THE SOCIAL SETTING ALCOHOLISM TREATMENT CENTER: AN EVALUATION

A Vera Institute of Justice Monograph

June 1978

THE SOCIAL SETTING ALCOHOLISM TREATMENT CENTER:

AN EVALUATION

Janet Quint
Vera Institute of Justice
June, 1978

This report was funded by the National Institute on Alcohol Abuse and Alcoholism. Points of view or opinions stated in this document are those of the authors and do not necessarily represent the official position or policies of the Vera Institute of Justice.

CONTENTS

LIST OF TABLES

ACKNOWLEDGMENTS

Although the title page of this report lists a single author, the work should be viewed as a collaborative venture. The research effort drew on the insights and ideas, cooperation and assistance of many people, only a few of whom can be mentioned here.

Dr. Robert Morgan, Project and Medical Director of the Manhattan Bowery Corporation, inspired much of the data collection for the Client Information Study. Ed Geffner, MBC's Administrative Director, was supportive of research and researcher.

The Social Setting Alcoholism Treatment Center staff were uniformly helpful and friendly toward research personnel. Credit for their receptive attitudes goes largely to Stephanie Bozzone, Project Director of the Social Setting Alcoholism Treatment Center, who from the outset paved the way for research efforts and smoothed over the frictions that inevitably arose. Francine Dobranski, the Center's Data Coordinator, assisted research staff in securing needed statistics and in "learning the ropes" of Center operations. Rick Passmore's deep familiarity with alcoholic behavior made him an excellent critic of questionnaire drafts and an invaluable source of general information.

Without the cooperation of Rescue Aide John Wickens and Police Officer Walter Cowles, the Approach-Referral Study would not have been possible. Officer Ernie Talbot of the MBP Rescue Team made many useful operational suggestions.

At Beth Israel Hospital, Dr. Henry Pinsker was instrumental in steering the controlled study through the hospital's research review committee, and Dr. Alex Richman willingly shared his mathematical model of readmission rates. That both men corroborated the hunches of a relatively novice "alcohologist" was a source of instant gratification; that they helped to clarify and flesh out these hunches is a cause of enduring gratitude.

Professor Eli Noam of Columbia University was responsible for the cost analysis. His work was impeded by the lack of readily available hospital data; but it is hoped that it will improve analysis in this insufficiently explored area.

Lucy Friedman of Vera gave a careful reading to an early draft of this manuscript and gave useful advice throughout. Joyce Sichel's grasp of research methodology helped to delimit the study in a sensible way. Cecily Swift was an able part-time research assistant.

This endeavor could not have been completed without the yeoman service of Kathy Schaffer, the project's research assistant. She handled tasks large and small, interesting and dull (and all too often large and dull) without complaint and with fastidiousness, wit, and aplomb.

SUMMARY

Although Skid Row alcoholics comprise only five percent of problem drinkers in the United States, they have been a chief object of public policy measures to control alcoholism and alcoholics. Until the mid-1960's, the criminal justice system was the primary agency of control: alcoholics were routinely arrested and jailed in "drunk tanks" to sober up. In 1967, the Manhattan Bowery Corporation (MBC) was established to relieve the criminal justice system of this responsibility, by developing and implementing a more humane means of removing public inebriates from the streets and providing them with medical attention and other rehabilitative services.

Ten years later, MBC opened the Social Setting Alcoholism Treatment Center (SSATC) to serve disaffiliated alcoholics on Manhattan's West Side and to test the proposition that, given a supportive setting, specially trained staff, and careful screening for possible medical complications, alcoholics can sober up safely without supervision by medical personnel and without the use of sedatives. This report assesses SSATC's effectiveness during its first seven months of operations.

During this period, the Center admitted 950 men (only men could be accommodated at this time), representing 1217 separate admissions. The majority were in their 30's or 40's with 45 the median age. About 60 percent of SSATC residents were white, one quarter were black and the rest were predominantly Hispanic. A study of client characteristics documents that SSATC has reached the disaffiliated alcoholics it set out to serve: only eight percent of the residents were married and living with their spouses, almost half had no permanent address, and only one in 20 was employed full-time on admission to the Center. Two-thirds of the men had been heavy drinkers for ten years or more, and three-fourths characterized their drinking problem as serious. The vast majority (85%) had detoxified previously, and of these, over half had done so within six months of admission to SSATC. More than half the clients had previously participated in residential or outpatient treatment programs.

SSATC drew half of its admissions from a police-civilian rescue team that patrols the catchment area and transports those alcoholics who request assistance either to SSATC or to a hospital for care. About a quarter of the admissions sought treatment at SSATC on their own, and the remainder were re-

ferred from hospitals and social service agencies. About a quarter of the people admitted left before completing the prescribed length of stay (5-7 days). Two-thirds of those who completed treatment received a referral for follow-up care. The evaluation addressed two issues concerning the efficacy of non-medical treatment: the safety of the withdrawal process and the rehabilitative impact of treatment. Clients interviewed about their experience at SSATC liked its pleasant atmosphere and praised the competence of the staff. Some said that sobering up without drugs left them more clear-headed, others preferred to receive medication in order to relieve the unpleasant effects of withdrawal.

Qualitative indicators of satisfaction are corroborated by data from program records that show SSATC to be as successful as other non-medical facilities in providing a safe environment for withdrawal from alcohol. Only about four percent of the clients admitted to SSATC had to be transferred to the Center's back-up hospital to complete treatment.

Of the first 100 clients admitted to SSATC, 42 percent were readmitted at least once within the six months after discharge. SSATC readmission rates are roughly comparable to those reported for other medical and non-medical detoxification facilities.

A cost-effectiveness analysis indicates that non-medical treatment is a highly economical alternative to detoxification in a hospital setting. From the taxpayer's viewpoint, treatment at SSATC is nearly four times more cost-effective than at a major New York City hospital.

In order to ascertain the proportion of public inebriates who can safely be treated in a non-medical setting, a study was conducted of all inebriates approached by the West Side rescue team during a four-week period. It is estimated that between 50 and 70 percent of those contacted could be treated at SSATC. The remainder had physical problems which precluded detoxification in a non-medical facility. Although this estimate is based on a limited sample restricted to a particular group of alcoholics, and needs further refinement, it suggests that the non-medical treatment modality is appropriate for a sizeable proportion of the public inebriate population. The best predictors of whether a client decided to accept the rescue team's offer of assistance were his age (younger clients were more likely to decline aid) and whether or not he had begun to experience withdrawal symptoms.

SSATC is successful in its mission of removing alcoholics from the streets and providing them with a safe environment in which to sober up and to retreat temporarily from the hardships of street life. Its operations are highly cost-effective in comparison with hospital-based detoxification programs. SSATC's long-term impact on its clients' drinking behavior appears to be constrained, however, because its resources are insufficient to permit close integration with the many additional services-- shelter, health care, income maintenance, low-stress employment, and vocational and psychological counseling, among others -- needed to rehabilitate the chronic alcoholic.

INTRODUCTION

The Social Setting Alcoholism Treatment Center (SSATC), established and operated by the Manhattan Bowery Corporation (MBC), is the first non-medical detoxification center in New York City supported by public funds. As such, an evaluation was required to monitor the effectiveness with which the Center operates and to assess the appropriateness of this treatment model for the public inebriate population as a whole. The results may be of particular relevance to policy-makers in light of the decriminalization of public intoxication and the need to establish alternative facilities for disaffiliated alcoholics.

This report presents the findings of the evaluation. It is divided into six sections. The first section provides a perspective on the background and objectives of detoxification programs in general and of non-medical detoxification programs in particular. The second section describes program operations and profiles SSATC clients. The third section assesses the degree to which the Center has achieved two major objectives of providing (1) safe detoxification and (2) successful referrals to rehabilitation programs. The fourth section compares the costs and benefits of detoxification in medical and non-medical settings. The fifth section considers the suitability of non-medical detoxification for public inebriates in the SSATC catchment area. The report concludes with a consideration of some policy issues associated with the treatment of chronic alcoholism.

I. THE BACKGROUND AND OBJECTIVES OF NON-MEDICAL DETOXIFICATION

Treatment for the Skid Row Alcoholic: The Historical Background

Skid Row alcoholics comprise only five percent of all problem drinkers in the United States.[1] But the unsightliness of the alcoholic derelict, his indigence, and the seeming intractability of his condition have placed the public inebriate in the spotlight of public policy measures to control alcoholism and alcoholics. The average alcoholic, a middle-class wage-earner with a house and family, may pose a greater threat to the public welfare than his Skid Row counterpart -- half of all fatal traffic accidents involve alcohol, and a quarter involve alcoholics[2] -- but he is unlikely to be found panhandling or urinating out in the open. The public inebriate is a public nuisance.

Life on Skid Row is unhealthy and sometimes dangerous. When the alcoholic has a permanent address, it is generally in a run-down hotel or boarding house; otherwise, he sleeps in doorways, parks, or flophouses. His first concern upon waking is

---

[1] See "Facts on Alcoholism," a publication of the National Council on Alcoholism, Inc. (10/73).

In this report, the terms "chronic alcoholic," "public inebriate," "derelict," "Skid Row alcoholic," "disaffiliated alcoholic," and the like are used interchangeably, following the usage of many professionals who treat or write about alcoholics.

Also, masculine pronouns are used when referring to this population. Female alcoholics constitute a small proportion of Skid Row alcoholics.

[2] Ibid.

to get a drink that will steady him through the day ahead. Eating is less important than drinking, and he may go for days without a full meal. If he works at all, it is generally in "spot jobs," as a low-skilled day laborer. His clothing is often shabby and dirty. He is a favorite victim of muggers, who show no compunction about taking what little he has while he is in a drunken stupor, sleeping, or otherwise incapable of resistance. Sometimes he walks around with an untreated infection, not infrequently he has diabetes, a liver ailment, or a communicable disease. If the derelict's lifestyle is offensive to the public, it also poses hardships for the man himself.

Two orientations -- one of control and containment, the other of therapy and rehabilitation -- that in turn reflect differing perspectives on the nature of alcoholism have guided public policy toward alcoholics in the past century. In the former view, alcoholism is an indication of self-indulgence, and the alcoholic is an individual who has brought his condition upon himself and who should be removed from society. To advocates of rehabilitation, on the other hand, the alcoholic is a sick person suffering from a disease with a complex etiology that includes physical, psychological, social and cultural factors. The object of rehabilitation is to raise the alcoholic to a higher level of physical and social functioning and ultimately, to re-integrate him into

society as a sober, productive individual, thereby eliminating the need for control efforts. Although many alcoholism programs combine elements of both approaches, in general programs geared toward one or the other have been implemented by different personnel and directed toward different groups of problem drinkers.[3]

Until the mid-1960's, the primary approach toward Skid Row alcoholics in New York City was toward control, with the criminal justice system serving as the instrument of that control. Considered to be public offenders, alcoholics were often arrested in "round-ups" under charges of disorderly conduct, brought into court without counsel, and discharged or given brief jail sentences. Although short jail stays forced temporary abstinence, as a rule the incarcerated alcoholic received little attention for his medical problems and no treatment for his drinking problem; it is hardly surprising, therefore, that when released, he often headed for the nearest bar. In its dealings with public inebriates, the criminal justice system was widely castigated as a "revolving door," ineffective in curbing alcoholism and wasteful of the scarce resources of law enforcement agencies.[4]

---

[3]See Jacqueline Wiseman, Stations of the Lost: The Treatment of Skid Row Alcoholics (Englewood Cliffs, N.J.: Prentice-Hall, Inc. 1970), p. 46 ff. Wiseman includes the work of religious missions under the second approach.

[4]See, for example, Thomas F.A. Plaut, Alcohol Problems: A Report to the Nation by the Cooperative Commission on the Study of Alcoholism (New York: Oxford University Press, 1967).

Middle-class alcoholics have traditionally been the beneficiaries of the more benevolent, health-oriented view of alcoholism. Only in the 1960's, however, has this orientation helped to shape public policy toward the Skid Row inebriate. In 1966, New York City Mayor John V. Lindsay asked the Vera Institute of Justice to plan and develop a means of relieving the criminal justice system of the responsibility for dealing with alcoholics, and of replacing jail detention with medical care. Vera recommended a project that would provide detoxification, medical diagnosis and treatment, and referral to rehabilitation, residential, and other medical facilities; and in November 1967 the detoxification ward of the Manhattan Bowery Project (MBP) opened on the fourth floor of the Men's Shelter operated by the New York City Department of Social Services. The New York City Police Department assigned four non-uniformed officers to patrol the Bowery area together with recovering (sober) alcoholics in unmarked police cars; these "rescue teams" approached inebriates and transported those who wanted to detoxify to MBP. Other officers who had formerly been assigned to arresting alcoholics were transferred to regular patrol duty. In this way, police officers, formerly the primary agents of derelict control, were transformed into agents of rehabilitation.[5]

---

[5] The operations of the police-civilian rescue team and of the Bowery Project do involve a degree of control, in that the alcoholic is, of his own volition, removed from the streets for the five to seven days needed to complete detoxification. (However, the client may leave MBP before completing treatment, although he does so against the advice of staff.) The referral services that MBP provides are intended to make control efforts, in the long run, unnecessary by helping the alcoholic off of Skid Row.

The establishment of programs, based in part on the MBP model, in other cities in New York State (notably, Rochester and Syracuse) and elsewhere in the country reflected changing public attitudes toward the treatment of alcoholics and toward the use of criminal justice system resources. And the elimination of public intoxication from the New York State Penal Code as of January 1, 1976 marked the disappearance from public policy of an explicitly control-oriented approach toward alcoholism.

The hospital detoxification ward has replaced the jail "drunk tank" as the major facility for dealing with alcoholic derelicts. In 1968, there were 8,181 arrests for public intoxication, along with an indeterminate number of arrests of alcoholics under other charges such as disorderly conduct, loitering for begging.[6] In 1975, there were only 421 arrests for public intoxication. By contrast, in 1976, there were 12,470 admissions for alcoholic detoxification in the twelve municipal and voluntary hospitals and other medical facilities which had contracts with the New York City government for the provision of in-patient alcoholism services, with two of these facilities, Beth Israel Hospital and the Manhattan Bowery Project, accounting for over a third of all admissions.[7] In all, 28 New York City hospitals have

---

[6] New York City Police Department Crime Analysis Bureau.

[7] Telephone interview, New York City Department of Mental Health, Mental Retardation, and Alcoholism Services, Alcoholism Services Bureau. It is not possible to determine whether all of these admissions were of Skid Row alcoholics.

detoxification units to which patients are admitted on their own or on referral from police or welfare agencies; other hospitals may provide detoxification in general care wards.

Hospital detoxification has thus been undertaken on a large scale, and it is an expensive activity. In the case of the public inebriate, the cost is borne by the taxpayer. In Fiscal Year 1977, the budget for inpatient alcoholism services provided by hospitals and other agencies contracting with New York City came to about $5.75 million. Not included in this total are the Medicaid-paid costs of hospital stays and doctors' visits for patients treated in facilities not under contract with the City. Per diem rates for detoxification vary with the hospital, but range upwards of $150.[8]

One rationale for providing detoxification in a hospital ward is to allow medical staff to oversee withdrawal, a physiological process whose symptoms often include insomnia, nausea, and loss of appetite and that in extreme cases may involve convulsions, hallucinations, delirium tremens (D.T.'s), and occasionally death. To alleviate these symptoms, sedatives such as phenobarbitol are routinely administered in decreasing dosages. In addition to supervising withdrawal, the hospital physician can diagnose the alcoholic's other health problems and begin a treatment regimen.

---

[8] Ibid.

