxication.

**Methods:** This was a retrospective review of health care utilization records (EMS, ED, and inpatient) of 529 individuals from 2000 to 2003. Judges offered individuals a 6-month outpatient treatment program in lieu of custody (Serial Inebriate Program). Demographics and health care utilization are reported overall and by treatment acceptance.

**Results:** From 2000 to 2003, 308 of 529 (58%) individuals were transported by EMS 2,335 times; 409 of 529 (77%) individuals amassed 3,318 ED visits, and 217 of 529 (41%) individuals required 652 admissions, resulting in 3,361 inpatient days. Health care charges totaled \$17.7 million (EMS, \$1.3 million; ED, \$2.5 million; and inpatient, \$13.9 million). Treatment was offered to 268 individuals, and 156 (58%) accepted. Use of EMS, ED, and inpatient services declined by 50% for clients who chose treatment, resulting in an estimated decrease in total monthly average charges of \$5,662 (EMS), \$12,006 (ED), and \$55,684 (inpatient). There was no change in use of services for individuals who refused treatment. There was a significant increasing trend in acceptance among individuals with longer jail sentences ( $<0.001$ ). Treatment acceptance was 20% among those with sentences of 0 to 30 days and reached 63% for those with sentences longer than 150 days. Operational costs and alternate care at clinics and nonparticipating hospitals were not analyzed.

**Conclusion:** This community-supported treatment strategy reduced the use of EMS, ED, and inpatient resources by individuals repeatedly intoxicated in public. [Ann Emerg Med. 2006;47:328-336.]

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## INTRODUCTION

Homeless individuals repeatedly intoxicated in public disproportionately consume resources through encounters with police, fire department, emergency medical services (EMS), and emergency department (ED) personnel.<sup>1-13</sup> Traditional chemical dependency treatments have been ineffective for this recidivist population. Intense case management has shown benefit in some<sup>2,5,10</sup> but not all<sup>11</sup> studies, and there is no effective strategy to address their condition. Motivation is essential for recovery, and legal pressure has been capable of motivating beneficial change in behavior for adults with alcohol and other drug problems.<sup>14</sup>

In January 2000, the San Diego Police Department initiated a pilot Serial Inebriate Program to assist a group of homeless individuals stuck in a "revolving door" between jail, EDs, and the downtown Volunteers of America inebriate reception (sobering) center. Early success allowed this program to evolve throughout the region as a partnership linking law enforcement, fire departments, EMS, hospitals, the public defender, the city attorney, the superior court, Volunteers of America, business, treatment providers, and local government. The goal of the Serial Inebriate Program is to provide patients who have exhausted traditional therapeutic options with a sober living

### Editor's Capsule Summary

#### *What is already known on this topic*

Chronic alcohol abusers, especially those who make a public nuisance of themselves, may exist in a perpetual cycle of arrest, incarceration, and health care visits for altered mental status or alcohol withdrawal. This cycle burdens health and law enforcement systems without improving the welfare of the subject or society.

#### *What question this study addressed*

This study examined whether a system in which chronic alcoholics could opt for halfway house treatment instead of jail time reduced health care utilization and cost.

#### *What this study adds to our knowledge*

The patients who chose to avoid jail by enrolling in the program utilized fewer medical resources—emergency medical services, emergency department, and inpatient, measured in dollars—in the short term compared with those who opted for jail.

#### *How this might change clinical practice*

This study does not help the emergency physician who is practicing in a community where no such system exists but provides a model for change that would preserve valuable resources for other community health needs.

alternative while reducing their adverse community impact. The Serial Inebriate Program aligns the judicial system with treatment to create incentive for individuals' participation in an outpatient recovery program tailored to their needs.

Law enforcement is responsible for providing individuals determined to be publicly intoxicated with a safe sobering environment. Individuals who lack other means of safe shelter are transported to the inebriate reception center, where they receive supervision and monitoring by treatment staff until sober. Such individuals receive counseling and are encouraged to enter the Volunteers of America recovery program, but many decline this offer and promptly resume drinking. California does consider public intoxication disorderly conduct, and under certain circumstances this misdemeanor can result in incarceration for up to 180 days. The California 4th District Court of Appeals determined that the state may incarcerate intoxicated individuals because it has a legitimate need to control public drunkenness when such behavior creates a safety hazard.<sup>15</sup> The court concluded that state law does not punish the mere condition of being a homeless, chronic alcoholic but rather the associated conduct that poses a public safety risk.

