The Revolving Door Revisited: Public Inebriates' Use of Medical and Nonmedical Detoxification Services in New York City

Susan Sadd, Ph.D.
Vera Institute of Justice
July 29, 1985

There has been a long-standing debate about the efficacy and safety of non-medical (or social setting) detoxification programs for public inebriates. While numerous evaluations of these programs have yielded promising results, the questions will not be put to rest until a controlled research design is used to compare these programs to more traditional medical detoxification programs. At the Vera Institute, we are currently conducting such a study, funded by NIAAA, and utilizing four existing detoxification facilities in New York City. The study sites include Beth Israel Medical Center's alcohol detoxification unit (BI), the Manhattan Bowery Corporation's freestanding medical detox (MB), and two non-medical programs, the West Side Social Setting Alcohol Treatment Center (SS) and the Lower Manhattan Sobering-Up Station (LM).

We are in the second year of this two-year study and have completed the data collection on nearly 1100 subjects. These include a group of individuals who refused to participate in the research, a group who were not accepted into the program to which they were assigned, and still others who comprise the treated sample. We have varying amounts of data on each of these groups. The subjects were drawn from those deemed eligible for non-medical detoxification and seeking detoxification services at the Manhattan Bowery facility or either of the two non-medical

facilities. Because all three of these programs specialize in serving public inebriates, virtually all our subjects are impoverished and homeless, with extensive histories of alcoholism. (We should note that both the Manhattan Bowery Project and the Lower Manhattan Sobering-Up Station are located in New York's Bowery area, long a neighborhood which exemplifies skid row. More than three-fourths of the men in our study indicated that they were homeless and another 13% resided in SROs (single room occupancy hotels). Preliminary data analyses suggest that these living conditions were fairly long term, averaging approximately eighteen months. In addition, 94% of them indicated that they were unemployed; 39% of them indicated that their major source of income was panhandling, 8% "hustling," and 14% had no income at all. Based on these data, we have no question about the desperate straits of our research population. Nor do we have any question that this is an alcoholic population; the SMAST (Short Michigan Alcoholism Screening Test) was administered to all men who agreed to participate. Their median score was 10 out of a possible 13, well over the number of positive responses necessary to qualify one as an alcoholic (3). We also know that they had extensive drinking histories, some of them starting as early as nine years of age.

Eligible men who entered these facilities during the intake period (February 1984 through January 1985) were randomly assigned, with their consent, to one of three detoxification facilities. [As is often the case with field research, a number of factors outside our control affected the research.

Specifically, the original design called for only one non-medical facility, the West Side program. Because the building in which that facility was located was sold, the program closed in July 1984. To ensure a large enough sample size to conduct statistical analyses, we obtained the agreement of the Lower Manhattan facility to serve as our non-medical study site for the latter part of the intake period. Thus, at any given time there were three facilities participating in the research.] Once admitted to a detoxification facility, research subjects were treated like any other detoxification client, and went through the program's standard detoxification process.

Thus this type of controlled design should enable us to reliably study the relative safety and efficacy of non-medical as compared to medical detox. The data consist of a considerable amount of background information on each subject, including drinking and alcoholism treatment history, medical history, and financial and employment status. The treatment received at each facility, in terms of the medication prescribed and administered, counseling sessions attended, etc., in combination with the background data, will be assessed for their effects on various outcome variables. It should be noted that this project is still in the very early stages of data analysis. The first task of this phase was to verify that we had a representative sample of public inebriates, and therefore, those were the first analyses to be run. The emphasis of this paper reflects the stage of the analysis process.

Although our site researchers spoke to nearly 1100 men, we

had a substantially higher refusal rate than we had originally anticipated; 421 of 1092 eligible men refused to be in the research, a refusal rate of 38.6%. Naturally, we were concerned that this problem would render our sample non-representative; however, we collected some data on those who refused (called Respondent Rejects). Analyses of the data suggested that there are no meaningful differences between the Respondent Rejects and the group who consented.