A pilot medical detoxification unit begun in 1968 and operated by the Addiction Research Foundation in Toronto, Ontario found, however, that no more than five percent of the public inebriates brought to the unit by the police required immediate medical attention. Accordingly, shortly thereafter the Addiction Research Foundation established a demonstration project to test the feasibility of non-medical detoxification. In a comfortable, relaxed environment, alcoholics were eased through withdrawal not with medication but with the close supervision and reassurance of specially trained non-medical staff. Although staff members were authorized to refer residents in need of medical assistance to the emergency department of a back-up hospital, fewer than five percent of all residents had to be sent to the hospital for any reason whatever.[9] Non-medical detoxification centers based on the Toronto model were established in Stockton and San Francisco, California; these centers, too, discovered that 95 percent of drinking alcoholics could be detoxified without medical intervention.[10] The Social Setting Alcoholism Treatment Center, which opened on Manhattan's West Side in late January, 1977, has drawn on the experiences of these prototypes.

---

[9]N.W. Petersen, "Hospital Based vs. Non-Hospital Based Detoxification Programs," paper presented at the General Sessions, Alcohol and Drug Problems Association of North America, Sept. 23-28, 1973.

[10]Robert G. O'Briant, M.D., et al, Recovery from Alcoholism: A Social Treatment Model (Springfield, Ill.: Charles C. Thomas Publishers, 1973); Robert O'Briant, M.D., N. William Petersen, and Dana Heacock, "How Safe is Social Setting Detoxification?" Alcohol Health and Research World, I (No. 2), 1977, 22-27.

The Aims of Non-medical Detoxification

Any detoxification center, whether hospital-based or non-medical, serves several functions.[11] First, it provides a means whereby alcoholics can be removed from the streets and treated humanely, outside the purview of the criminal justice system. Second, it supplies an environment in which the individual can withdraw safely and comfortably from alcohol and at the same time clean up and eat well. Finally, the detoxification center serves as an entry point into the network of aftercare and rehabilitation programs for alcoholics.

Advocates of non-medical detoxification contend that specially selected and trained non-medical staff (some of whom may themselves be recovering alcoholics) are especially effective in dealing with the chronic inebriate, that they are sensitive to the alcoholic's difficulties and tolerant when relapses occur.[12] In an atmosphere of acceptance and understanding, the alcoholic is less likely to experience those feelings of shame and guilt which both occasion and are occasioned by drinking.

Furthermore, its supporters argue that non-medical detoxification can effect significant savings of personnel and financial resources. Doctors and nurses can devote time and attention to patients in real need of medical assistance. And the

---

[11] See Petersen, op. cit.

[12] See, for example, the writings of Petersen and O'Briant, op. cit.

cost of providing custodial care and counseling is much lower in a non-medical facility than in a hospital.

All of these objectives of non-medical detoxification were set forth in the original funding proposal for the SSATC, quoted below:

- to provide effective detoxification
- to discourage drug dependence and encourage self-help
- to use scarce medical resources efficiently
- to provide a focal point for the development of a continuum of care for the disaffiliated alcoholic
- to promote recovery from alcoholism by providing access to aftercare services and by motivating the individuals served to use the services
- to demonstrate the utility of the non-medical model for programs to be instituted now that New York State has decriminalized public intoxication
- to provide a base for training new non-medical detoxification teams
- to promote community understanding of alcoholism
- to relieve some pressure on the community by diminishing the frequency and duration of episodes of public intoxication.

Another objective, implicit in the preceding ones, can be set forth explicitly:

- to demonstrate the cost-effectiveness of the non-medical detoxification model.

These can be subsumed into four broad aims:

1. To provide safe detoxification;

2. To serve as a staging area for rehabilitative efforts directed toward curbing problem drinking and public intoxication;

3. To use scarce financial and personnel resources efficiently; and

4. To inform public policy and attitudes toward the treatment of alcoholics.

How successfully is SSATC meeting these goals? After a description of SSATC operations and a statistical sketch of the Center's residents, this report presents the findings of an evaluation addressed toward assessing the degree to which the Center has achieved the first three aims. The report concludes with reflections about the use of detoxification centers in the treatment of chronic alcoholics.

II. THE SOCIAL SETTING ALCOHOLISM TREATMENT CENTER: OPERATIONS AND CLIENTS

The preceding section set forth an historical and theoretical perspective from which to view the issues relating to non-medical detoxification. While this section presents some data, its function is similarly introductory: to describe the way the Center has operated and the clients it has treated since it opened in late January 1977. An assessment of the program's effectiveness must begin with the recognition that the majority of its clients have long-standing drinking problems associated with severed family ties and with an attachment to the labor force that is transient at best. In other words, their external stakes in recovery from alcoholism are few.

SSATC: The Facility and its Operations

The Treatment Center is located in a newly-renovated three-story building on West 51st Street in Manhattan, near 12th Avenue and the Hudson River piers. The Center serves a catchment area bounded by West 38th and West 94th Streets on the south and north and by Central Park-Fifth Avenue and the Hudson River on the east and west.

In its decor, the Center follows strictures established by its Toronto and California prototypes: the physical plant is clean, well-lit, cheerful and comfortable. Furniture is modern, walls are freshly painted in bright colors

and decorated with abstract hangings and posters about alcoholism. The 40 beds in four large rooms have enough space between them to allow for a feeling of privacy for the occupant and are placed so that the rooms look like dormitories rather than hospital wards. Each bed, covered with brightly colored sheets and blanket, has a large headboard which serves as a private storage area for belongings. Two recreation rooms are equipped with television, magazines, and games. The dining room is large and bright; meals are served cafeteria-style three times a day, and decaffeinated coffee, juice, and snacks are available in the dining room. Counselors maintain an informal atmosphere in their style of dress and in their interactions with clients and each other.

The Center is staffed 24 hours a day, in three shifts. The staff consists of a program director, an associate administrative director, three team leaders, eleven counselor/aides, a data coordinator, six custodial and service people, and one rescue team member. Ten staff members are recovering (sober) alcoholics. The program director, who has an MSW and experience in administration of alcohol programs, is responsible for clinical operations and for direct supervision of all staff. The associate administrative director oversees plant maintenance, purchase of supplies, and fiscal matters. One team leader is assigned to each shift; the duties of the

position include client intake and counselor supervision. Counselors provide counseling and referral services and assist with intakes and discharges, showering residents, and miscellaneous tasks. The data coordinator maintains all records and statistics for the Center. Staff participated in a three-week training program before the Center opened.

The year-to-date statistics contained in SSATC's Weekly Activities Report (see Table 2.1) provide a summary of program operations. The figures cover the seven-month period between January 26, when the Center admitted its first resident, and August 28, 1977. During that time, SSATC treated 950 individuals, with 1217 admissions among them.[13] Figure 2.1 charts the average daily census for each week since the Center opened; it shows that within a month, SSATC was operating at 75 percent of capacity or better, and that about half the time at least 90 percent of its beds were filled.

Half of all admissions resulted from referrals by the police-civilian rescue team patrolling the catchment area.[14]

---

[13]The unit of analysis in the Weekly Activities Report is the admission, not the individual. Thus, in the year-to-date statistics an individual who was admitted twice would have been counted twice. In any given week, however, the number of admissions is equal to the number of individuals admitted.

[14]Composed of a police officer from the 20th precinct and a Rescue Aide with previous experience at the Manhattan Bowery Project, the rescue team approaches potential clients on the street and transports those who want to detoxify either to the Center or, if clients have Medicaid and/or require medical supervision, to St. Clare's Hospital (SSATC's back-up facility) or to another West Side hospital.

Table 2.1

SOCIAL SETTING ALCOHOLISM TREATMENT CENTER WEEKLY ACTIVITY REPORT

Week of 2/22/77 - 2/28/77

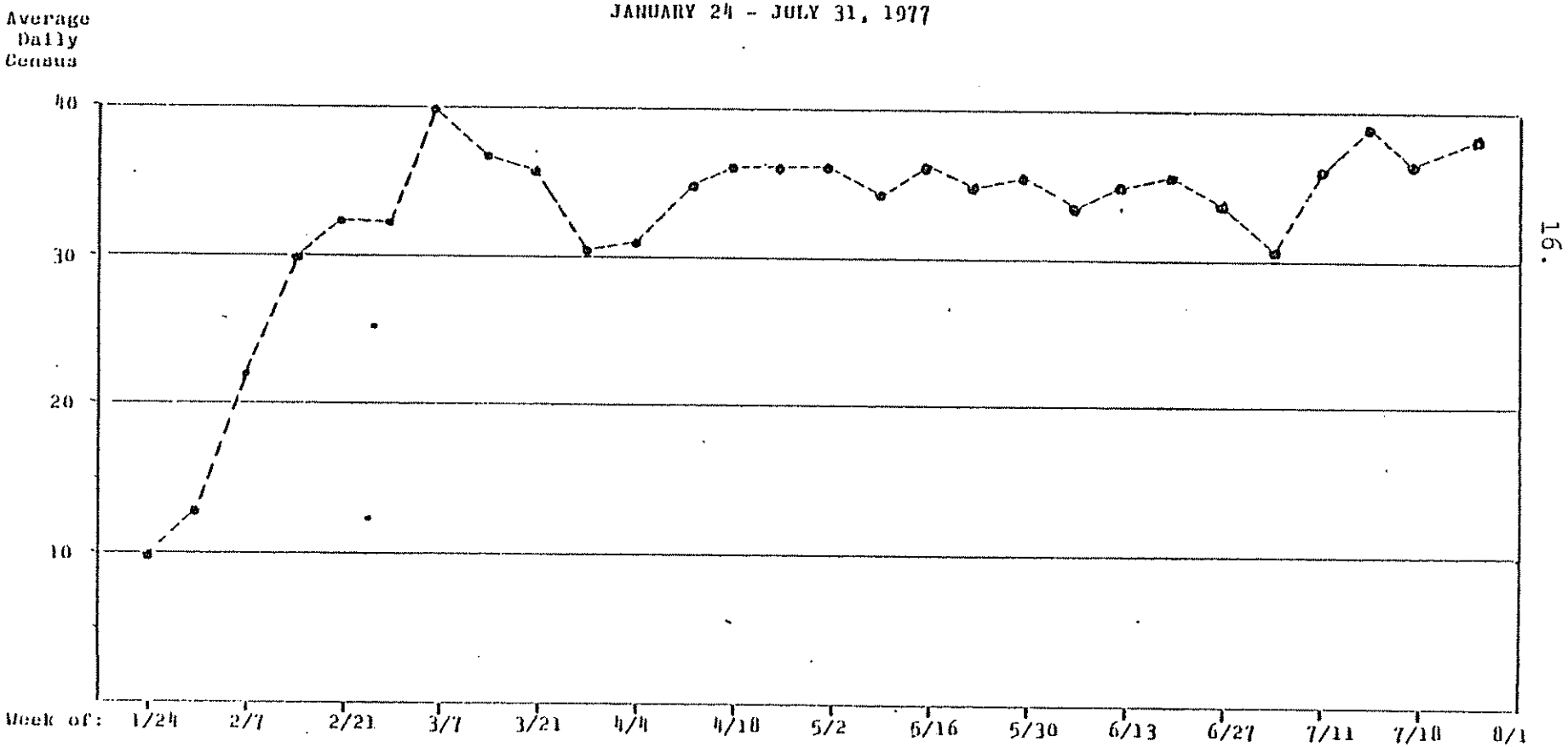
I. DAILY CENSUS (as of 11 P.M.)

Monday	39
Tuesday	37
Wednesday	36
Thursday	37
Friday	34
Saturday	32
Sunday	34

	THIS WEEK		YEAR TO DATE (from Jan. 26, 1977)	
II. AVERAGE DAILY CENSUS	34		33	
III. ACTS OF ASSISTANCE	52		1439	
IV. ADMISSIONS	# 40	%	# 1217	%
A. Intake Source	40	100	1217	100
Rescue Teams	21	53	611	50
St. Clare's	1	3	59	5
Other Hospitals	—	—	38	3
Social Agencies	4	10	163	13
Walk-In	11	28	309	25
Other	3	8	48	4
B. New Clients	32	—	950	—
C. Sex	40	100	1217	100
Male	40	100	1217	100
Female	—	—	—	—
D. Age	40	100	1217	100
Under 30	7	18	139	11
30-39	13	33	368	30
40-49	13	33	395	32
50-59	0	0	240	20
60+	3	8	108	9
Unknown	—	—	7	1
E. Ethnicity	40	100	1217	100
White, non-Hispanic	30	75	1156	95
Black, non-Hispanic	10	25	391	32
Hispanic	2	5	134	11
Other	—	—	16	1
V. NON-ADMISSIONS	12		222	
	#	%	#	%
A. Reason for Non-Admission	12	100	222	100
Medical Reasons	2	17	67	30
Refused Assistance	—	—	13	6
No Available Bed	10	83	91	41
Other	—	—	70	32
B. Referrals to Other Care	12	100	161	73
St. Clare's	1	8	35	16
Elsewhere	11	92	126	57

Figure 2.1

AVERAGE DAILY SSATC CENSUS,
BY WEEK OF OPERATIONS:
JANUARY 24 - JULY 31, 1977



Clients who sought treatment independently ("walk-ins") accounted for another quarter of the admissions, and the remaining quarter were the result of referrals by hospitals, social agencies, clergy, and friends or relatives.

The rescue team conducts a preliminary screening to determine whether the client can tolerate non-medical detoxification. A more extensive screening takes place when the client is interviewed at intake; pulse and temperature are taken and medical and demographic information recorded. A number of factors enter into the intake decision, although none is automatic grounds for exclusion from treatment at SSATC:

- a chronic medical condition, such as heart trouble, diabetes, epilepsy, or hypertension
- the need to take daily medication
- a recent traumatic injury
- a fever of 101 or above
- a pulse rate above 130
- the counselor's "feeling" or common-sense judgment that the applicant does not look right.

If a client exhibits any of these conditions, he is taken for a medical examination to St. Clare's Hospital, three blocks away. If the examining physician determines that he does not require hospital care, he is returned to the Center, otherwise, he is admitted either to St. Clare's or to another hospital, if a bed is available.

Table 2.1 indicates that, during the seven month period, there were 222 occasions on which applicants who approached the Center for assistance were not admitted; the table also details reasons for non-admission. Only three percent of all those who applied to SSATC for admission (48 of 1439) were found to have physical problems that precluded entry into a non-medical facility -- strong prima facie evidence that the rescue team and other referral sources are effective in weeding out clients with medical problems.

The 48 clients requiring medical supervision for detoxification accounted for about a quarter (22%) of all instances in which applicants were not admitted. In another 41 percent of these cases, no bed was open. Occasionally (6% of the time) an applicant who had initially sought to detoxify subsequently decided against that course of action. The remaining 31 percent were rejected for a variety of reasons. Some were excluded because SSATC imposes a 30-day waiting period before a former resident is eligible for readmission. A number of applicants were judged not to need detoxification at all (a few of these were found to be psychotic but not alcoholic, and some merely needed a place to spend the night). In 70 percent of the instances in which clients were not admitted to SSATC, staff referred them elsewhere for assistance.

Once a client is admitted, a counselor helps him to shower, gives him a robe and pajamas, and assigns him to a bed. If there are no complications, the entire intake process takes about

a half hour. Newer residents sleep in the first-floor dormitory opposite the counselors' office. Counselors regularly check the dormitories, and residents are observed every hour for at least 36 hours after admission or until they appear stable.

The degree of discomfort a client experiences in detoxifying depends on the length of time he has been drinking and the amount he has consumed, but counselors report that most are highly uncomfortable for about 72 hours, a view confirmed in interviews with several clients. During the initial stages, the person is generally tremulous and sweaty, his pulse rate increases, and he finds it difficult to keep food down and to sleep. More serious reactions include seizures, hallucinations, and (very rarely) D.T.'s. Seizures differ in their seriousness and in the ways in which they can be handled. Patients who experience repeated or prolonged seizures or other severe reactions are transferred to St.Clare's Hospital.[15] During the study period, about one in twelve admissions were subsequently referred to St. Clare's, either because of a complication related to detoxification or because of an injury or infection that called for medical attention. Over half of all clients referred to St. Clare's were returned to SSATC to complete detoxification; only four percent of all admissions involved subsequent referral to and retention in the back-up medical facility.