California law also provides judges the option of offering such individuals an opportunity to complete an alcoholism treatment program in lieu of custody. Before the implementation of Serial Inebriate Program, local treatment programs were unwilling to accept these clients because of their

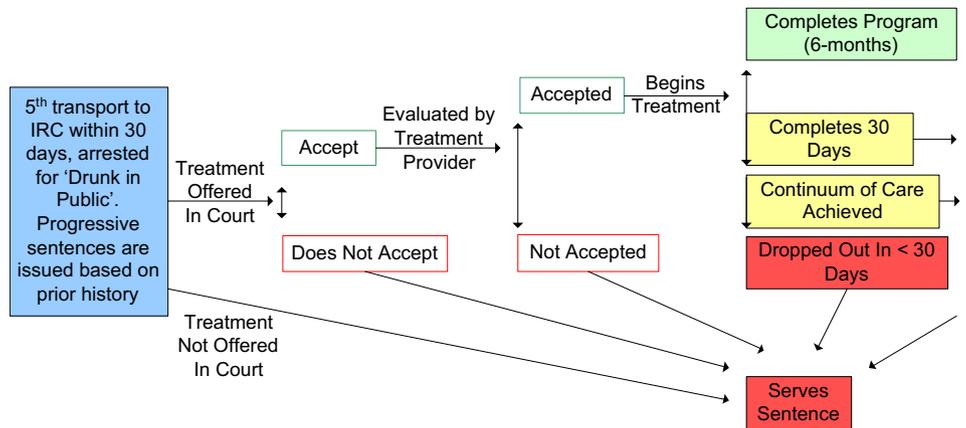
recidivist behavior, and jails rarely housed them longer than 72 hours. In 1999, the San Diego Police Department recruited a treatment provider to collaborate in the development of a novel pilot program tailored to this population. The San Diego Police Department also secured the support of the city attorney to develop new booking and sentencing procedures. Importantly, the public defender lent its critical support to program development after concluding clients would be afforded valuable new support and care. Volunteers of America staff were asked to define the criteria that should constitute a "chronic inebriate" (and therefore Serial Inebriate Program client), and the superior court endorsed a trial program.

In January 2000, the court began offering eligible individuals the option of a 6-month outpatient treatment program in lieu of custody (Serial Inebriate Program). Serial Inebriate Program police officers assumed responsibility for monitoring client progress while enforcing laws governing violations of probation. This study was designed to evaluate the impact of the Serial Inebriate Program on the use of EMS, ED, and inpatient resources during its first 4 years of operation.

## MATERIALS AND METHODS

The city of San Diego is the nation's seventh largest, with a population of 1.3 million residents. The city encompasses 73 square miles and is home to 12 acute care hospitals. The city is served by 1 paramedic provider (the San Diego Medical Services Enterprise), a public/private partnership between the San Diego Fire-Rescue Department and the Rural/Metro Ambulance Company. Individuals determined to be publicly intoxicated and for whom there are no other means of ensuring safety are transported by police to the inebriate reception center. The inebriate reception center is not staffed with nurses or physicians, and clients must be medically stable and ambulatory without assistance. Publicly intoxicated individuals judged by paramedics or law enforcement to be nonambulatory are transported by paramedics to area hospitals. Two tertiary care medical centers serve the downtown region and beach communities where the majority of such alcohol-related calls arise. Both hospitals provide screening, brief intervention, and referral substance abuse services to all ED patients.

Figure 1 illustrates the Serial Inebriate Program process. Individuals accumulating 5 transports to the inebriate reception center within 30 days are considered "chronic" by inebriate reception center staff and rejected. Police transport these persons to jail, where they become sober, receive medical care, and remain until arraignment and trial. Judges issue progressive sentences based on previous convictions in a typical sequence: first conviction, "time served, probation granted"; second conviction, incarceration for 30 days; third conviction, 60 days; fourth conviction, 90 days; fifth conviction, 120 days; sixth conviction, 150 days; seventh conviction, 180 days. With each sentence, judges exercise the option of offering an intense 6-month, outpatient clinical intervention program in lieu of custody (Serial Inebriate Program).



**Figure 1.** Serial Inebriate Program process from the time of arrest to program completion or jail, San Diego, CA, January 1, 2000, to December 31, 2003.