RESPONDENT REJECTS

We found no relationship between place of residence and refusal to be in the research: 37% of the homeless men, 41% of those who lived in an SRO or mission, and 37% of those who lived in a private home refused to participate. Furthermore, we found no difference between consenters and respondent rejects on the number of months they had been living in their current "residence"; the mean for both groups was 18.1 months. While we did find a significant relationship between agreement to participate and race/ethnicity, this relationship is confounded by the differential rate of entry at the various sites. That is, MB provided 75% of the entrants, must of whom are black. It is likely that this relationship is an artifact of the different rates of refusal at the various sites, and we do not consider it to be a problem. [Sixty-nine percent of blacks, 58% of whites, and 57% of hispanics agreed to be in the research.] There was also a small but significant difference on age at entry; the mean for consenters was 41.9 and for respondent rejects was 43.3. This is a very small difference, and we do not consider it a problem.

We were concerned about the possibility that the men who refused to participate, especially those who indicated they were concerned with the severity of withdrawal, might be sicker than those who agreed to participate in the research. For those respondent rejects who were treated at the medical facility, we were able to collect data on their vital signs at intake and compare them to vital signs at intake for consenters from all three sites. We found no consistent differences between the consenters and respondent rejects on vital signs, and this reinforced our conclusion that we do, in fact, have a representative sample of public inebriates participating in our study.

The most interesting data we collected from the respondent rejects were their reasons for refusal. We coded up to seven reasons for each person and cross-tabulated the results by entry site. Only 6 of 410 respondent rejects indicated that they were opposed to medical detox in general, as compared to 165 who were opposed to non-medical detox. As would be expected, all the men who gave this reason for refusal entered at the medical facility, and represented 54% of the respondent rejects at that site. Similarly, 64% of the respondent rejects at that site indicated that they would not participate in the research because they were concerned with the severity of their withdrawal.

The lack of differences between consenters and respondent rejects, taken with the reasons given for refusal, and our own observations led us to conclude that the "real" major reason for refusal had to do with familiarity with a particular facility or

negative impressions of another site. We also had the feeling that for some of the men agreement or refusal was almost a whim -- more than one person who voiced opposition to a particular facility eventually showed up at that very facility for detox. Furthermore, some of the respondent rejects who were subsequently readmitted to the detox facility would indicate their willingness to participate in the research at that time.

This impression was reinforced by the finding that a substantial proportion of those approached refused because they had a special preference for the entry facility. While we have not yet completed the analysis, we believe that many of them are the same people who indicated that they were concerned with the severity of their withdrawal. Furthermore, the prevalence of this response varied by entry site: 61% of those who entered at MB, as compared with 41% of those who entered at SS gave this response. In addition to preferring a particular site, some respondent rejects voiced opposition to going to a particular site, and this too was related to entry site. Opposition to a particular site was of importance because of the random assignment; the site researcher stressed to each eligible man that agreement to participate in the research would result in assignment to any of three facilities. This response was most prevalent among those entering at SS, where 63% of the respondent rejects voiced opposition to MB. In contrast, 4% of the respondent rejects who entered at MB voiced opposition to SS and less than 1% were opposed to LM. Three percent of the MB respondent rejects and 4% of the SS respondent rejects said they were opposed to going to Beth Israel.

DEMOGRAPHICS

Because we are in the very early stages of data analysis, the data that we have right now are only preliminary. However, we have no doubt that our research sample is composed of the homeless population at which the study was directed. As was indicated above, fully 75% of the men indicated they were homeless and an additional 15% lived in SROs or missions. Forty-five percent of the sample was white, 39% were black, and 16% were hispanic. The majority of the sample (53%) had never been married, 37% were divorced, 6% indicated that they were widowed, and 7% were married or cohabiting. Less than half the subjects had graduated from high school: 6% had a sixth grade education or less; 21% had between 7 and 9 years of school; 30% had some high school; 29% were high school graduates; and 13% had gone beyond high school.

Although 94% of the men were unemployed at the time they entered the sample, we collected data on their usual occupation when they worked.

OCCUPATION

Laborer	36%
Service	23%
Operative	14%
Skilled Worker	12%
Clerk	8%
Professional	3%
Other	5%

That only 7% of these men indicated that they were currently married or cohabiting, that 90% were homeless or living in an SRO, and that 94% of them were unemployed, is all evidence that this is a disaffiliated population. Additional evidence is provided by their relative lack of contact with other family members: 38% indicated they had no family contact, 20% that they seldom saw or spoke to their family, 21% that they did so occasionly, and 21% had frequent contact with their family.