[15]Between March 17 and August 29, there were 25 notations of clients' seizures in the Counselor "Pass-On Book"; 12 of these seizures resulted in a referral to St. Clare's. There were 13 instances in which clients had hallucinations; in five of these, clients were referred to the hospital.

Should a person demand to leave before he has completed the prescribed length of stay of five to seven days, he is discouraged but not prevented from doing so. About one in four discharges during the study period occurred when the client left against advice. Counselors agree that clients who leave early usually do so to resume drinking.

After three or four days, when the resident is feeling better, he is encouraged (but not forced) to attend group and individual counseling sessions and nightly Alcoholics Anonymous meetings. Group counseling, led by a staff member, is held every morning and twice a week in the evening. Counselors do not routinely assist clients with non-alcohol related problems, such as getting on welfare or Medicaid; such help is given in individual cases if feasible.

Recreational activities available to residents include bingo, ping pong, and other games; a collection of books and magazines; television; and movies shown twice a week. While clients vary in their opinions about whether there is enough to do, counselors say that most clients do not seem to want to engage in a great deal of activity. Observations suggest that most residents spend the majority of their unscheduled time talking and watching television.

During the latter part of the client's stay, his counselor gathers further information about his background and drinking history and helps formulate an aftercare plan.

Counselors say they try to determine, through several conversations and counseling sessions, and through observations of the client's behavior during his stay, the sincerity of his intention and desire to stop drinking. On the basis of this determination and of the client's concrete needs (such as a permanent residence), the counselor will make an aftercare referral to an outpatient program or to a residential facility.

During the study period, about a third of the clients who completed their stay (26% of all those who were discharged) left by choice without a referral, to pursue their own plans. According to one counselor, residents in this category usually leave with the full intention of making it on their own; but counselors agree that in all probability most will return to drinking. The remaining two-thirds of those who stayed the full term--half of all discharges--received a referral for follow-up care. About a third of these referrals were to organizations such as the Salvation Army and the Volunteers of America which operate residential and work programs that are not therapy-oriented; another quarter were to rehabilitation units (live-in programs where clients are offered therapy, vocational rehabilitation services, etc.). One in five referrals was to an outpatient alcoholism program operated by a local hospital, and one in twelve was to a halfway house (either the STEP II program run by the Manhattan Bowery Corporation or a similar facility). A small number of residents

were referred to medical facilities for inpatient medical or psychiatric care. SSATC does not transport clients to their aftercare referrals and there are no formal procedures to check on a client's arrival or stay at a facility.[16] Telephone verifications are sporadic.

Staff training emphasizes that, at least initially, failure is to be expected; many clients go through the rounds of detoxification repeatedly before they make a determined effort to be sober -- if, in fact, they ever do so.

The People SSATC Serves: Findings from the Client Information Study

To learn more about SSATC's treatment population, research staff sampled and analyzed data on one-third of all admissions to the Center during June and July, 1977. These 119 admissions represented 118 different individuals for whom basic demographic and health data were collected.[17] Additional information was available for 96 of the 118 clients.[18]

---

[16] Since the beginning of September, routine telephone verifications of arrival at referral facilities have been made.

[17] One man was admitted twice during the eight weeks, but data were recorded only on the first admission.

[18] Eleven clients signed out early (generally within 24 hours after starting detoxification), four were referred to St. Clare's Hospital to complete treatment, and errors in record-keeping were responsible for the remaining gaps in information.

Percentages appearing in this section are based on the number of respondents for whom data on each item are available. It may be that those who left the Center early were less stable in terms of family and labor force ties than those who stayed the full term, but there is no way of ascertaining whether this was the case.

How credible is the information supplied by Skid Row alcoholics? One study suggests that although they may be forgetful about details (specific dates and places), alcoholics are generally as truthful as members of other disadvantaged populations. See H.M. Bahr and K.C. Houts, "Can You Trust a Homeless Man? A Comparison of Official Records and Interview Responses by Bowery Men," Public Opinion Quarterly, Fall 1971, pp. 374-382.

Table 2.2 demonstrates that, in terms of age and ethnicity, clients in the sample generally resembled all admissions during these two months, as well as during the entire seven months under study. The majority of clients were in their 30's and 40's; the mean age of Client Information Study sample members was 45. It is reasonable to assume, too, that the demographic characteristics, work histories, and drinking behavior of sample members are typical of all SSATC residents. (Summary statistics for the Client Information Sudy appear in Appencix A.)[19]

Demographic Characteristics

Age and ethnicity were, in fact, related, as Table 2.3 makes clear. Half of the Hispanics served were under 40, as opposed to 42 percent of the blacks and only one-third of the whites. Conversely, one out of three whites, one out of five blacks, and only one out of twelve Hispancis was over 50.

---

[19] It is also possible to compare the age and ethnicity of clients admitted to SSATC and those treated in the detoxification ward of the Manhattan Bowery Project. Data on admissions to MBP from March through August reveal that the MBP caseload included a larger proportion of whites (62%) and a smaller proportion of blacks (26%). Also, as a group, MBP clients were older than their counterparts at SSATC: 44 percent of the former group were over 50, as opposed to 29 percent of the latter group.

Table 2.2

AGE AND ETHNICITY OF SAMPLE MEMBERS AND ALL SSATC CLIENTS

Age and Ethnicity	Percentage of Clients in Category, by Sample and Population		
	Client Information Study Sample (n=118)	All Admissions, 5/30/77-7/31/77 (n=374)	All Admissions, 1/26/77-8/29/77 (n=1217)
Age			
under 30	13	11	10
30-39	26	26	29
40-49	34	31	32
50-59	17	21	20
60+	10	11	9
Total	100	100	100
Ethnicity			
White	59	56	56
Black	27	34	32
Hispanic	11	9	11
Other	3	1	1
Total	100	100	100

Table 2.3

AGE OF CLIENT INFORMATION STUDY SAMPLE MEMBERS, BY ETHNICITY[a]

Age Group	White (n=67)	Black (n=35)	Hispanic (n=13)
	Percentage of Clients in Age Category, by Ethnicity		
under 30	10	11	23
30-39	22	31	31
40-49	33	37	38
50-59	19	14	8
60+	15	5	0
Total	100	100	100

NOTES: Percentages may not sum to totals because of rounding.

[a]The table excludes three people whose ethnic group was classified as American Indian.

Ethnicity was related not only to age but also to frequency of treatment at SSATC. Overall, a third of the 118 sample members had detoxified previously at the Center, and blacks were disproportionately represented among the repeaters: although they comprised only 27 percent of the study sample, they constituted 40 percent of the readmitted group. Whites made up 59 percent of the total sample, but only 45 percent of those with prior admissions.

Most of the residents grew up in urban environments: 61 percent identified their community of origin as a city of 100,000 or larger, and only six percent came from rural areas. Forty percent were born in New York State; the next largest bloc of residents (19%) came from the South. Whatever their place of birth, most were confirmed New Yorkers: three quarters had lived in the City for ten years or longer, and only seven percent had come to New York within the past twelve months.

As a group, SSATC clients were not well educated. Under half (45%) were high school graduates, and almost a fifth had not gone beyond eighth grade.[20]

Only eight percent of the clients were married and living with their spouses; another eight percent were widowers. The remainder of the sample was evenly divided between those who had never married and those who were separated or divorced. The degree to which alcoholism was responsible for the dissolution or lack of formation of family ties is uncertain; what is clear is that in many cases the disruption was lasting: 60 percent of the clients, both black and white, had not been in touch with any members of their families during the month prior to SSATC admission. The majority of clients (59%) reported that no one else in their family had a drinking problem.

---

[20] Data from the 1970 Census would seem to suggest that in terms of education, SSATC clients were no worse off than other New Yorkers: in 1970, 48 percent of New York City men aged 25 and over were high school graduates, and almost a third (32%) had less than nine years of schooling. These statistics are probably accounted for in large part by the high proportion of New Yorkers of foreign birth who in their childhoods had limited educational opportunities. See 1970 Census of Population, Population Characteristics, Vol. I, Part 34 (Washington, D.C.: United States Department of Commerce, Bureau of the Census, 1972).

Almost half the respondents (49%) lacked permanent residences, and about two-thirds of these (32% of the entire sample) had had no fixed address throughout the twelve months preceding their admission to SSATC. The remainder did have a place to live, but even so, their addresses can be described as only relatively "permanent": 77 percent of those who had a "permanent" address had moved at least once during the previous year. About a fifth of the sample lived in a house or apartment, and 30 percent lived in rooming houses, hotels, or single room occupancy units. Whites were no more likely than blacks to report having permanent addresses.

Links to the labor force were also tenuous. While 95 percent of the clients had held a regular job at some point, for most that point was several years in the past. Only five percent of the residents were employed full-time on admission to the Center; the average client had last worked steadily five years before admission. When clients worked at all, it was likely to be in menial and temporary "spot jobs"; almost half the men gave as their current or most recent occupation "laborer" or "day worker." Part-time and full-time jobs provided the major source of the last month's income for a quarter of the clients; another 36 percent subsisted on welfare payments or pensions. Other income sources included contributions from family or friends, panhandling, and savings; and one in twelve clients reported no source of income at all. Only four of the

118 men were supporting anyone other than themselves. Given their lack of connection to either the public assistance system or to regular employment, it is not surprising that 62 percent of the respondents had no health insurance.

Drinking Behavior and Alcoholism Treatment

SSATC clients seldom denied their alcoholism: only five percent said that their drinking posed no problem or a slight problem, while three-fourths characterized that problem as severe. Almost two-thirds had started to drink frequently or heavily by the time they were 30, and had continued to drink for upwards of ten years. Almost four in ten had been heavy drinkers for twenty years or more.

The offense of public intoxication was removed from the New York State Penal Code as of January, 1976; but three-quarters of the men had been arrested at some time in the past, generally on such alcoholism-related charges as drunkenness, vagrancy, disorderly conduct, or driving while intoxicated. Three clients claimed to have been arrested 50 times for alcoholism-related offenses. Of those arrested, most had spent time in jail; indeed, one in eight sample members for whom information was available had spent more than five years in jail or prison.

Most SSATC clients had received prior treatment for alcoholism. Eighty-five percent had detoxified previously, and one-fifth claimed to have detoxified ten times or more. Of those

who had ever detoxified, more than half (62%) had done so within the past six months. More than half the clients (54%) had participated in residential or outpatient alcohol programs, and most had at least a passing acquaintance with Alcoholics Anonymous. (Almost a quarter reported regular A.A. attendance at meetings outside of detoxification facilities, and 60% said they went to such meetings occasionally.) Four in ten had tried Antabuse, a drug which induces nausea if mixed with alcohol. But while 77 percent of the respondents stated that they had had periods of sustained sobriety, for most these periods were brief, lasting six months or less. Only 18 percent of those who had ever gone on the wagon managed to stay sober for more than a year.

By and large, the men had used few drugs other than alcohol. Only 17 of the 118 reported having taken any other drug within the past 30 days; all of these had smoked marijuana. (In addition, one client had used cocaine, one had used heroin, and two were on methadone maintenance.) As might be expected, those who had used marijuana were, on average, younger (by ten years) than all SSATC patients; they were also disproportionately likely to be black.[21]

---

[21]The low incidence of polydrug abuse is not characteristic of all alcoholics. Dr. LeClair Bissell, Chief of the Smithers Alcoholism Treatment and Training Center of Roosevelt Hospital, reports that a substantial proportion of patients at that rehabilitation center are users and abusers of drugs, particularly sedatives. Dr. Bissell maintains that use of drugs is associated with ability to acquire drugs, either through purchase or through Medicaid prescriptions. Most Smithers patients, unlike SSATC clients, have third-party insurance coverage; a substantial proportion are employed. In addition, research has documented that female alcoholics are more likely to abuse drugs than males; and women comprise a sizable proportion of the Smithers caseload. Personal communication, Dr. LeClair Bissell, Smithers Alcoholism Treatment and Training Center.

SSATC clients had experienced a variety of physical ailments. Three in ten reported high blood pressure, and about one in seven had liver trouble or a venereal disease. Alcoholism-related symptoms were also prevalent: over 60 percent of the residents had experienced tremors and blackouts, and 40 percent reported having had hallucinations or D.T.'s.

One in six clients reported having been mugged within the preceding month. Over half the residents (60%) had been hospitalized within the past twelve months, most frequently for alcoholism. Fifteen percent had received treatment within the past twelve months for other physical conditions, and three percent had received psychiatric care. (Thirteen percent had been in a mental hospital at some point in their lives, often because of alcohol-related physical or mental problems.[22])

Sixty percent of the clients in the Client Information Study sample were brought to SSATC by the rescue team. Blacks were more likely than whites to enter the facility via this route (72% vs. 56%), and this finding may help to explain the fact that blacks were more apt than whites to have had prior admissions. It is also possible that blacks are less likely to be affiliated with the social agencies that serve alcoholics in New York City and thus more likely to be picked up on the streets.

---

[22] Before general hospitals began to admit alcoholics for detoxification, this treatment frequently took place in mental hospitals.

Counselors rated the physical condition of most clients at intake as "fair." Only a quarter were judged to be "shaky" and only three percent were hallucinating, probably because over 90 percent had been drinking right up until the time of admission.

Seventy-seven percent of the residents completed their full stay at SSATC; 18 percent left early, against the advice of staff. (These figures parallel closely the statistics presented in Table 2.1 for all clients, not just those in the study sample.) During the course of treatment, eleven people (9% of the sample) were referred to St. Clare's Hospital, four for reasons related to detoxification, and seven because other physical problems required attention. Six of these people (5% of the entire sample) were retained at St. Clare's to complete detoxification. Most clients who stayed were given a referral to aftercare, with rehabilitation units and non-rehabilitative residences figuring most prominently among the places to which people were sent.

\# \# \#

This profile indicates that SSATC has reached the disaffiliated alcoholics it set out to serve. By and large, its clients exist on the margin of society, with few bonds to work, home or family. The institutions to which they are connected are the hospitals, detoxification units, and outpatient programs through which alcoholics are cycled. How SSATC fits into this cycle is discussed in the next section.

III. THE EFFECTIVENESS OF NON-MEDICAL DETOXIFICATION

The goals of a detoxification center are several: to get alcoholics off the streets, to deal with them outside the jurisdiction of the criminal justice system, to give them an opportunity to withdraw safely from alcohol, clean up, and eat nutritiously, and to refer them to aftercare facilities. Concerns about the efficacy of treatment have centered on two of these goals: the safety of the withdrawal process, and the rehabilitative impact of treatment. This study set out to address two questions: can these aims be achieved equally successfully by medical and non-medical facilities? And, can non-medical facilities effect significant savings in treatment costs?

It should be said at the outset that this evaluation has not resolved these issues in a satisfactory way. A controlled study addressing the problem met programmatic obstacles and constraints imposed by limited funds and time, so that it proved usable primarily as a source of qualitative data. Some inferences, however, may be drawn on the basis of SSATC operational statistics. These indicate that, in conjunction with its medical backup facility, the Center has provided a safe setting in which public inebriates can detoxify. Whether the Center has made any inroads against the alcohol problems of its clients is more difficult to determine. Although the lack of adequate follow-up data makes it impossible to render a full accounting of

the costs and benefits of medical vs. non-medical treatment, the cost of detoxification per se is demonstrably lower at SSATC than in a hospital.

This section first describes efforts to evaluate the effectiveness of non-medical detoxification, along with the difficulties that were encountered. It goes on to present findings, based on research at SSATC and elsewhere, in three areas: client attitudes toward detoxification in both treatment settings; safety of non-medical detoxification; and rates of readmissions to medical and non-medical detoxification facilities.