Persons expressing interest in the Serial Inebriate Program treatment alternative are evaluated by counselors while in custody. Those with histories of violent crime, arson, or child abuse are excluded because of the limitations of group living. Individuals accepted for treatment are released from jail directly to the custody of a Serial Inebriate Program police officer who provides transportation to a participating group residential treatment site. Successful completion of the 6-month treatment program fulfills a condition of probation, and these Serial Inebriate Program graduates are subsequently referred for additional support services and assistance. However, those clients who resume drinking or otherwise fail to complete treatment are returned to custody and are required to complete the balance of their previously imposed sentence.

This study was determined to meet the criteria of the US Department of Health and Human Services Code of Federal Regulations allowing for waiver of informed consent<sup>16</sup> and was approved by the Human Research Protection Programs at the University of California, San Diego and the Scripps Mercy Hospital.

This study used a historical cohort design to evaluate the effectiveness of the Serial Inebriate Program in reducing the use of EMS, ED, and inpatient services and the corresponding health care costs.

From law enforcement records, 1 Serial Inebriate Program officer abstracted a list of demographic information, arrest and arraignment information, court sentence, treatment (offered and whether accepted), program placement, and outcome (rearrest warrant issued or treatment completed) for the defined population. A spreadsheet containing names, social security numbers, and dates of birth of these individuals was submitted to the information systems departments of the city EMS ambulance provider and the 2 regional hospitals participating in this study. One information systems analyst at each site performed a single electronic search of their agency or institution's billing records to identify dates of service, billing records, and the nature of encounters for these individuals

between January 2000 and December 2003. These 3 analysts were unaware of the purpose of the query. The initial reports were reviewed for accuracy by 2 authors (EC, JD), and duplicate entries and billing irregularities were referred for clarification. Final reports were merged and made anonymous by deleting all protected health information. EMS provider data included dates of ambulance transports, as well as billing and payer information; other nontransport paramedic contacts were excluded. Hospital data included ED and inpatient dates of visits, billing, and payer information and primary diagnoses. Inpatient data also included admission and discharge dates. ED and inpatient data from other regional hospitals to which these individuals may have also received care were not available.

### Primary Data Analysis

Frequencies and percentages for demographic information and health care utilization are reported. Individuals were categorized into treatment acceptors and nonacceptors. Pre- and postperiods were calculated for each person based on the date of accepting treatment in court for the first time (for those who accepted treatment) and the date of first arrest for those who did not accept treatment. Average monthly EMS transports and ED or inpatient admissions and associated charges were calculated for pre and postperiods for treatment acceptors and nonacceptors and medians, and associated interquartile ranges are reported. To assess the effect of increased sentences on the acceptance of treatment during arraignment, the number of overall acceptances was compared to the duration of sentences imposed using a test for linear trend. Data were analyzed using SPSS version 11.5 (SPSS, Inc., Chicago, IL).

### RESULTS

From January 2000 to December 2003, 529 individuals were rejected by inebriate reception center staff and categorized "chronic" after being transported to their facility 5 times within 30 days for public intoxication. The majority of the individuals were men (92%), white (75%), and 35 to 50 years of age

**Table 1.** Type of health care resources used by 529\* Serial Inebriate Program clients,† San Diego, CA, January 1, 2000, to December 31, 2003.

Resources	Total	Range	Median (Interquartile Range)
EMS transports (n=308)	2,335	1–52	4.0 (2.0,9.0)
ED visits (n=409)	3,318	1–100	4.0 (2.0,10.0)
Inpatient admissions (n=217)	652	1–21	2.0 (1.0,3.0)
Length of stay (days) (652 visits)	3,361	0–181	3.0 (2.0,5.0)

\*Seventy-nine serial inebriated individuals had no record of use of health care resources.  
†Defined as visiting the inebriate reception center 5 or more times within 30 days.

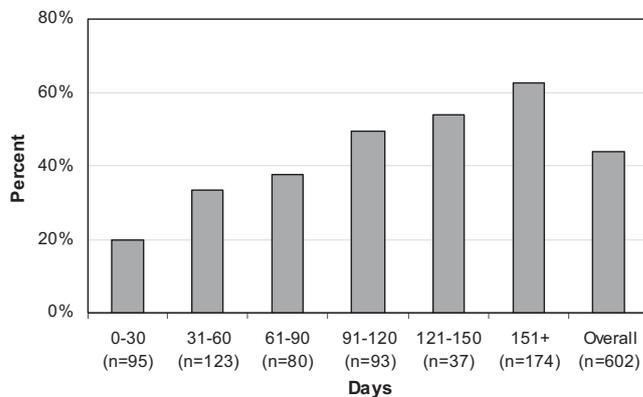
**Table 2.** Payment information by type of care for 529\* Serial Inebriate Program clients† who used health care services, San Diego, CA, January 1, 2000, to December 31, 2003.