AVAILABILITY OF MEDICAL DETOXIFICATION

The research was designed to test the safety and efficacy of non-medical detoxification, and therefore, consenting subjects were randomly assigned to treatment facilities. We discovered very early in the study that comparing hospital-based medical, freestanding medical, and non-medical detoxification would not be a straightforward statistical process because our subjects experienced a great deal of difficulty in gaining admission to the hospital-based facility. We regard this as a major finding of the research, and have pursued the issue of availability of medical detoxification to public inebriates. The particular hospital facility that was involved in our study was a private, non-profit hospital in New York City, whose admissions policies are governed by PSRO criteria and Medicaid requirements. Therefore, we had anticipated that some of our subjects would be denied admission, but rather than the 70% we had expected, admission to this facility was limited to only 25% of the subjects assigned there.

During the very early stages of the research, we sent each BI assigned subject to the hospital for screening. We discovered, however, that without either a valid Medicaid card or extensive identification documents, a subject would have to be exhibiting fairly severe withdrawal symptoms to be admitted. Members of this population generally appear for detoxification while still intoxicated; in fact, one of the non-medical programs "required" that their clients be intoxicated (as indicated by Alcometer readings) to be admitted. Because the hospital screening process generally involved two or more hours of waiting before an individual was declined admission, our site researcher did "pre-screening" before deciding to actually send the subject to the hospital. That is, we obtained a list of documents necessary to establish Medicaid eligibility, and asked each BI-assigned subject whether he had them. In addition, the site researcher would call the BI financial screening office and inquire whether the subject had been admitted to the hospital before (which would mean they had copies of his identification papers). In addition, vital signs were taken at the entry facility; thus, the site researcher was able to assess the likelihood of the subject's being admitted to the hospital and only send those who had a chance of being admitted.

Our data indicate substantial differences between those subjects treated at the hospital and those who were not admitted for treatment. Those admitted to the hospital were more likely to be receiving public assistance and have insurance coverage than were those who were not treated at BI. While the large

majority of both groups received no welfare payments, 19% of the treated subjects received home relief and 17% received SSI as compared to the 8% of the untreated subjects who received home relief and 7% who received SSI. (It should be noted that those subjects who did not receive welfare were in worse straits than those who did; these tended to be individuals whose welfare ID had been consistently stolen or who did not have the wherewithal to obtain identification necessary to demonstrate their eligibility for welfare. Often, those subjects not on welfare had no income at all.) There was a stronger relationship between having insurance and admission to the hospital: 81% of the untreated subjects, as compared to 28% of the treated subjects had neither insurance nor the identification necessary to be considered Medicaid-eligible. Of those admitted to the hospital, 37% had Medicaid, 9% had Medicare, and 26% were Medicaid-eligible.

Despite these differences, there were no other significant demographic differences or differences in "stability" between these two groups. There was no significant relationship between ethnicity and being admitted to the hospital. Those who were admitted were no more likely to be domiciled than those who were not; nor were they any more likely to be married. The educational levels of the two groups were also equal.

There were, however, significant differences in the withdrawal symptoms displayed at intake by these two groups. As was explained above, the hospital had rather stringent criteria regarding withdrawal symptomatology, required to demonstrate need

for hospitalization to collect third-party payments. Among the symptoms of withdrawal we measured were tremors, sweating, hallucinations, elevated temperature, pulse, and blood pressure. While there was no difference in the incidence of hallucinations at intake between the two groups, there were substantial differences in observed sweating and tremors. Thirty-nine percent of the treated subjects exhibited moderate or severe sweating at intake, as compared to 16% of those who were not admitted to the hospital. Similarly, 57% of the treated subjects and 16% of the untreated subjects exhibited moderate or severe tremors. There was a small but significant difference between the two groups on their average temperature at intake; the mean for treated subjects was 98.5 and for untreated subjects the mean was 99.1. There were significant and larger differences on pulse and blood pressure: the mean pulse at intake for subjects treated at BI was 105 as compared to 88 for untreated subjects. The means for both systolic and diastolic blood pressure were higher for treated (146/99) than for untreated subjects (130/81).