The Controlled Study and Client Follow-Up

Proponents of non-medical detoxification do not contend that it is suitable for all alcoholics. The key question this evaluation set out to answer is: for those alcoholics who can tolerate detoxification without medication, do the sequelae of treatment in medical and non-medical settings differ? Specifically, is the incidence of serious withdrawal effects (seizures, hallucinations, etc.) higher in a non-medical facility, and if so, is the patients' well-being endangered? And is one type of facility more capable than another of providing effective referrals to aftercare?

The best way to answer these questions is to compare groups of alcoholics judged able to withstand non-medical detoxification and randomly assigned to either a hospital or to a non-medical setting for care. Such a controlled experiment was

instituted for this evaluation. Research staff solicited the participation of three hospitals: one agreed to cooperate but subsequently closed because of financial problems; one, after long delay, refused the request; and the third, Beth Israel Hospital, agreed to serve as the "control" (medical) facility. For a four-week period, the rescue team was asked to identify and transport eligible clients to SSATC, where they were randomly assigned either to the Center or to Beth Israel for detoxification. (Appendix B details the procedure of the controlled experiment and contains sample in-treatment and follow-up interviews.)

There were several conditions for eligibility for the experiment:

1. Participants had to be physically capable of detoxifying in a non-medical facility. (As the data in a subsequent section suggest, between 50 and 70 percent of the candidates approached by the rescue team met this standard.)

2. Participants had to have health insurance coverage. (This was true of only half the people approached by the rescue team. Furthermore, those with such coverage were more likely to have physical problems that precluded non-medical detoxification.[23])

3. Those who had not completed the requisite waiting period between detoxifications (30 days at SSATC, 60 days at Beth Israel) were excluded.

4. At first, participation was limited to those who would accept detoxification at either facility. Three clients refused treatment at Beth Israel. (This procedure was relaxed so that those who did not agree to hospital detoxification could nonetheless belong to the SSATC sample.)

---

[23] See below, p 68.

These criteria proved so restrictive that at the end of the month, there were only 11 members of the two samples, eight at SSATC and three at Beth Israel. One client left each facility within a day after admission, so that only nine interviews were completed. The limited research budget prevented extension of the experiment.

A second attempt was made to follow up on two groups of clients who at the time of treatment reported having permanent addresses. Members of the first group had been discharged from SSATC approximately six months before the inception of follow-up, and members of the second group had been released one month earlier. A postcard sent to each sample member promised $5.00 plus carfare if the person would consent to a 45-minute interview. In all, 50 postcards were sent: 17 to members of the six-month sample, 26 to members of the one-month sample, and seven to those participants in the controlled experiment who had permanent addresses. The mailing netted five appointments for interviews, and two men showed up.[24] The low response rate does provide evidence of the high mobility of public inebriates as a group: 11 postcards were returned with the notation that the addressee had moved or was unknown. One postcard indicated that the addressee (a 33-year old black male) was deceased.

---

[24] Both claimed to have gone on just one "bender" in the month since SSATC release; however, the interviewer noted alcohol on the breath of one respondent.

Follow-up studies of highly transient, unstable populations are likely to run into problems similar to the ones encountered here. Three lessons have emerged for conducting research on such groups:

1. Field staff is needed to make contact in the hotels, bars, and corners where alcoholics "hang out."

2. An alternative or supplementary approach to direct interviewing is to contact aftercare agencies to find out whether discharged clients have availed themselves of post-detoxification services. If this course is chosen, current federal regulations relating to confidentiality probably make it necessary to obtain clients' consent in advance.

3. Either course of action is expensive. Field investigations are costly; and a large-scale undertaking is also involved in contacting the many aftercare facilities in New York City. Serious follow-up efforts require time, people, and money.

Client Attitudes Toward Treatment

Although nine in-treatment and two follow-up interviews are clearly insufficient to permit generalization about the efficacy of non-medical detoxification, the interviews are useful for the attitudinal data they contain. Respondents were asked to compare sobering up with and without drugs, to rate the treatment they had received, and to discuss their plans for the future.[25]

---

[25] Alcoholics, like other habitual clients of social agencies, are known for their ability to tell agency staff what they want to hear. The interviewer was a member of the Vera research staff, not an employee of the Treatment Center, but her daily presence at SSATC made it likely that residents saw her as a "regular." The fact that even clients who gave SSATC a positive rating would not recommend non-medical detoxification for everyone suggests that their responses were, on the whole, honest.

The nine men who were interviewed while in treatment ranged in age from 37 to 72. Their drinking patterns varied: one man drank only wine, another only hard liquor, and others apparently drank whatever they could whenever they could. All except one had drunk steadily throughout the month prior to admission to SSATC or Beth Israel. And all except one had detoxified before: six within the previous four months, and two of these within the previous 30 days. Most had had a drink on waking every morning and frequently missed meals because of drinking. And most worried about their health and about other problems, such as securing decent living quarters, finding and keeping a job, and having enough money to live on.

Asked to describe their experiences in detoxification, the seven respondents treated at SSATC gave answers ranging from "beautiful" to "O.K.". The seventh had a blackout or seizure (he could not recall what had happened). Detoxification in a hospital setting did not seem to ease patients' symptoms -- or their minds. One Beth Israel patient mentioned the "shakes" (tremors) and nightmares and claimed to be sicker on the third day after entry than at intake. He complained vociferously about his treatment at Beth Israel: "They don't help you. I need to be in a hospital. They don't do anything for you here. They don't take care of you."[26] The other was less crabby, but plainly worried: "It's been a little leery...I've been going through this for 13 years, I've been hospitalized 25 or 30 times, and no one has been able

[26] The following excerpt is taken verbatim from the interview:
Respondent: "I need to be in a hospital."

(Cont'd. on p. 38)

to help me. They told me my blood pressure went up; they took me off salt."

Although medication eases withdrawal from alcohol, three of the respondents said they preferred to detoxify without drugs. The following quotations are typical of those who preferred the "cold turkey" route:

> "With the drug it gives me a letdown feeling. Without, I feel much better."
>
> "Detoxing without drugs is hard, but you get a better strength against alcohol than you do with drugs. Medication gets you down just as well as alcohol. Some hospitals overmedicate you, some don't give you enough. Cold turkey is much better for you if you can take it."

Several men had mixed views:

> "If I'm very sick I like to have medication. [But] when I did without, I felt my body wasn't dependent on anything. I didn't have to come down."
>
> "If they [drugs] are weak, I prefer to detoxify with them. Not if they're strong. I think it does you more good without them than with them. With them, you're not there as much. You have more of a human reaction to problems without them."
>
> "[With drugs] it's better, easier getting over it, but I don't know if it's better for the mind or not."

As might be expected, those who had the roughest time detoxifying were most likely to endorse the use of medication.

(Cont'd. for p. 37)

Interviewer: "You are in a hospital, Mr. M."
Respondent: "This is no hospital. They don't do anything for you here."

While at Beth Israel, however, Mr. M received a check-up, chest x-ray, and nose x-ray.

The respondent, a homeless white male in his 40's, is the one participant in the controlled study about whom follow-up information is available. One week after he had been referred by Beth Israel counseling staff to a religious mission in New Jersey, he appeared at SSATC, drunk and seeking admission.

Six of the seven clients said they liked the pleasant, quiet atmosphere of SSATC. (The lone exception, the man who had suffered a seizure, gave a neutral response: "I don't bother anybody. I mind my own business. I do what I'm asked, so I don't have anything bad to say about the place.") They praised the competence of the staff and the accessibility of counselors, but none mentioned specific problems with which help was needed. One resident complained that his own counselor didn't have time for him, but stated that the others were "quite good." One Beth Israel respondent liked the hospital but had not yet seen a counselor at the time of his interview; the second was as negative about counseling as about everything else: "I don't like it, period. They're phony. I know more about alcoholism education than they do."

All the men had attended at least one Alcoholics Anonymous meeting at SSATC, but the organization's appeal was limited. While two respondents said they identified with the speakers and had gained insight into their own problems, more typical responses were: "I don't think A.A. or anyone else can solve my drinking problem -- I have to solve it myself," and "If you've been to one, you've been to them all." That the A.A. model may be more appropriate for verbal, middle-class alcoholics is suggested by the following comment: "It doesn't really mean much to me. I don't really have anything to say."

Two SSATC residents had specific ideas for improvements. One suggested occupational therapy because "the more a person has to do, the better off he would be." The other recommended installation of a pay telephone.

All the SSATC clients who were questioned said that they would recommend the Center to a friend who needed a detox, and three said they already had.[27] One of the hospitalized patients called Beth Israel a "good place to dry out"; the other said he would have recommended the hospital in the past but would not do so at present --"maybe because I'm sicker now."

Respondents were vague as to their plans for aftercare. Comments were on the order of: "Get a better place to live and not hang around where drunks are" "Hoping to get into a program"; and "I don't have the slightest idea." One respondent, allowed to leave SSATC to pick up his welfare check, returned intoxicated and was discharged from treatment. Asked what he planned to do, he said only: "Go out on the street again." Three SSATC clients received referrals (one had been offered a referral but refused it): two referrals were to hospital outpatient departments and one to the Salvation Army shelter in Brooklyn.

---

[27] The question "Would you recommend this place to a friend who needed a detox?" was intended to tap the respondent's willingness to return to SSATC if he needed to detoxify again. In pre-testing the interview, the question was asked, "Would you return to this place if you needed another detox?" The respondent, a veteran of many prior detoxifications, replied "That's not the way to ask that question." He said that the interviewer should not imply that the alcoholic will relapse, no matter how likely that prospect may be. The respondent suggested the alternative wording of the question.

The Safety of SSATC Operations

In hospital detoxification wards, drugs are used to ease withdrawal symptoms, and medical staff and technology are readily available should complications develop. The burden of establishing that the absence of these elements does not threaten patients' well-being rests with non-medical detoxification facilities such as SSATC. While it has not been possible to compare the incidence of detoxification-related difficulties in a hospital and at SSATC (other than to note that the two hospitalized interviewees in the controlled study were not more comfortable than their SSATC counterparts), it is noteworthy that there were no deaths among the 950 individuals treated at SSATC during the study period.

It is also possible to compare data from SSATC with those from the non-medical detoxification programs in Toronto and San Francisco. Such comparisons are necessarily imprecise for three reasons. First, each program compiles statistics on hospital referrals in a different way (Toronto and San Francisco define referrals as "emergency" and "non-emergency," while SSATC classifies referrals as detoxification-related and non-detoxification-related). Second, the intake criteria employed by the three programs differ. The admissions standards used by the Toronto program are not spelled out, and the guidelines followed in San Francisco appear to be more permissive than those at SSATC.[28] Third, the data suggest that the Ontario

---

[28] A description of the San Francisco program states: "Non-medical staff are employed with the program, and they have been trained to use the following criteria for admission:
(1) Persons arriving in an ambulance are not to be admitted.
(2) Persons must be able to ambulate with minimal assistance.
(3) No one with traumatic injuries is to be admitted."

treatment population was less "disaffiliated" than its New York City counterpart: the Canadian men were more likely to be married (24% vs. 8%), more likely to have their own apartments (46% vs. 19%), and more likely to be employed at the time of entry into detoxification (69% vs. 7%). All of these factors may exert a positive influence on health and thereby increase ability to tolerate non-medical detoxification.[29]

These caveats notwithstanding, there is striking consistency in the finding that only about five percent of the alcoholic patients admitted for detoxification to any facility required emergency medical attention.

Table 2.1 (page 15) presents the relevant statistics for SSATC. Eight percent of all admissions resulted in a subsequent referral to the back-up hospital, and four percent of these were retained there. (Similarly, 5% of Client Information Study Sample members completed detoxification in the hospital.)

The Toronto statistics are similar:

> "At no time were more than 5% of the intoxicated persons brought into this [non-medical detoxification] unit sent to this [back-up] hospital emergency department for any reason."
>
> "To date, we have had very close to 25,000 admissions in our detox units in Ontario, and to my knowledge, we haven't

---

[29] Conversely, it has been argued that more socially "intact" alcoholics are in worse physical shape than Skid Row inebriates because the former drink for longer periods and more secretively, and are less apt to seek detoxification services. It should be noted that in other respects, clients at the three detoxification centers were similar. The mean age of patients at all three facilities was 44-45. And identical proportions of clients at SSATC and in San Francisco had experienced tremors, hallucinations, and seizures at some time in the past.

> had a serious medical emergency or a serious behavioral problem. What I mean by this is that any medical symptoms or problems that have arisen, the staff have been able to spot and transport the person, either by taxi or by car to the emergency department of a hospital where an appropriate medical diagnosis can be made. Each staff member has the authority, if they see any changes in behavior or appearance of the resident, to make the decision on his own accord to facilitate this referral to the emergency department of the hospital. Even with this complete freedom of referral to the hospital by the staff, we still have found that under 5% of the residents in all the units have to be sent to the hospital for any reason whatever."[30]

And the San Francisco program reports:

> "Since the opening of 1335 Guerrero Street [a non-medical detoxification center] in December 1974, approximately 5 percent of the total admissions have subsequently been referred for medical care. Of the 5 percent referred, 2 percent were classified as emergency referrals, while the other 3 percent were judged non-emergency."[31]

The data suggest, then, that SSATC is as successful as other non-medical facilities in providing a safe environment in which detoxification can take place.

Rates of Readmission to Treatment Facilities

Detoxification is usually viewed as the first link in a chain of treatment programs aimed at curbing alcoholism. The original research design called for the use of follow-up interviews to measure the frequency with which clients discharged from SSATC arrived at the aftercare programs to which they were referred. More generally, the research sought to assess SSATC's role in reducing the incidence and duration of drinking episodes.

---

[30] Petersen, op. cit.

[31] O'Brian, Petersen, and Heacock, op. cit.

As noted above, these interviews were not obtained.[32] Although SSATC's effectiveness in making referrals could not, therefore, be ascertained, another gauge of the Center's impact may be the frequency with which discharged clients were readmitted for subsequent detoxification.[33]

There are several perspectives from which to assess the extent of relapse, and three are presented here. Where possible, comparative data from the Beth Israel and Ontario treatment programs are also shown.

First, one can examine the distribution of prior admissions among clients in treatment at a given point in time; the Client Information Study provides this type of information. As the following table shows, there were 171 admissions among the 118 people who constituted the study sample.

---

[32] It is doubtful whether clients who might have appeared for follow-up interviews would have been typical of the range of clients treated and discharged. It seems reasonable to believe that clients who have been relatively successful in maintaining sobriety (or who feel they can carry off that image) are more likely to take part in follow-up efforts, since abstinence is a behaviour for which the client can expect to receive interviewer approval.

[33] In any event, it is difficult to measure SSATC's effectiveness in making referrals. Three separate elements are involved: making a referral for an individual client; the client's actual appearance at and acceptance into the aftercare facility to which he was referred; and the effectiveness of the treatment provided by that facility. Thus, a high rate of referral-making of the detoxification center is not necessarily associated with positive changes in clients' lifestyles.