Type of Care	Range (\$)	Total (\$)	Paid, %
EMS transports (n=308)			
Charges	237–30,789	1,276,977	13.8
Payments	0–9,282	176,725	
ED visits (n=409)			
Charges	18–59,567	2,530,398	15.4
Payments	0–12,200	389,286	
Inpatient admissions (n=217)			
Charges	2,824–1,031,076	13,939,910	19.7
Payments	0–142,051	2,742,850	
Total (n=450)			
Charges	18–1,068,590	17,747,285	18.6
Payments	0–147,608	3,308,862	

\*Seventy-nine serial inebriated individuals had no record of use of health care resources.  
†Defined as visiting the inebriate reception center 5 or more times within 30 days.

(69%). Table 1 demonstrates the use of ED, EMS, and inpatient services by this population at the 2 hospitals and the city’s sole paramedic transport agency. Of the 529 individuals, 79 (15%) individuals had no record of using any health care service during the study period. One hundred thirteen (21%) individuals used 1 service, 190 (36%) individuals used 2 services, and 147 (28%) individuals used all 3 services. The ED was the most common service used by these 529 individuals, with 409 (77%) clients accumulating a total of 3,318 total ED visits. The next most commonly used service was EMS with 308 (58%) clients accumulating 2,335 transports. Two hundred seventeen (41%) clients required 652 admissions to hospital and accrued a total of 3,361 inpatient days.

Table 2 includes charge and payment information for the study population. The total charges accrued by these persons for health care services were \$17.7 million. The services with the



**Figure 2.** Percent acceptance of treatment\* by duration of imposed court sentence, San Diego, CA, January 1, 2000, to December 31, 2003.

\*Graph includes offers in which individual either accepted or refused treatment (n=602); all other incidents excluded (denied, failed, or offering unknown/not stated).

most charges were inpatient admissions (\$13.9 million), followed by ED visits (\$2.5 million) and EMS transports (\$1.3 million). Among the 3 services, reimbursement rates were inpatient (19.7%), ED (15.4%), and EMS (13.8%). Overall, payments were received for 18.6% of charges.

Individuals could be offered enrollment in a treatment program after any conviction for public intoxication. Because duration of the imposed sentence was related to the number of previous convictions, clients usually accepted treatment only after repeated convictions. Figure 2 illustrates treatment acceptance by length of sentence. Judges issued a total of 602 Serial Inebriate Program offers to 268 (51%) individuals between 2000 and 2003. There was a significant increasing trend in acceptance among individuals with longer jail sentences (<0.001), from 20% among those with sentences of 30 days or fewer to 63% among those with sentences of 150 days or more. The most common reason for not being offered treatment was a first conviction wherein the court typically grants probation rather than custody. Other reasons for treatment not being offered included coexisting criminal charges and individuals with histories of violent behavior incompatible with group living arrangements.

A total of 156 (58%) individuals accepted the treatment alternative at some point. Comparisons of demographic characteristics between those who accepted treatment and those who did not accept (or were not offered) are presented in Table 3. There was no important difference in age or sex for those who accepted treatment compared with those who did not. Whites were more likely to accept treatment compared with other race or ethnic groups.

For the preperiod, the average number of months for follow-up was 23.73 (13.67) for those who did not accept treatment and 22.84 (13.28) for those who accepted treatment. For the postperiod, the average number of months for follow-up was 24.94 (13.67) and 25.82 (13.28), respectively. Figure 3

**Table 3.** Demographic characteristics for 529 Serial Inebriate Program clients\* by treatment acceptance, San Diego, CA, January 1, 2000, to December 31, 2003.