Thus, it is clear that to be admitted to Beth Israel's detox, it is necessary to have insurance coverage and evince symptoms of withdrawal. Only about one-fourth of our subjects met these criteria, and we believe that without the site researcher's help, even fewer would have been admitted. As part of our research, we have been interviewing administrators of all detoxification programs in New York City. They have confirmed that BI's practices are not anomalous. Rather, with the

exception of beds in municipal hospitals, public inebriates are generally excluded from hospital detoxification. This means that the only medical detox available to them in lower Manhattan, where large numbers of homeless alcoholics congregate, is the freestanding medical facility at the Manhattan Bowery Project.

SAFETY OF NON-MEDICAL DETOXIFICATION

This finding highlights the importance of the question the study was designed to answer, "Is non-medical detoxification safe for public inebriates?" With medical detoxification so difficult to come by, the alternative treatment is the sobering-up station or social setting detoxification. With the exception of Queens, there is at least one sobering-up station in each borough of New York. These non-medical facilities are heavily utilized by homeless alcoholics, and tend to be located in the neighborhoods with the heaviest concentrations of public inebriates. Our research focused on two such programs, one located on the upper west side of Manhattan and the other in the Bowery area. (As was indicated above, only one of these programs was involved at any given time.)

One of the first questions to be raised was what proportion of the randomly assigned public inebriates would be refused admission because they were considered unable to withstand a non-medical detox. Each non-medical program in New York has a triage plan by which they determine whether an applicant is well enough to detox in that facility. Conditions which render an individual inappropriate include a recent heart attack, head trauma; or other acute, serious medical condition addiction to another drug

from which they would undergo withdrawal; psychosis; and in some cases, a history of difficult withdrawal. Each of two non-medical facilities we studied has a relationship with a hospital or community health facility to which they send questionable cases for medical screening prior to admission. The majority of our research subjects assigned to the non-medical facilities were admitted (62% at LM and 82% at SS). Lower Manhattan tends to be more cautions about men over the age of 60, and that is reflected in their higher rejection rate.

We are still in the early stages of the data analysis, but we are able to report on the frequency of hospital referrals from non-medical programs, and the outcomes of those referrals. We also have data on withdrawal symptoms and vital signs during detox at all four faciliites. The two non-medical programs differed in the frequency of hospital referrals prior to or during detox, 40% of the <u>treated</u> subjects at LM, as compared to 7% of those at SS had such referrals. The most common reason for a trip to a medical facility was alcohol withdrawal problems, generally seizures, which were treated and the man returned to the non-medical facility. Other conditions which would trigger a hospital referral include tuberculosis or other lung disease or a need for blood work. These, too, generally resulted in treatment and return to detox.

Central to the issue of safety of non-medical detoxification are the experiences of persons who undergo withdrawal without medication. We were able to analyze the withdrawal symptoms and vital signs of subjects in the various facilities on each of the

five days of detox. The withdrawal symptoms data consist of observed sweating, tremors, and hallucinations. Vital signs data were coded from patients' charts and consist of the highest recorded temperature and pulse for each day. We found very little variation in temperatures, either among sites or across days: the means ranged from 98.2 to 99.7. There was greater variation in pulses, however; for the first three days of detox, there were significant effects for pulse. On each of those days, the highest mean pulse was at Beth Israel. (See Table below).

Mean Pulse

	Site			
Day	BI	LM	MB	SS
1	106	93	94	91
2	93	87	87	89
3	90	86	84	87
4	88	85	85	87
5	89	85	85	87

These data remind us that the treated subjects at BI are not randomly assigned; rather, they represent those with the most severe withdrawal symptoms. More intereting, however, and the similarities among the other three sites. Subjects who detoxified at LM or SS received no withdrawal medication, yet they did not experience higher pulse rates than the MB subjects who received large doses of phenobarbital.

The withdrawal symptoms data are somewhat problematic: one of the non-medical facilities had consistently higher scores on sweating and tremors, but these were not related to the vital signs at that site. Therefore, additional analyses will be

necessary before we are able to draw any firm conclusions. However, there is no consistent evidence that subjects in non-medical facilities exhibited more severe withdrawal symptoms than those in the medical facilities. The LM subjects tended to exhibit less severe withdrawal symptoms than those in the medical facilities. Thus, it appears that, for the majority of the public inebriates in our sample, non-medical detoxification is as safe as medical detoxification.