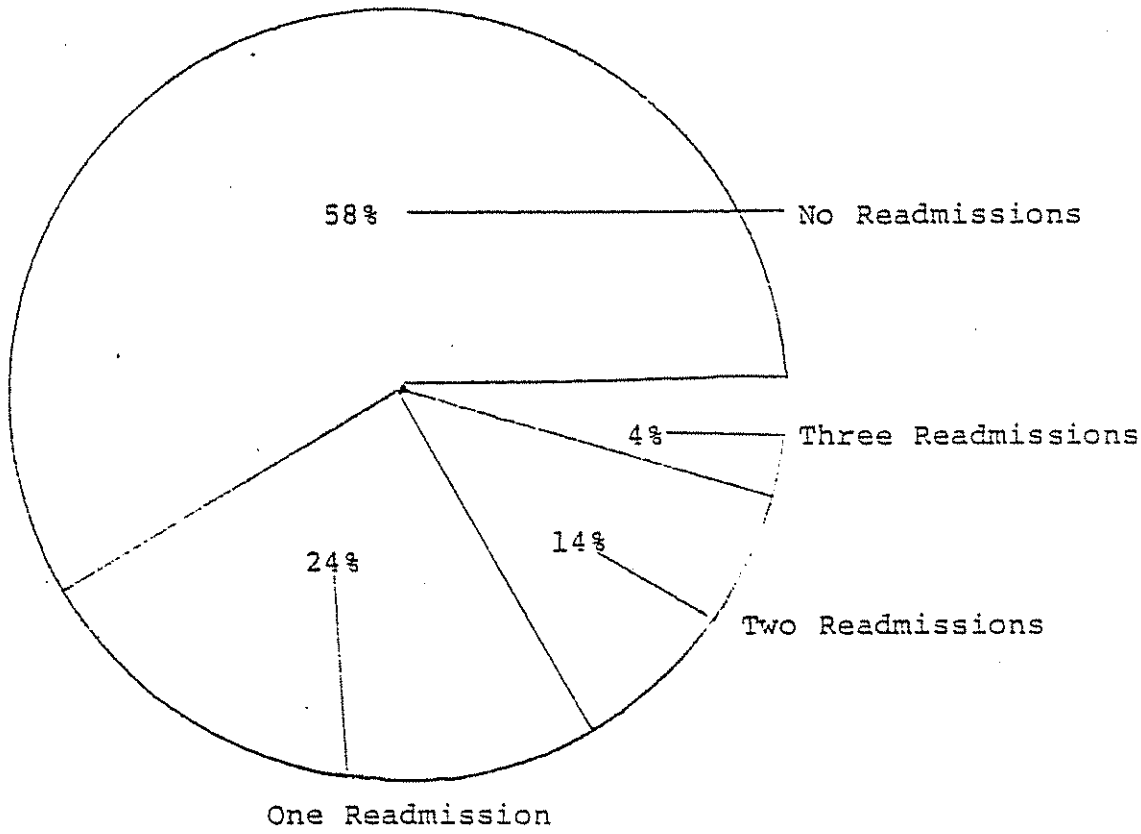
Number of Admissions	Number of Clients	Total Admissions
1	78	78
2	24	48
3	9	27
4	2	8
	118	161

Put another way, a third of the clients accounted for half of the detoxifications received by the group.

A second approach to measuring alcoholic relapse involves "cohort tracking" -- following up a group of clients admitted to treatment at the same time. Research staff identified the first 100 clients admitted to SSATC and searched the records to ascertain whether or not they were readmitted within six months after discharge. Figure 3.1 shows the results.

Figure 3.1

READMISSIONS IN A COHORT OF SSATC CLIENTS
FOLLOWED UP FOR SIX MONTHS AFTER INITIAL DISCHARGE



In all, 42 percent of the sample was readmitted during the follow-up period: 24 percent only once, 14 percent twice, and 4 percent three times. (No client had a fifth admission.)

As a rule, readmissions occurred sooner rather than later. One third of all clients who returned to SSATC for a second detoxification did so within two months after discharge from treatment, and 85 percent did so within four months. A reasonable hypothesis, then, is that as the time since discharge increases, the probability of readmission decreases.

Because SSATC residents have histories of long-standing alcoholism, relapse per se may be a less appropriate measure of program effectiveness than the length of time between detoxifications. If treated alcoholics remain abstinent longer, drink less, or otherwise extend that interval, the program may be regarded as at least partially effective.

SSATC's success in this regard is unclear. On one hand, only one third of those clients who were admitted twice to SSATC showed up for a third detoxification (at least within the confines of the study period). On the other hand, for 10 of the 14 clients who returned for a third detoxification, the length of time between second and third admissions was no longer than that between first and second admissions. There were only four clients who returned to SSATC four times; and data on these individuals do not fall into any pattern.

Cohort studies have also been undertaken at Beth Israel Hospital and in Canada. The study conducted at Beth Israel Hospital traced the treatment histories of 299 patients admitted to the hospital's detoxification unit between January and March, 1974 and followed up through the end of 1975.

Half of the patients were readmitted at least once, 29 percent were admitted twice, 15 percent three times, and 10 percent four times or more.[34] These rates are not comparable with those found at SSATC, as they apply to a 21-24 month follow-up period.

A six-month follow-up of 522 first admissions to three Ontario detoxification centers yielded results similar to those discovered at SSATC: 52 percent of the Canadian sample were readmitted to treatment, as opposed to 42 percent of the SSATC group.[35] The disparity is probably attributable to methodological differences between the two studies: in the case of SSATC (and Beth Israel), only readmissions to the same facility were considered, while the Canadian study sought treatment records from all health care agencies in the area. (It is likely that both the SSATC and Beth Israel studies understate the true amount of recidivism and the amount of time that derelict alcoholics spend in the "grand circuit" of treatment facilities.)

A third kind of analysis considers the proportion of readmissions among admissions during a specific time period or series of time periods. Figure 3.2 illustrates this approach: it charts the number of SSATC clients with prior admissions as

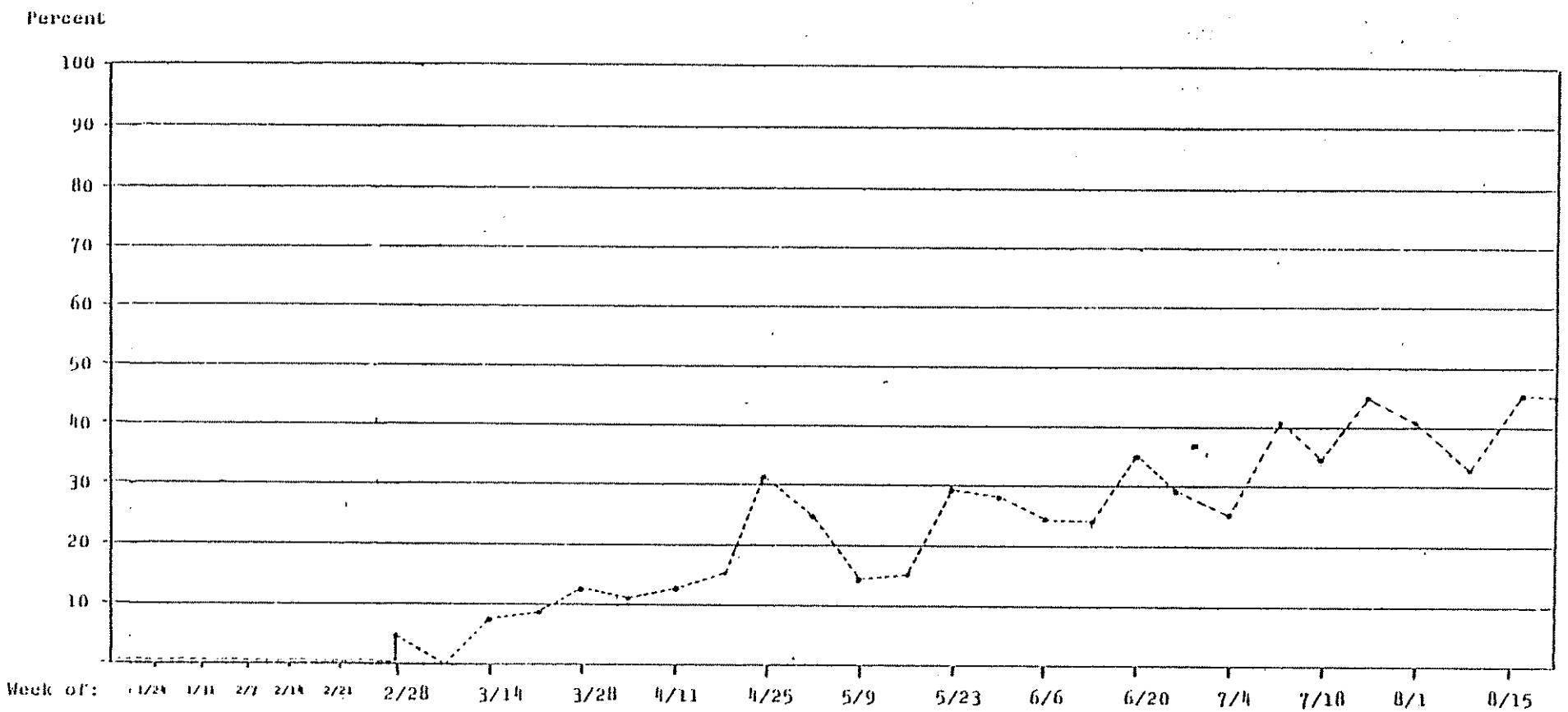
---

[34] Alex Richman, M.D., M.P.H., "Estimating Bed Needs for Detoxification from Alcohol," paper presented at the Second Annual National Center for Health Statistics Data Use Conference, Dalas, Texas, March 28-30, 1977.

[35] H.M. Annis and R.G. Smart, "A Follow-Up of Men Admitted to Detoxication Facilities: Arrests, Readmissions and Treatment Involvement," (Toronto, Canada: Addiction Research Foundation Substudy No. 762, 1976).

Figure 3.2

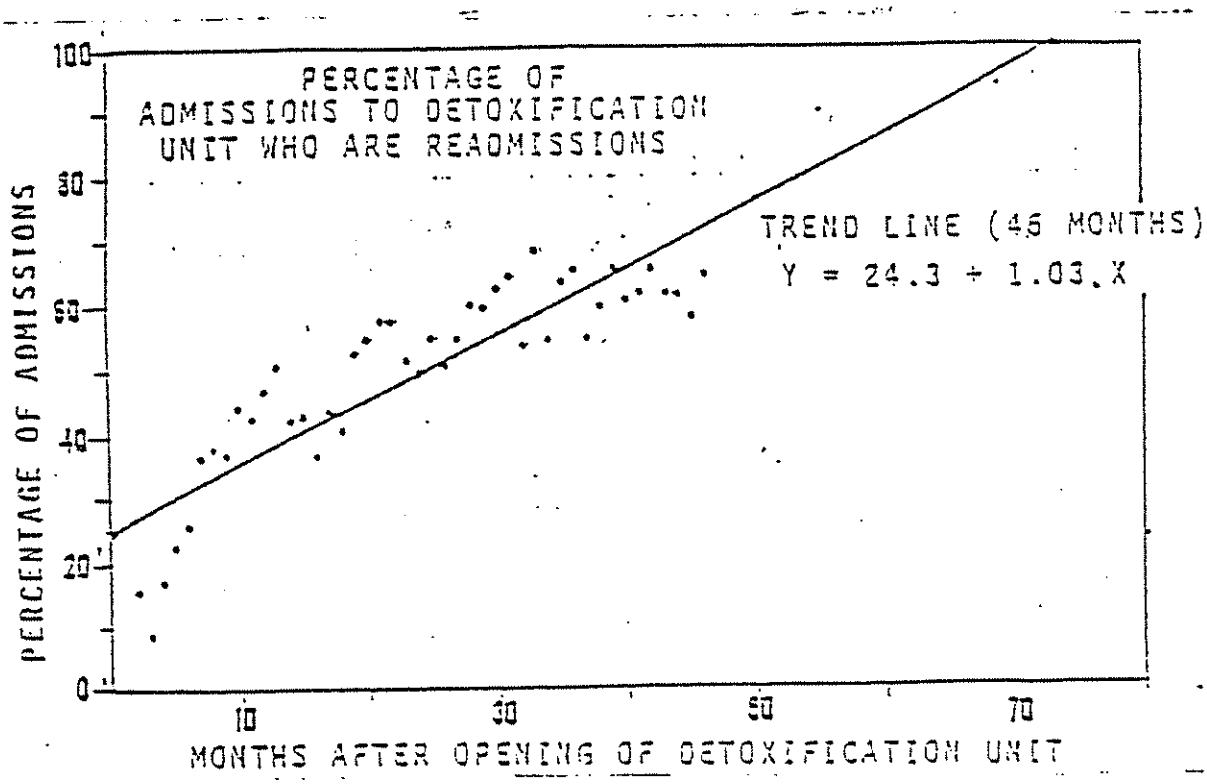
READMISSIONS AS A PROPORTION OF ALL SSATC ADMISSIONS,
BY WEEK OF OPERATIONS:
JANUARY 24 - AUGUST 28, 1977



a percentage of all clients admitted during each week between January 24th and August 22nd, 1977. As would be expected given the 30-day waiting period between admissions, there were no re-admissions during the first five weeks of program operations. By the third month after the program's inception, 30 percent of the clients admitted had detoxified at SSATC in the past; by the sixth month 42 percent of the admissions were readmissions.

Figure 3.3 presents similar data based on 50 months of operations of the inpatient detoxification program at Beth Israel Hospital. It indicates that readmission rates during the first several months after the unit's opening were lower than at the non-medical facility. (Although the current waiting period between admissions at Beth Israel is now 60 days, during the period under study it was 30 days, as at SSATC.). A number of factors may account for the disparity in readmission rates. One possible explanation is that the Beth Israel catchment area, which includes the Bowery, contains a larger number of alcoholics than does the West Side area served by SSATC. The hospital thus could draw from a larger pool of candidates for first-time detoxification. Second, there is reason to think that the alcoholics treated at Beth Israel in the early 1970's were more middle-class than their counterparts at SSATC -- or than alcoholics currently admitted to Beth Israel for detoxification. Because the different characteristics of the treatment populations may be associated with different rates of recidivism, a more reliable comparison would

Figure 3.3



SOURCE: Alex M. Richman, M.D., M.P.H., "Epidemiology in Alcoholism Program Planning," paper presented at Epidemiology, Public Policy and Alcohol Problems in Canada Workshop, Ottawa, Canada, Nov. 15, 1976.

involve more up-to-date hospital data, not currently available. Third, intake physicians at Beth Israel may have exercised greater selectivity in admitting relapsed alcoholics than did SSATC counselors.[36] In any event, by the 50th month after opening, 70 percent of Beth Israel's patients were readmissions.[37]

SSATC appears to be as successful as other non-medical programs in providing a safe, comfortable environment in which to detoxify. The rate of relapse at the Center is slightly higher than at Beth Israel Hospital's detoxification ward; but the difference is not large and may be attributable to factors other than the treatment provided by either facility. Relapse rates enter into calculations of the costs and benefits of medical versus non-medical treatment in the next section.

---

[36] Personal communication, tephanie Bozzone, former Chief Social Worker at Beth Israel Hospital

[37] Alex M. Richman, M.D., M.P.H., "Epidemiology in Alcoholism Program Planning," paper presented at Epidemiology, Public Policy and Alcohol Problems in Canada Workshop, Ottawa, Canada, Nov. 15, 1976. Although Richman has drawn a trend line, it appears equally likely that the increase levels off at 50-70% between the 30th and 50th months after opening. His linear equation can be used to estimate the readmission rate for the first six months of operations at .32.

IV. THE COSTS AND BENEFITS: SSATC AND HOSPITAL DETOXIFICATION COMPARED*

A cost-benefit analysis represents a practical technique for determining the relative merits of alternative public expenditure projects over time. Properly undertaken, it can provide help in making choices among alternative public policies. It must be emphasized, however, that the quality and usefulness of the information to be obtained from such analysis will vary with the quality of the data base. In addition, the analysis rests on a clear understanding of what the societal goal is, how it can be measured, and how its value should be quantified, if at all. It must be stressed that this analysis is based on the limited data that were available. It is necessary to improve on that base in order to make the results more generally applicable. It is also necessary to have follow-up results for a more extended time period if the long run impact of the program is to be investigated.