Characteristic	Treatment Not Offered or Accepted		Treatment Accepted		P Value
	Number	(%)	Number	(%)	
Age group					.197
<35 y	34	9.1	11	7.1	
35-50 y	262	70.2	102	65.4	
51+ y	77	20.6	43	27.6	
Sex					.199
Male	339	90.9	147	94.2	
Female	34	9.1	9	5.8	
Race/ethnicity					.036
White	270	72.4	129	82.7	
Black	49	13.1	8	5.1	
Hispanic	38	10.2	13	8.3	
Other	16	4.3	6	3.8	

\*Defined as visiting the inebriate reception center 5 or more times within 30 days.

illustrates the distribution of health care utilization and associated charges for the study population by treatment acceptance. The distribution of health care utilization among those who did not accept treatment remained relatively unchanged from the pre- to postperiod. However, the distribution for those who accepted treatment shifted to the left from the pre- to postperiods, which indicates the use of fewer services. Additionally, the Serial Inebriate Program affected the high-end users of hospital and ambulance resources. The median average monthly EMS and ED visits per person for those who accepted treatment were nearly 2 times more than for those who did not accept treatment. More important, the median per person use of EMS, ED, and inpatient resources declined by at least 50% from the pre- to postperiods for individuals who accepted treatment (0.13 to 0.05, 0.16 to 0.05, and 0.05 to 0.02, respectively), whereas there was no change or an increase in the median use of these services among persons who refused treatment and chose to remain in custody (0.06 to 0.07, 0.06 to 0.06, and 0.02 to 0.04, respectively). The resulting overall decrease in health care contacts among the group who accepted treatment was considerable. The total monthly average utilization decreased by an estimated 15 EMS transports among the 198 EMS users, 29 ED visits among the 277 ED users, and 4 admissions among the 136 individuals who used inpatient services. For those who did not accept the Serial Inebriate Program, the estimated total monthly average ED contacts decreased by 10 among the 132 ED users, whereas the total monthly average EMS transports increased by 6 among the 110 EMS users, and inpatient admissions increased by 3 among the 81 individuals who used inpatient services.

As expected, the distribution for charges associated with health care utilization followed similar patterns as contacts (Figure 3); the distribution remained relatively unchanged for

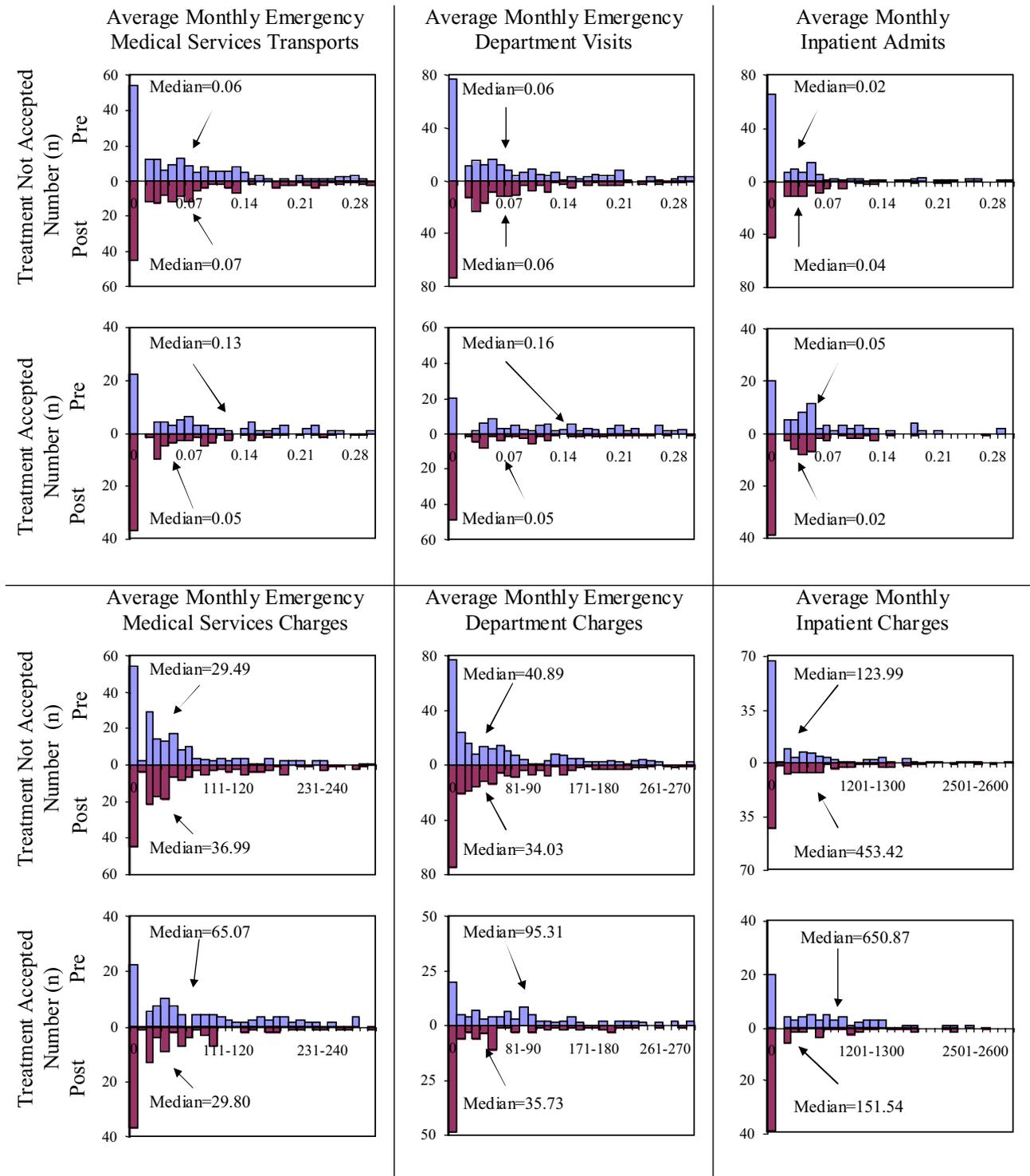
those who did not accept treatment from the pre- to postperiods, whereas the distribution for those who accepted treatment shifted toward lower charges. For those who accepted treatment, the median average monthly per person charge decreased for all types of care from the pre- to postperiods (\$65.07 to \$29.80 for EMS, \$95.31 to \$35.73 for ED, and \$650.87 to \$151.54 for inpatient). For those who refused the offer of treatment, these charges remained unchanged or increased (\$29.49 to \$36.99 for EMS, \$40.89 to \$34.03 for ED, and \$123.99 to \$453.42 for inpatient). The resulting total overall decrease in charges among the group that accepted treatment was also substantial. For those who accepted treatment, the total monthly average charges decreased by an estimated \$5,662 for EMS transports, \$12,006 for ED visits, and \$55,684 for inpatient admissions. For those who did not accept treatment, the total monthly average ED charges decreased by an estimated \$434, whereas charges for EMS and inpatient services increased by \$6,521 and \$205,506, respectively.