Defining Costs and Benefits

In undertaking such an analysis, the first step is to define costs and benefits. In measuring the costs and benefits of hospital or non-medical detoxification, costs present the smaller problem, because they are measurable -- to a large extent -- and can be expressed in monetary units. Properly speaking, the listing of resource costs is only a partial account of

---

* This section was written by Professor Eli Noam, Columbia University.

real costs, because there are also some indirect costs that are not reflected through the price system. For example, the use of social workers, doctors, and other professionals in one project reduces their availability for other purposes, and a social cost is associated with that foregone opportunity. The measuring of this opportunity cost would require an elaborate investigation into the theoretical or "shadow"-price of different social service occupations, and cannot be undertaken here. Thus, like most similar studies, this investigation assumes that the social cost is the direct cost, and is reflected by market prices.

It is much more difficult to conceptualize, measure, and quantify the benefits of a detoxification program. There are more than the usual serious analytical problems. First, one must distinguish between direct and indirect benefits. Direct benefits are the benefits received by the patients, or by the institutions that pay for their upkeep, that are attributable to the program. These include, if the program is successful in helping clients to curb excessive drinking, such positive results as improved health, reduced medical expenses, longer life-expectancy, increased job performance, reduced unemployment compensation or welfare payments, and many more. Most of these factors are long-term in nature. It is difficult to measure such a differential impact over the years; and assigning a monetary value to these benefits presents a formidable problem as well. This is also true for

the category of indirect benefits. These are "spill-over" effects such as the social benefits of safer streets, lower unemployment, etc.

Because the "output" of such programs is so difficult to quantify, it is advisable to approximate their relative magnitudes by the use of a one-dimensional proxy-variable. In this case, among the possible variables the most practicable choice is to use the rate of recidivism, or relapse. The lower the rate of recidivism, the more effective the program's impact.[38] This seems a valid simplifying assumption. It is important to note that it is not recidivism as an absolute rate that can provide analytically useful results. What is required is relative differential recidivism, i.e., a comparison of the reduction in recidivism with that of other programs. Here, the impact of the non-medical Social Setting Alcoholism Treatment Center is contrasted with the impact of a more traditional medical detoxification clinic operated by Beth Israel Hospital. That impact is the difference between alcoholic recidivism absent any treatment, and recidivism after treatment.

---

[38] In his follow-up studies of alcoholics treated at Beth Israel Hospital, Dr. Alex Richman adopts Wilkins' definition of recidivism as "the progressive increase in the time-specific rates of readmission for persons with increasing numbers of previous admissions." (L.T. Wilkins, "Recidivists and Recidivism," in Evaluation of Penal Measures, New York: Random House, 1969)). Here a simplified definition is used: the rate of first readmission into a detoxification facility within a given time period. Second and third readmissions are not taken into account.

Richman contends that a treatment program may have favorable outcomes for the majority of individuals at the same

Calculating Cost-Effectiveness

The cost-effectiveness calculation takes four basic factors into account: 1) the recidivism rate at SSATC minus the no-treatment recidivism rate; 2) the cost of treatment at SSATC; 3) the hospital recidivism rate minus the no-treatment recidivism rate; and 4) the cost of treatment at the hospital. These factors are mathematically related as follows:

$$\text{Cost-Effectiveness Ratio} = \frac{\dfrac{\text{Recidivism rate at SSATC minus no-treatment recidivism rate}}{\text{Cost of treatment at SSATC}}}{\dfrac{\text{Recidivism rate at hospital minus no-treatment recidivism rate}}{\text{Cost of treatment at hospital}}}$$

The exact formulas used for calculating this ratio appear in Appendix C.

The cost of treatment is the cost of treating one patient at either facility. For the medical clinic, cost per patient is defined as per diem standard Medicaid reimbursement rate times the average number of days spent by a patient in the hospital. The latter figure is obtained from United States hospital utilization studies in which average days spent are

---

(Cont'd from p. 55)

time that it has high recidivism rates for a minority; he argues, therefore, that recidivism by itself is an insufficient measure of program effectiveness. The choice of recidivism as the sole criterion of effectiveness in this cost-benefit analysis is due to necessity rather than choice: other data on client outcomes were not available.

given for three types of alcoholics as 5.9, 6.0, and 6.4.[39] A weighted average value of 6.13 was calculated. The choice of the per diem Medicaid reimbursement rate as the cost per patient per day reflects the official cost of the treatment. It is of course likely that the actual hospital outlay per alcoholic patient is lower than the rate of $238 that Beth Israel charged to Medicaid during the summer of 1977; nevertheless, the latter is the cost of the treatment to the public.[40] Cost per patient in a hospital setting is thus the cost per day times the number of days = $238 X 6.13 = $1459.

The cost calculations for SSATC required an investigation of the budget. It is necessary to subtract from that budget those items that are in the nature of start-up investments, and add to it costs that may be borne by different agencies, but which are properly part of Social Setting operating expenses. Because the budget for 1976/77 reflects both heavy start-up costs and limited operations, it is more useful to look at the 1977/78 projected and budgeted expenses, to the extent that these were made available. Total budgeted and approved cost was $580,000, of which $227,000 came from New York

---

[39] Length of Stay in P.A.S. Hospitals, by Diagnosis, United States Northeastern Region, 1974. Commission on Professional and Hospital Activities, Ann Arbor, Michigan, September, 1976. Mean lengths of stay given are for patients 35 to 49 years old admitted on a single alcoholism-related diagnosis and not operated on during the course of treatment.

[40] The "average" alcoholic patient admitted to a hospital for detoxification is likely to receive limited medical attention beyond a physical examination, and in this sense, alcoholics may be viewed as subsidizing the cost of care for other hospital patients. However, the $1459 also covers the cost of care for alcoholics who receive more intensive services.

State, and the balance from the federal government. Not included is a budget carry-forward from last year for renovations. In the 1977/78 budget there appear to be only relatively minor expenses that could be classed as start-up investments. (New laundry equipment [$4800] and a breathalizer [$2200] should not be included. Further deductible items may be obtained upon availability of the present budget.)

Added to the SSATC budget are time contributions by the Manhattan Bowery Project.

Associate Director	$2500
Fiscal Officer	3000
Bookkeeper	1590
Nursing Consultant	2083
Other	4000
TOTAL	$13,173

It is not possible to determine conclusively whether this amount should be added to the budget or whether it would constitute double counting. At present it has not been included. A further potential cost item is the salary of the police officer who is part of the rescue team. At present these costs, along with the expense of operating and maintaining the rescue team's car, are borne by the New York City Police Department. Part of this cost should properly be included in the cost of SSATC. The officer fulfills some regular patrol duties, and his dealing with alcoholics relieves the need for

other police officers to fulfill this traditional police function; it was therefore decided to include 1/3 of his salary and benefits ($10,000) as a city subsidy to the program, and to omit the remainder.

SSATC's operational budget is thus $583,000. There are 40 beds in the facility; 34 beds, on average, are occupied. The average stay is 5.77 nights. These figures would indicate that 2150 clients are treated per year. Looking at the last seven months' experience, which included the start-up time, a similar annual rate of 2086 is obtained. Thus, given the operating budget figure and the number of clients, the average per client cost is estimated at $583,000/2150 = $271.

Rates of recidivism over a six-month period were presented in the previous section. For SSATC, that rate is .42, for Beth Israel .32.[41] These rates are used for the calculations in this chapter.

The measure of the recidivism rate absent any detoxification treatment is conceptually and empirically difficult to determine. It was not possible to obtain such a measure for the New York City area. As an approximation, results of a study on detoxification in Toronto were used.[42] Examining the histories of patients admitted to detoxification facilities, the

---

[41] See above, p. 47, p. 51, fn. for a discussion of these rates and of the problems involved in measuring recidivism.

[42] Reginald Smart, Joan Finley, and Rick Funston, "The Effectiveness of Post-Detoxication Referrals: Effects on Later Detoxication Admissions, Drunkenness, and Criminality," Drug and Alcohol Dependence, 2 (1977), 149-155. Also, personal communication, Dr. Reginald Smart, Addiction Research Foundation.

Canadian research team found that during the six months prior to admission, the probability of incidents of alcoholism occurring (as measured by detoxification admissions, drunkenness arrests, and criminal convictions) was .6825. This figure may be taken as a proxy for the alcohol recidivism rate if no treatment is provided. In any event, an exactness of this rate is not critical for an approximation, because it is subtracted from both the rate of recidivism at SSATC and that at Beth Israel and thus tends to cancel itself out, at least in part.

It is now possible to calculate the cost-effectiveness ratio:

$$\text{Cost-Effectiveness Ratio} = \frac{\dfrac{\text{Recidivism rate at SSATC minus no treatment recidivism rate}}{\text{Cost of treatment at SSATC}}}{\dfrac{\text{Recidivism rate at hospital minus no treatment recidivism rate}}{\text{Cost of treatment at hospital}}}$$

$$= \frac{\dfrac{(.42-.68)}{271}}{\dfrac{(.32-.68)}{1459}} = 3.89$$

This result shows that the cost-effectiveness of the non-medical social setting program is nearly four times that of the medical clinic. The medical clinic shows a slightly greater reduction in recidivism, but this difference cannot overcome the substantial cost spread between the two types of treatment. The costs of the medical treatment per patient are over five times higher than those of SSATC. In consequence, whatever small differential in absolute effectiveness may exist, in terms of cost-effectiveness the Social Setting program seems to be superior.

V. THE SUITABILITY OF NON-MEDICAL DETOXIFICATION

The findings of the preceding sections suggest that non-medical detoxification is a safe and cheap alternative to hospitalization for those individuals who can undergo withdrawal without the cushion of medication. But, in order to determine whether and how much the non-medical model should be expanded and to allocate resources most efficiently between medical and non-medical detoxification facilities, it is essential to know what proportion of the alcoholic population can be treated safely in each type of detoxification unit.

That question was addressed through a study of all persons approached by the West Side rescue team during a four-week period in June, 1977. For each client, the rescue aide completed a questionnaire, which included demographic information and ascertained the reasons for referral either to SSATC or to a hospital.[43]

---

[43] Testing was conducted to gauge the reliability of the observations recorded on the questionnaire -- that is, the degree to which variability in recorded responses could be attributed to actual differences in observers' perceptions rather than to ambiguities in the instrument itself. Prior to the inception of the Approach-Referral Study, an SSATC staff member rode with the rescue team and, along with the rescue aide, filled out questionnaires for the nine individuals contacted during the tour of duty. Identical responses were given on 85 percent of the items. Predictably, discrepancies were much more frequent in areas where personal judgments were called for (the client's physical condition, coherence, and age, for example) than on questions of fact, and it did not prove possible to use several of the former items in the subsequent analysis.

A statistical summary of the responses on each item appears in Appendix D. In all, 137 individuals were approached, an average of seven per working day. Of these, 48 (35%) refused assistance, and the rest were referred for treatment.

Table 5.1 summarizes the major findings of the study. Of the 89 individuals referred to any detoxification unit by the Rescue Team, 57 (64%) were initially brought to SSATC, and 48 (54%) were admitted for detoxification.[44]

Five of these 48 clients were subsequently referred to St. Clare's Hospital, two because of difficulties experienced during detoxification and three because of other physical problems requiring attention (two needed dental care and one had stitches removed). All but one of these patients were treated at St. Clare's and returned to SSATC to complete their stay. (These figures closely parallel the data on hospital referrals presented in the second section.)

The table also shows that eight clients judged physically capable of non-medical detoxification were initially referred to a hospital because the center was operating at full capacity, because SSATC cannot accommodate women, or because they had detoxified at SSATC within the past 30 days and were therefore in-

---

[44] The more intensive medical screening conducted by SSATC intake staff indicated that three clients had physical problems undetected by the rescue aide's preliminary diagnosis: one had a high fever and complained of a pain in his chest, one was a diabetic, and the third had severe psychiatric problems. Two of these individuals were sent to St. Clare's Hospital. In addition, five individuals were not admitted for other reasons: two had been at SSATC within the past 30 days, and two refused assistance once they had arrived at the reatment enter. The reason why one person was not admitted is unknown.

Table 5.1

DISPOSITIONS OF REFERRALS MADE BY THE WEST SIDE RESCUE TEAM, JUNE, 1977

Initial Place of Referral, Treatment Status, and/or Reason for Referral	Number		Percentage	
SSATC Referrals, by Treatment Status	57		64	
Admitted		48		54
*Treated without complications		43*		48*
Referred to hospital		5		6
* Returned from hospital		4*		5*
Not Admitted		9		10
Medical reasons		3		3
**Other reasons		6**		7**
Medical Detoxification Unit Referrals, by Reason for Referral	32		36	
**No available SSATC bed		4**		5**
**Client is female		1**		1**
**SSATC detox within past 30 days		3**		3**
Physical problem		21		24
Refused non-medical detox		1		1
Unknown		2		2
All Referrals	89		100	

NOTE:

A single asterisk indicates clients who were treated at SSATC without serious complications. A double asterisk indicates individuals who were not admitted to SSATC but whose characteristics suggest that they could have safely detoxified in a non-medical facility.

eligible for readmission. One other individual, who also passed SSATC's screening test, refused treatment in a non-medical facility. (This person, a 45-year-old white male, had been admitted to SSATC twice previously. The first time, he signed out after one day, acknowledging that he wanted to continue his drunk. During the second stay, he had two seizures and was sent to St. Clare's Hospital for treatment. He was brought back to SSATC a third time because his most recent detoxification, at St. Clare's, had taken place within the past 60 days, and he was therefore ineligible for hospital treatment.)

The single asterisks in Table 5.1 denote those groups of individuals who were treated at SSATC without serious incident. Double asterisks mark groups of individuals who were not admitted to SSATC but whose records suggest that they could have been successfully treated in a non-medical facility. A conservative estimate, based on what actually took place, is that at least 50 per cent of the public inebriate population served by the West Side rescue team can be detoxified in a non-medical setting. A more liberal estimate puts that proportion at 70 per cent.

Three caveats are in order when attempting to generalize from these findings.

First, the scale of the study is relatively small. More conclusive results await an expanded sample.

Second, it is conceivable that chronic alcoholics in other areas of New York City (the Bowery, for instance) are less

healthy than those on the West Side and that therefore, a lower proportion of them could be safely treated at a non-medical facility.[45] (It is also possible, however, that disaffiliated alcoholics move so frequently from one part of the city to another that geographically distinct groups cannot be identified.)

Third, because the study deals only with public inebriates, the applicability of its findings to the alcoholic population as a whole is uncertain. Several studies have documented the differences between Skid Row derelicts and other alcoholics, and different groups may well require different modes of treatment.

All these points merit further investigation before deciding how to mete out resources between medical and non-medical detoxification units. Nonetheless, these preliminary data indicate that non-medical detoxification is appropriate for a sizable proportion of the public inebriate population.

Table 5.2 represents additional information relating to the health of clients who were referred either to SSATC or to a medical facility for care. It is not surprising that SSATC referrals had no serious health problems[46] and did not take regular medication, since such conditions would have disqualified them for non-medical treatment. The data in the last

---

[45] As noted above (p.22,n.) alcoholics admitted to the MBP medical detoxification clinic during a two-month period were older than their SSATC counterparts.

[46] One person referred and admitted to SSATC had a fractured leg.

Table 5.2

HEALTH CHARACTERISTICS OF CLIENTS REFERRED FOR DETOXIFICATION, BY INITIAL PLACE OF REFERRAL

Client Characteristic	Percentage of Clients, by Initial Place of Referral: Persons Referred to SSATC (N=57)	Persons Referred to Medical Facility (N=32)	Total (N=89)
Type of Physical Problem			
Epilepsy	0	22	8
Heart Disease	0	3	1
Diabetes	0	13	4
High Blood Pressure	0	6	2
Recent Injury	0	13	4
Other	2	16	6
None of These	98	34	76
Use of Regular Medication	0	31	11
Abuse of Drugs	0	0	0
Type of Previous Detoxification[a]			
Hospital only	51	69	57
Non-medical only	19	13	17
Both Hospital and non-medical	5	3	4
Other/unknown	1	3	2
No previous detoxes	23	13	19
Date of Most Recent Detox[a]			
Less than 1 month ago	9	14	11
1-2 months ago	39	29	35
3-6 months ago	27	29	28
More than 6 months ago	25	18	22
Unknown	--	10	4
Type of Health Insurance			
Medicaid	33	72	47
Medicare	--	6	2
Other/unknown	2	3	2
None	65	19	48

NOTE: Percentages may not sum to totals because of rounding.