## LIMITATIONS

This study has several limitations. Medical charges were used to reflect the expense of care, but charges and costs are not equivalent. Second, hospital charges are likely underestimated because only 2 of the city's dozen hospitals participated in the study. However, these 2 hospitals are the primary receiving facilities for neighborhoods with the greatest numbers of police calls related to alcoholism. Third, this study did not address the direct or indirect costs of operating the Serial Inebriate Program. The costs incurred by law enforcement, the city attorney, the county jail, and those associated with treatment and housing were not analyzed. However, in 1990 the San Diego Police Department estimated that the annual cost of arresting, transporting, jailing, and filling out paperwork for a similar group of 90 downtown individuals was \$320,000.<sup>17</sup> That analysis did not reflect the cost to city government for public defenders, prosecutors, and court time, nor the social costs or financial impact of these individuals on the private sector.

This study compared individuals who accepted treatment versus all others and assumes the latter population shares a similar use pattern regardless of whether they rejected or were not offered treatment. Furthermore, this study did not measure the success of the Serial Inebriate Program in achieving long-term sobriety or reducing homelessness or the use of medical care at other locations. Serial Inebriate Program clients are referred to outpatient medical facilities for ongoing care, but the extent of their use of such services was not available for analysis. It is therefore possible that the reduction in charges demonstrated by this study overestimated the actual decrease in use of health care resources. However, private transportation to clinics is typically preferable to repeated EMS transport to EDs.

Follow-up was not performed to assess the possibility that some individuals might have died or relocated. Attrition occurs in frequent ED users,<sup>1,7,11</sup> and some authors have suggested



**Figure 3.** The distribution of health care utilization and associated charges for 529\* Serial Inebriate Program clients<sup>†</sup> by treatment acceptance status,<sup>‡</sup> San Diego, CA, January 1, 2000, to December 31, 2003.

\*Seventy-nine serial inebriated individuals had no record of use of health care resources.

<sup>†</sup>Defined as visitors to the inebriate reception center 5 or more times within 30 days.

<sup>‡</sup>Outlying monthly averages to the right of the graph were excluded from the graph to focus on the bulk of records but were included in determining the median.

that interventions should be targeted only toward patients who remain frequent ED users for at least 2 years.<sup>1</sup> However, the Serial Inebriate Program is intended to offer treatment independently of the frequency of ED visits, recognizing that hospitals will benefit if the program is successful. Finally, this study could not determine health care utilization as a function of actual months in treatment or incarceration. The true duration of treatment or incarceration varies among individuals based on coexisting legal issues. Because precise treatment and incarceration periods were unavailable, a simple pre- or postformat using the entire follow-up period was used.