[a]Percentage is of those with any previous detoxifications.

column are more interesting: they provide rough estimates of the incidence of such conditions as epilepsy and diabetes in the public inebriate population as a whole.

Data from the Approach-Referral study also confirm the finding of the Client Information study that SSATC residents seldom abused other drugs.

For most rescue team referrals, detoxification was a familiar experience. Only one quarter of the clients referred to SSATC and one eighth of those referred to a medical facility had never detoxified previously,[47] and of those who had ever detoxified, about 75 per cent had done so within the previous six months. Most clients had never received prior treatment in a non-medical facility, a fact that points up the novelty of the non-medical approach. However, 17 of the 48 clients admitted to SSATC were returning patients: 13 were back for a second stay, two for a third, and two for their fourth visit in the five months since SSATC began operations.

Table 5.2 also points to a strong relationship between the place to which referrals were made and the availability of health care insurance. (Since most public inebriates are indigent, Medicaid was, predictably, the most frequently held type of insurance.) Although as a whole the sample was almost evenly divided between those who were covered and those who were not, 86 percent of those individuals without

---

[47] This disparity is not statistically significant.

any kind of health insurance were referred to SSATC, while only 42 percent of those with insurance were referred to the non-medical facility. Three factors appear to explain this disparity. First, many New York City hospitals do not accept patients who lack third-party coverage except on an emergency basis, and the less severe symptoms of alcoholic withdrawal often do not qualify as emergency conditions. The rescue aide is understandably unwilling to refer an individual to a facility that will not admit him. Secondly, those people who had health insurance appeared to be sicker than those who did not: 40 percent of the insured group were listed as having some kind of physical ailment which would have precluded admission to SSATC, whereas only nine percent of the uninsured were so afflicted. Finally, the rescue aide reported that he prefers to place clients in a hospital when possible, since he believes that detoxification without drugs imposes physical hardships on clients.

The rescue aide also gathered information on individuals who were approached but chose not to detoxify. The first part of Table 5.3 compares data on three groups of public inebriates: those referred for detoxification at SSATC, those referred to a medical detoxification unit, and those who refused detoxification altogether; here, columns add up to 100 percent.[48] In the second part of the table, the same data emphasize the association between client characteristics and acceptance or refusal of treatment; here rows sum to 100 percent.

---

[48] It should be noted that these categories are not necessarily mutually exclusive. A client who refused treatment at one point may have accepted service at a later time, and would be counted twice in this report.

Table 5.3

CHARACTERISTICS OF PERSONS APPROACHED BY THE WEST SIDE RESCUE TEAM, JUNE, 1977, BY TREATMENT STATUS

Client Characteristics	Percentage of Clients, by Treatment Status			
	Persons Refusing Assistance (N=48)	Persons Referred to SSATC (N=57)	Persons Referred to Medical Facility (N=32)	Total (N=137)
Sex				
Male	94	100	97	97
Female	6	0	3	3
Total	100	100	100	100
Estimated Age				
Under 30	38	5	9	18
30-39	44	18	25	28
40-49	15	44	28	30
50-59	4	23	31	18
60+	--	11	6	6
Total	100	100	100	100
Ethnicity				
White	37	51	63	49
Black	42	42	25	38
Hispanic	21	5	12	12
Other	--	2	--	1
Total	100	100	100	100
Prior Rescue Team Contact				
Prior Treatment	27	37	44	35
Prior Verbal Contact	13	4	13	9
Previously seen	23	9	6	13
Unknown	38	51	38	43
Total	100	100	100	100

All Clients	35	42	23	100 (N=137)
Sex				
Male	34	43	23	100 (N=133)
Female	75	--	25	100 (N= 4)
Estimated Age				
Under 30	75	13	13	100 (N= 24)
30-39	54	26	21	100 (N= 39)
40-49	17	61	22	100 (N= 41)
50-59	8	52	40	100 (N= 25)
60+	--	75	25	100 (N= 8)
Ethnicity				
White	27	43	30	100 (N= 67)
Black	38	46	15	100 (N= 52)
Hispanic	59	18	24	100 (N= 17)
Other	--	100	--	100 (N= 1)
Prior Rescue Team Contact				
Prior Treatment	27	44	29	100 (N= 48)
Prior Verbal Contact	50	17	33	100 (N= 12)
Previously Seen	61	28	11	100 (N= 18)
Unknown	30	49	20	100 (N= 59)

NOTE: Percentages may not sum to totals because of rounding.

The table shows that, except in terms of the health characteristics explored in Table 5.2, individuals referred to SSATC did not differ greatly from those brought to a hospital for treatment. Hospital referrals tended to be older or younger than non-medical referrals, but the differences are not large. Less than 10 percent of the men in both groups were under 30 years of age. Blacks and Hispanics comprised a higher proportion of referrals to SSATC than to hospitals (47% vs. 37%), but again the difference is not significant.

Clients who refused assistance were considerably younger than those who accepted a referral: 77 percent of the individuals who rejected help were estimated to be under 40, as opposed to 27 percent of those who accepted service. The second part of the table underscores these disparities: three out of four clients under 30 refused help, while none of those over 60 did so. This finding suggests that the rescue team should focus its efforts on older alcoholics, men who have been battered by years of heavy drinking and the rigors of street life.

The table also implies that blacks and Hispanics were more likely than whites to reject an offer of assistance from the rescue aide (who on 16 of the 19 days for which data were collected was a white male). This seeming ethnic bias is, however, spurious; it results from the fact that Hispanics and blacks who were contacted were younger than their white counterparts. (While only one third of the whites whom the rescue team encountered were under 40 years of age, for blacks and His-

panics the corresponding proportions were 52% and 61%, respectively.) When the data are controlled for the client's age, non-whites were no more likely than whites to refuse help.

Aside from age, the best predictor of accepting aid was the degree to which the client had already begun to experience withdrawal symptoms. Only one of the 15 people whom the rescue aide judged to be "shaky" refused a referral. And clients who were not drinking when they came into contact with the rescue team were significantly more likely to accept a referral (81%) than those who were still imbibing, or near whom a bottle was clearly visible (53%).

Other factors proved irrelevant to the client's decision about whether or not to detoxify. The majority of clients, whatever their treatment status, were familiar faces to the rescue team and about a third had been brought to SSATC or to a hospital in the past; however, individuals whom the rescue team had previously referred for treatment were no more likely to decide to detoxify at this go-round than those who were strangers to the team. Clients who were alone when approached were no more liable to accept detoxification than those who were with others. Meteorological explanations of behavior patterns also do not hold: clients were not significantly more likely to enter a detoxification facility when the weather was cloudy or rainy than when it was warm and clear.[49]

[49] All observations took place during a relatively warm month, however. Prospective clients may be more willing to detoxify -- or get in out of the cold -- during the winter.

Whether or not the client chose to detoxify, his attitude toward the rescue team was generally friendly.[50] On a third of the questionnaires, the rescue aide recorded that the individual gave the reason for his decision to accept or refuse treatment; several of these responses indicate trust in rescue team or in SSATC operations (e.g., "I know you'll help me." "That's a good place." "I'll go with you."). The most frequestly cited reason to detoxify was the need to "straighten out," "do something," or "get it together." Just what these rather vague terms signify is unclear: the goal may be ambitious -- to regain sobriety -- or more modest -- to recover temporarily from the effects of long and hard drinking. What is notable, however, is that a number of the respondents who decided to detoxify mentioned that they wanted to sober up and return to work. The prospect of future employment is apparently a powerful incentive to stop drinking. Although a few people gave responses such as, "I have to go somewhere," or "I need a place to stay," on the whole, the clients did not look on detoxification facilities as "flops" (or if they did, they were discreet in their comments to the rescue team).

Several clients who chose not to detoxify when contacted left open the possibility that they would seek treatment in

---

[50] The rescue aide was instructed to judge the client's attitude on the basis of behavioral indicators: for example, a "friendly" attitude might be marked by a smile or verbal expression of goodwill, while a "hostile" attitude might be denoted by a scowl or a curse.

the future. A frequent response was, "I'm not ready yet," or, more explicitly, "I need to do some more drinking." As one respondent said, "I'm okay. See you some other time." One man expected to receive his welfare check the next day, and another said he had a job and didn't "want to be bothered" with detoxification.

Finally, the rescue aide was asked to note the location where each approach took place. The map below charts these contacts and holds few surprises for West Side area residents, who are aware that large numbers of public inebriates cluster along Eighth and Ninth Avenues, around Columbus Circle, and at the intersections of Broadway with major two-way cross-streets (72nd, 79th, and 86th).

VI. THE BROADER ISSUES

The Social Setting Alcoholism Treatment Center has demonstrated that non-medical detoxification "works" for the disaffiliated alcoholics whom the Center was established to serve. SSATC's screening procedures have proven effective: only one in 20 clients has required transfer to the Center's back-up hospital. Rates of relapse are in line with those of other non-medical and medical facilities, and SSATC operations are highly cost-effective in comparison with hospital detoxification wards. Preliminary data also suggest that non-medical detoxification is suitable for a substantial proportion of disaffiliated alcoholics on Manhattan's West Side, although further research is needed to inform policy decisions about expanding the non-medical treatment model and extending it to middle-class alcoholics.

Like many studies, this investigation has raised as many questions as it has answered. The remainder of this section outlines some broader issues related to detoxification in particular and to the treatment of alcoholics in general, and indicates some directions which future research might take.

First, to what extent do detoxification centers, whether hospital-based or not, serve clients with clearly established emergency medical needs? The severity of withdrawal varies markedly from individual to individual, and from one drinking episode to the next, and as noted, few SSATC residents experienced severe withdrawal symptoms. It seems reasonable to con-

clude that for the majority of clients, the facility addressed needs that are psychological as much as physiological. It providesaa place where the alcoholic can sober up in a supportive, comfortable environment, removed from the pressures to resume drinking that normally surround him.

If emergency care is needed, must it be supplied in an inpatient setting? An alcoholism treatment program in Orange County, California reported that of those patients who experienced acute withdrawal, under half needed inpatient care; and of those who started outpatient detoxification, 82 percent completed treatment. The cost of outpatient care was approximately $20 per service day.[51] Other experiments with outpatient detoxification have been less successful;[52] it may be that Orange County alcoholics were less disaffiliated than their counterparts in other communities and more susceptible to treatment in an outpatient setting. Further research may make it possible to identify those patients for whom outpatient detoxification is appropriate.

Inpatient care may have positive health effects that go beyond the meeting of emergency medical needs and that justify continuing this type of treatment even if outpatient care is feasible and less costly. For instance, the client's physical

---

51 Daniel J. Feldman et al., "Outpatient Alcohol Detoxification: Initial Findings in 564 Patients," American Journal of Pathology, 132:4 (April, 1975), pp. 407-412.

52 Personal Communication, Stephanie Bozzone, Clinical Director, Social Setting Alcoholism Treatment Center.

problems may be more likely to come to the attention of the staff of an inpatient facility than of an outpatient program, so that a course of treatment can be instituted more promptly. The chance to rest up and eat well, even on an occasional basis, may help prevent debilitation and thereby have beneficial long-term consequences. Beth Israel Hospital reported a lower incidence of cirrhosis of the liver after establishing its detoxification clinic. Inpatient care may have psychological benefits as well as physical ones: sobering up in an unpressured environment may make the client more receptive to counseling and better equipped to make decisions about future treatment. All of these possibilities should be explored systematically.

To what extent does detoxification constitute more than a brief interruption of an alcoholic career, that is, to what extent does it, and can it, have a rehabilitative impact? Because the course of treatment is so short SSATC staff do not expect detoxification per se to produce long-term lifestyle changes; therefore, to the extent that the Center aims at rehabilitation, it does so by referring clients to aftercare. Because of methodological problems, the proportion of SSATC clients receiving a referral to an aftercare facility who actually followed through could not be determined. During the study period, clients were expected to get to post-detoxification treatment facilities on their own, and verification of arrival was not routine.[53] An Addiction Research Foundation

---

[53] Both of these problems are being remedied: as noted above, SSATC staff now make regular telephone verifications, and the Center expects to have a car available to transport patients to their referrals.

study of 114 men admitted to detoxification and subsequently referred to an outpatient clinic, a halfway house, and a long-stay farm ascertained that 60 percent of those who were referred arrived. [54]

The study could not assess the impact of referrals on those SSATC clients who received them, and some research have called the value of such referrals into question. An Addiction Research Foundation study found that there were no overall differences between treated and untreated patients in a number of readmissions to detoxification facilities, arrests for drunkenness, or criminal convictions. As measured along the above criteria, successes were less frequent than failures in all treated groups, and proportions of successes and failures did not vary between those treated and not treated. "In general," the authors concluded, "the data provide little cause for optimism about the value of post-detoxification referrals." [55]

A frequently-heard argument is that while the first or second or tenth detoxification episode may fail to produce the desired effect, eventually the alcoholic patient will "see the light." A recidivism study at Beth Israel Hospital cited earlier in this report found, on the contrary, that as the number of previous admissions increased, readmissions became more rapid and more frequent; as the author put it, "The allegation that 'the more treatment, the better the result' does not apply to detoxification." [56] An alternative interpretation

---

54 Reginal G. Smart, "The Effectiveness of Post-Detoxification Referrals.....," op. cit.

55 Ibid.

56 Alex Richman, M.D., M.P.H., "Estimating Bed Needs for Detoxification from Alcohol," op. cit.

is that increased treatment is associated with reduced tolerance for alcohol: habitual inebriates may have to return for detoxification more quickly despite the fact that they are drinking less.

One problem with both studies may be that their gauges of rehabilitation are too narrow. The client who is, as a result of treatment, able to avoid drinking for a week or a month will be in better physical shape than the one who does not abstain during that period. And in the meantime, he may be able to work at spot jobs, find a place to live, and develop greater stakes in prolonging sobriety.

However, the Addiction Research Foundation and Beth Israel studies do point to an issue of particular concern to alcoholism program administrators: the adverse effect that patients who have failed to respond to previous efforts may have on new patients, referral sources, and treatment facility personnel.[57] To date, morale at SSATC has been high, and if it remains so as the program's track record lengthens, other treatment programs may want to adopt the staff selection and training techniques employed by the Center.

Another unresolved question involves the appropriate length of stay at detoxification facilities. Systematic investigation is needed to determine whether the length of the sobering-up period has an impact on acceptance of aftercare referrals, subsequent drinking, health, or rates of readmission to detoxification facilities. In response to the decriminalization of public intoxification, the New York State Department of Mental Hygiene has established "sobering-up stations" to deal with public inebriates. These centers are similar to SSATC in their operations -- they

---

[57] Ibid.

provide temporary shelter and meals to applicants who do not have potential medical problems, they do not dispense drugs, and they make referrals to aftercare institutions -- but the length of stay at sobering-up stations is only half that at SSATC. It may be that a three-day stay is sufficient to meet the emergency needs of clients; and higher turnover rates would allow more people to be treated within a given time period. On the other hand, research may show that adequate referrals cannot be made in such a brief time period.