## DISCUSSION

This study documents the extraordinary consumption of EMS, ED, and inpatient resources by one city's population of homeless chronic alcoholics. Assuming an average observation period of 4.5 hours (Dunford, unpublished data) these patients consumed nearly 15,000 hours of ED staff time at 2 of San Diego's major regional hospitals, which equates to a 34% chance that a Serial Inebriate Program client was occupying an ED bed at one of these facilities at any moment during the 4-year study. These data provide evidence that a relatively small number of individuals can have a large impact on a community's safety net.

This study also demonstrates that a community-supported alcohol treatment strategy that incorporates legal consequence can reduce the consumption of emergency health care resources. There was a 50% decline in the use of ED, inpatient, and EMS resources for the 156 individuals who accepted a 6-month outpatient treatment program in lieu of custody. Conversely, there was no change in resource consumption by the 112 individuals who elected not to enter treatment. The Serial Inebriate Program's success derived primarily from its impact on the most recidivist individuals. Those accepting treatment were typically older men who had been transported by EMS and treated in ED twice as often as nonacceptors.

There are many questions raised by this study. It is unclear which factors determine the need for medical care in this population. Curiously, during 4 years there is no evidence that 79 (15%) of the 529 Serial Inebriate Program clients were ever transported by paramedics or received hospital treatment. Furthermore, it is unknown which aspect of the Serial Inebriate Program motivated change. Alcoholism research suggests that motivation is essential to recovery.<sup>18</sup> A series of stages (precontemplation, contemplation, preparation, action, and maintenance) describes the process an individual experiences when undergoing behavioral change. It has been suggested that legal pressure may have particular potential to motivate change in drug and alcohol behavior because it can be more consistently applied than other social pressures.<sup>14</sup>

According to treatment providers familiar with this population, it is remarkable that any, let alone 156, of the community's most refractory individuals accepted treatment. It may be that individuals with chronic alcoholism come to view themselves differently than inmates incarcerated for other crimes

(Dunford, oral communication, 2005). Given the progressive sentencing structure of the Serial Inebriate Program, some individuals have explained their participation in treatment as the "lesser of 2 evils." If it could be substantiated that one longer initial sentence was as likely to result in treatment as the current stepwise process, more rapid initiation of therapy and significant cost savings might be achieved.

Ten percent of the nation's homeless are considered chronically homeless (more than 1 year without permanent shelter),<sup>19</sup> and in San Diego that figure may be as high as 19%.<sup>20</sup> The US Interagency Council on Homelessness estimates that 10% of the nation's homeless consume 50% of public resources, including EMS, detoxification, shelter, law enforcement, and psychiatric and correctional care.<sup>21</sup> The effect of publicly inebriated individuals on EMS and ED has been previously described. Purdie et al<sup>6</sup> reported that 14 of 16 ED patients with more than 1 visit per month for 6 months at the Denver General Hospital were intoxicated. Two hundred twenty-three (84%) of their 267 ED visits involved 911 paramedic transport. Biros<sup>4</sup> reported that the Hennepin County ED treated 20 similar individuals a total of 1,858 times in 1 year. In 2002, 5.6% of all ED visits to that facility were related to alcohol intoxication.<sup>2</sup> At the San Francisco General ED, frequent use of the ED correlated with alcohol-related problems, including intoxication (relative risk, 2.4), seizures (relative risk, 3.0), and dependence (relative risk, 3.4).<sup>1</sup>

There have been efforts to reduce the use of emergency services by this population.<sup>2,5,13,14</sup> Hennepin County developed a housing and street case management program for individuals who had failed detoxification treatment, referrals, mental health holds, and involuntary commitments.<sup>2</sup> Although the program reduced the number of visits to detoxification centers and EDs for 96 individuals, overall visits for medical illness did not decline, and the program did not attempt to achieve patient sobriety. Okin et al<sup>5</sup> demonstrated that intense case management can reduce the inordinate use of ED resources. Fifty-three patients treated in the San Francisco General ED 5 or more times within 12 months were voluntarily assigned to a psychiatric social worker. The median number of ED visits declined from 15 to 9 ( $P < .01$ ), median ED costs declined from \$4,124 to \$2,195 ( $P < .01$ ), median inpatient costs declined from \$8,330 to \$2,786 ( $P < .01$ ), and alcohol use was reduced by 25% ( $P = .05$ ). The authors concluded that each dollar invested yielded a \$1.44 savings.

Not all states consider public intoxication as a public offense. For example, the Nevada legislature has declared that the handling of alcohol abusers within the criminal justice system is ineffective and inappropriate, whereas treating alcohol abuse as a health problem allows prevention and treatment while relieving law enforcement agencies of a burden.<sup>22</sup> Nevada transferred the handling of public intoxication from statutes providing criminal sanctions (including loitering and vagrancy) to statutes providing for civil protective custody. A person found in a public place in Nevada under the influence of alcohol, in such a condition that he

is unable to exercise care for his health or safety or the health or safety of other persons, must be placed under civil protective custody by a peace officer. If a licensed facility for the treatment of persons who abuse alcohol exists in the community where the person is found, he must be delivered to the facility for observation and care. If no such facility exists, the person so found may be placed in a county or city jail or detention facility for shelter or supervision for his health and safety until he is no longer under the influence of alcohol.

San Diego views public intoxication fundamentally as a health problem also. The goal of the Serial Inebriate Program is to improve the health of its clients and the community. The Serial Inebriate Program is designed to encourage individuals to reconsider the benefits of treatment while addressing the public safety consequences of their medical condition. Repeated efforts are made to link chronically intoxicated persons with comprehensive treatment. Only after such efforts prove futile (in the eyes of treatment providers themselves) does the Serial Inebriate Program become available as a therapeutic option for judges. This study demonstrates that incarceration alone is not beneficial in reducing the need for episodic emergency care. Clients who chose to serve time in custody rather than enter the Serial Inebriate Program treatment characteristically resumed high rates of EMS, ED, and inpatient consumption after returning to the street. However, those who chose the treatment pathway subsequently enjoyed a reduced need for ambulances, EDs, and hospitalizations. The opportunity for such success after years of failure was a key factor in securing and retaining the support and trust of the Office of the Public Defender for this program.

To build partnerships such as the Serial Inebriate Program that address multifactorial public health issues, EMS medical directors can play valuable roles as "champions" through their affiliations with public safety, hospital, and public health resources. Communities should embrace novel approaches such as the Serial Inebriate Program to improve the care of traditionally difficult-to-serve populations.

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*Author contributions:* JVD conceived the study, supervised its implementation, and led the writing. EMC assisted with the study and completed the statistical analyses. SPL assisted with the analyses. PJ assisted in the data collection. TCC and GMV assisted with writing. JVD takes responsibility for the paper as a whole.

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*Address for correspondence:* James V. Dunford, MD, University of California, San Diego Medical Center, 200 West Arbor Drive, # 8676, San Diego, CA 92103; 619-533-4359, fax 619-543-3115; E-mail [jdunford@ucsd.edu](mailto:jdunford@ucsd.edu)

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### **Volunteer for a Committee and Lend Your Experience and Expertise ACEP and Emergency Medicine Need Your Assistance**

The process to select members to serve on ACEP committees is beginning, and all ACEP members are encouraged to apply.

EMRA resident members who are interested in serving as that organization's representative on an ACEP committee should also apply. The process is the same for resident and active members, and you can expedite the process by using the online application.

You must submit a current CV to volunteer for a committee and you can either attach the file to the online form or mail it to ACEP headquarters. You may also want to submit a letter of support from your chapter. Members who do not know how to contact their state chapters should call Gloria Thompson, Chapter Services Manager, at 800-798-1822, ext. 3227, or send an e-mail to [gthompson@acep.org](mailto:gthompson@acep.org). The procedure to submit both forms is included with the online application: <http://www2.acep.org/1,32336,0.htm>

The majority of committee work is accomplished through e-mail, correspondence, and conference calls. However, committee members are expected to attend the organizational meetings at the *Scientific Assembly* in New Orleans, October 15-18, 2006.

You must submit your committee interest forms by May 15, 2006. This is a month earlier than previous years. If you have any questions, please contact Rochelle Ross at 800-798-1822, ext. 3145, or [ross@acep.org](mailto:ross@acep.org). Brian Keaton, MD, FACEP, ACEP's President-Elect, will finalize committee appointments in June.

Remember, your participation will make a difference. Please consider volunteering. ACEP and emergency medicine need your experience and expertise.