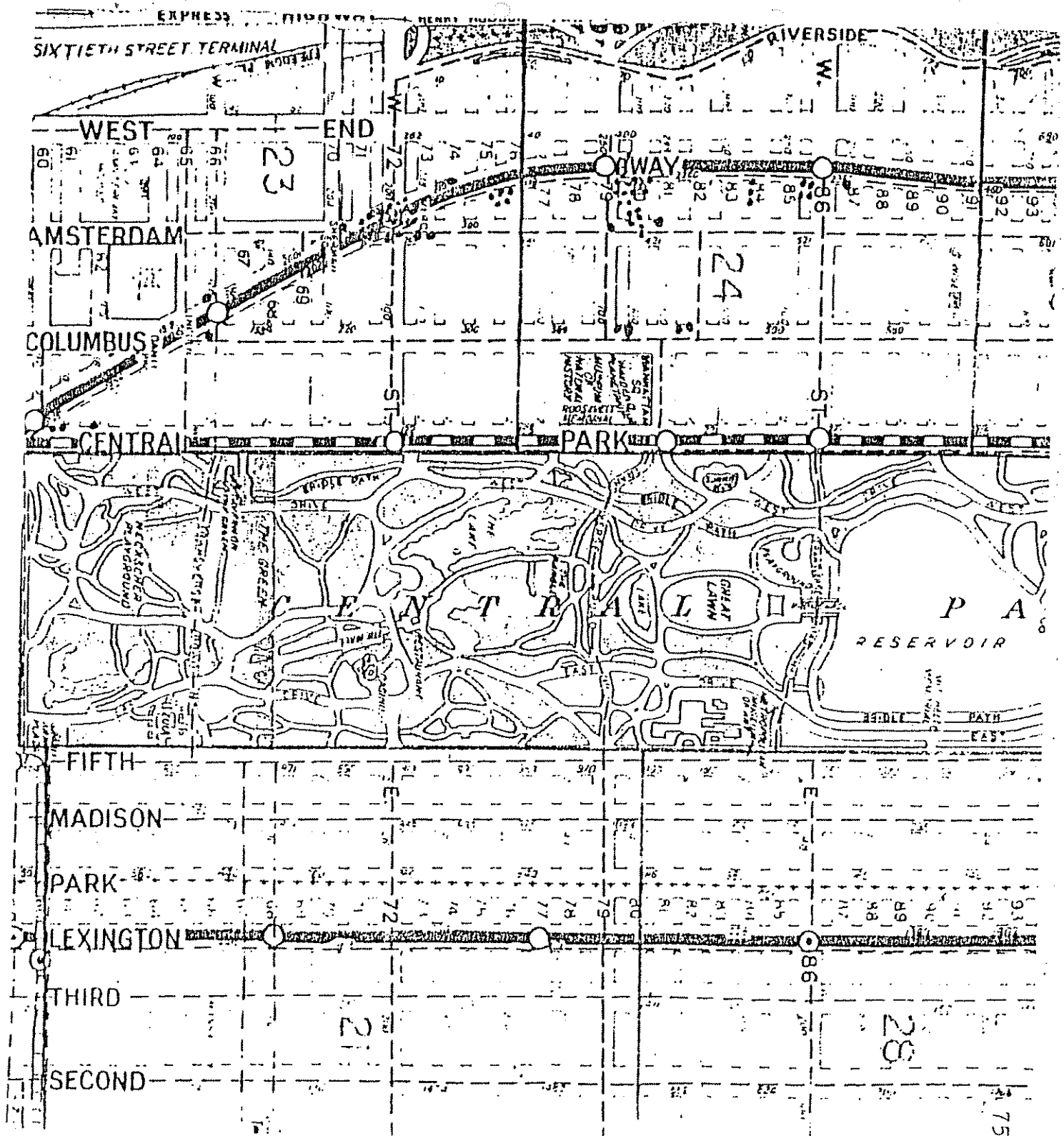
SSATC clearly performs valuable services for its clients. The Center's philsophy and mode of operation are humane. Most residents are grateful for the chance to clean up, eat heartily, sleep on clean sheets, and in general have a week-long respite from the rigors of street life. But there may be ways of restructuring SSATC and other detoxification centers so that they can have a greater rehabilitation impact on their clients. Most Skid-Row alcoholics face a constellation of problems that go beyond excessive drinking to include poor health, unemployment and inadequate income, lack of decent living quarters, and disrupted social ties. But SSATC is funded for a single purpose. Because it is not linked to a comprehensive alcoholism program offering a variety of services to all clients, the Center's residents frequently must shunt from agency to agency to receive assistance. The components of an integrated treatment program could either be developed by the Manhattan Bowery Corporation or supplied by already existing facilities. Only the outlines of such a program can be mentioned here: an intensive medical work-up; a decent, low-cost shelter with sympathetic staff;

nutritious meals; low-stress employment; assistanee with problems related to welfare and Medicaid; remedial education; psychological counseling; and recreational activities. To implement such a program on a large scale would be costly. But millions of dollars are spent in New York City each year to process patients through detoxification units. Massive intervention is expensive; but without that intervention, detoxification facilities, medical and non-medical will serve primarily to clear drunks off the streets in a humane way.

Until such programs can be tested, and afterwards as well, the treatment model presented by SSATC merits full support. Social setting detoxification has proved a safe, cost-effective way of providing temporary assistance to the disaffiliated alcoholic and of relieving the burden he imposes on society.

---

58 Whether sobriety should be required at these shelters remains an unresolved question. Although some facilities for chronic inebriates report that some of their residents drink low-alcohol beer in moderation (the New York City-operated Camp La Guardia and Ontario's Bon Accord Farm are cases in point), other facilities have reported high levels of tension when drinkers and abstainers live under the same roof.


SIXTIETH STREET TERMINAL
RIVERSIDE
WEST END
AMSTERDAM
COLUMBUS
CENTRAL PARK
CENTRAL PARK
RESERVOIR
FIFTH
MADISON
PARK
LEXINGTON
THIRD
SECOND
72 ST
79 ST
86 ST
E. 72 ST
E. 79 ST
E. 86 ST

APPENDIX A

CLIENT INFORMATION FORM

SUMMARY STATISTICS

		#	%
1.	Total Admissions	118	100
2.	Admission No.	118	100
	1	78	66
	2	29	25
	3	9	8
	4	2	2
3.	Sex	118	100
	Male	118	100
	Female	--	--
4.	Age	118	100
	under 30	15	13
	30-39	31	26
	40-49	40	34
	50-59	20	17
	60+	12	10
5.	Veteran	115	100
	Yes	65	57
	No	50	43
6.	Household Composition	118	100
	Lives Alone	42	36
	In Institution	--	--
	Lives with Others[a]	22	19
	With Spouse	9	8
	With Parents	2	2
	With Children	3	3
	With Siblings	2	2
	With Other Relatives	1	1
	With Others	8	7
	No Permanent Address	54	46
7.	Ethnicity	118	100
	White	70	59
	Black	32	27
	Hispanic	13	11
	American Indian	3	3
	Oriental	--	--
	Other	--	--

a Categories may sum to more than total because of multiple coding

	#	%
8. Marital Status	118	100
Never Married	49	42
Married	9	8
Remarried	--	--
Separated	27	23
Div/Annulled	23	19
Widowed	10	8
9. Current or Most Recent Occupation	118	100
Professional/technical	9	8
Farmer	--	--
Manager/official/proprietor	--	--
Clerical	6	5
Sales	--	--
Craftsman/foreman/skilled worker	14	12
Operative/driver/semi-skilled worker	19	16
Private household worker	1	1
Service	11	9
Farm laborer	--	--
Laborer/day worker	56	47
Occupation not reported	2	2
Housewife	--	--
Student	--	--
10. Employment Status	118	100
Employed full time	5	4
Employed part time	2	2
Unemployed, prior to current illness	56	47
Unable to work due to current illness	39	33
Unable to work due to illness or disability other than current illness	5	4
Retired	3	3
Unknown	8	7
11. When did client have last drink?	105	100
Same day	96	91
Day before	6	5
More than 1 day before	3	3
12. Intake Source	118	100
Rescue Team	71	60
St. Clare's	1	1
Other Hospital	2	2
Social Agency	3	3
Walk-in	31	26
A.A. Intergroup	6	5
Other	4	3

	#	%
13. Degree of Intoxication on Intake	118	100
Mild	18	15
Moderate	70	59
Severe	30	25
14. Physical Condition on Intake	118	100
Good	13	11
Fair	86	73
Poor	19	16
15. Is Client Shaky?	118	100
Yes	30	25
No	88	75
16. Is Client Hallucinating?	118	100
Yes	4	3
No	114	97
17. Admissions Resulting in Referral to Hospital	11	9
18. Number of Hospital Referrals	11	9
Detox-related referrals	4	3
Non-detox-related referrals	7	6
19. Number of Referrals Returned to SSATC	5	4
Detox-related	1	1
Non-detox-related	4	3
20. Nights Spent in Center	118	100
Less than 4	22	19
4	3	3
5	10	8
6	5	4
7+	78	66
21. Disposition	118	100
Left against advice	21	18
Completed stay	91	77
Own Plans	37	31
Referred Out	54	46
Rehabilitation Unit	21	18
OPD	6	5
Other Medical Unit	1	1
Step II	3	3
Other Halfway House	1	1
Residential (Non-Rehab)	19	16
Other	3	3
Hospital Post-Admission	6	5

Drinking History	#	%
22. Number of Previous Detoxes	115	100
0	17	15
1-2	33	27
3-4	24	21
5-9	17	15
10+	24	21
23. Most Recent Detox	115	100
2 wks. ago or less	2	2
15-30 days ago	9	8
30-60 days ago	24	21
60-180 days ago	26	23
More than 180 days ago	37	32
None	17	15
24. Age Started Frequent/Heavy Drinking	96	100
under 20	35	36
20-29	30	31
30-39	19	20
40+	12	13
25. Mean Age	28	
26. Number of Years of Frequent/Heavy Drinking	96	100
Less than 5 years	9	9
5-9 years	15	16
10-19 years	36	37
20+ years	36	37
27. Client Description of Current Drinking	95	100
No problem	3	3
Slight problem	2	2
Moderate problem	19	20
Severe problem	71	75
28. Does Anyone in Client's Family Have a Drinking Problem?	95	100
Yes	39	41
No	56	59
29. Has Client Participated in Residential or Outpatient Alcohol Programs?	94	100
Yes	51	54
No	43	46

	#	%
30. Has Client Participated in A.A.?	95	100
Regular or frequent attendance	22	23
Occasional attendance	60	63
Never attended	13	14
31. Has Client Sought Help for Drinking from any Other Sources?	93	100
Yes	14	15
No	79	85
32. Has Client Ever Taken Antabuse?	95	100
Yes	38	40
No	57	60
33. Has Client Ever Had Periods of Sustained Sobriety?	92	100
Yes	71	60
No	21	18
34. Longest Period of Sobriety	71	100
Less than 3 months	23	32
3-6 mos.	23	32
7-12 mos.	10	14
13-36 mos.	11	15
More than 36 mos.	2	3
Unknown	2	3
35. When Was Last Period of Sobriety?	71	100
Less than 6 months ago	19	26
6-12 mos.	26	37
13-36 mos.	10	14
More than 36 mos.	12	17
Unknown	4	6
36. Other Drugs Used in Past 30 Days	118	100
None	101	86
Some drug used[a]	17	14
Marijuana, hashish	17	14
Cocaine	1	1
Heroin	1	1
Methadone maintenance	2	2
Street methadone	--	--
Barbiturates	2	2
Amphetamines	1	1
LSD, other hallucinogens	--	--
Other	--	--

a Categories may sum to more than total because of multiple coding

Medical History	#	%
37. Number of Admissions to a Hospital Within Past 12 Months for:		
Alcoholism treatment	54	46
Medical treatment	18	15
Psychiatric treatment	3	3
38. Number of Admissions with History of:		
Tuberculosis	9	8
Diabetes	--	--
Heart Disease	1	1
High Blood Pressure	13	11
Pneumonia	34	29
Liver Trouble	16	14
Epilepsy	1	1
Syphilis/Other Venereal Disease	19	16
Convulsions/Seizures	25	21
Tremors	76	64
Hallucinations, D.T.'s	48	41
Blackouts	83	70
Mental Hospitalization	15	13
Bone Fracture in last month	3	3
Mugging in last month	20	17
None	9	8
39. Does Client Currently Take Prescribed Medication?	118	100
Yes	4	3
No	114	97
Client Information		
40. Has Client Been in Touch with Any Family Members?	95	100
Yes	38	40
No	57	60
41. Birth Order in Family	94	100
Oldest	26	28
Youngest	23	24
Middle	31	33
Only Child	13	14
Twin	1	1
42. Community of Origin	95	100
Large city (100,000)	58	61
Small city/town	31	33
Rural non-farm	4	4
Farm	2	2

	#	%
43. State of Origin	95	100
New England	8	8
Middle Atlantic	48	51
East North Central	3	3
West North Central	2	2
South Atlantic	18	19
East South Central	5	5
West South Central	1	1
Mountain	--	--
Pacific	2	2
Puerto Rico	2	2
Outside USA	6	6
44. Type of Residence	96	100
House, apartment	19	20
Rooming house, hotel, SRO	28	29
Group quarters (halfway house, mission)	2	2
Other	--	--
No permanent address	47	49
45. Change in Address in Last 12 Months	95	100
Same address throughout	22	23
Moved once	10	11
Moved twice	10	11
Moved three or more times	23	24
No permanent address throughout	30	32
46. Time Lived in New York City	96	100
Less than 1 year	7	7
1-3 yrs.	7	7
More than 3, less than 5 yrs.	2	2
5-10 yrs.	9	9
More than 10 yrs.	71	74
47. Last Grade of School Completed	94	100
6th grade or less	4	4
7-8th grade	13	14
Some high school	34	36
High school graduate	29	31
Vocational, business, technical school	2	2
Some college	8	8
College graduate	4	4
Advanced degree	--	--
48. Number of Years Ago Client Last Held Regular Job	87	100
Less than 1 year ago	27	31
1-5 yrs.	34	39
6-10 yrs.	16	18
11-15 yrs.	3	3
More than 15 yrs.	3	3
Never held regular job	4	5

	#	%
49. Mean Number of Years Ago Last Held Regular Job	5	
50. Length of Time Client Has Held Current Job	96	100
Less than 6 months	1	1
6-12 mos.	--	--
13-36 mos.	1	1
More than 36 mos.	4	4
Currently holds no regular job	90	94
51. Major Source of Income in Past Month	95	100
Job*	24	25
Spouse	--	--
Family or friends	8	8
Public assistance/welfare	28	28
Pension (including Social Security, Veterans' pension)	7	7
Insurance (including Unemployment Insurance, Workmen's Comp.)	1	1
Savings	2	2
Panhandling	12	13
"Hustling"	5	5
Other	--	--
None	8	8
52. Welfare Category	92	100
Home relief	9	10
S.S.I.	15	16
Other	1	1
None	67	73
53. Type of Health Insurance	91	100
Medicaid	25	27
Medicare	4	4
Blue Cross/Blue Shield	4	4
Private Insurance	2	2
Other	--	--
None	56	62
54. Number of People Client is Supporting, Including Self	96	100
1	92	96
2	1	1
3	2	2
4	--	--
5+	1	1
55. Client Ever Arrested?	91	100
Yes	68	75
No	23	25

*Includes "spot jobs"

	#	%
56. Number of Admissions Arrested For:	89	100
Drunknenness, vagrancy, or disorderly conduct	42	47
Auto accident, traffic violation	10	11
Driving while intoxicated	9	10
Assault and battery	13	15
Drugs or narcotics	5	6
Other	17	19
57. Time Spent in Jail	89	100
Less than 30 days	12	11
30-90 days	5	6
91-180 days	5	6
181-360 days	4	4
1-5 years	15	17
More than 5 years	11	12

APPROACH/REFERRAL FORM

SUMMARY STATISTICS

Rescue Aide: John Wickens (15 Days)
Joe Casey (1 Day)
Alton DuConge

	#	%
1. Total Number of Days	19	
2. Total Number Approached	137	
3. Intake Source	137	100
Rescue Team	137	100
St. Clare's Hospital	-	-
Other Hospital	-	-
Social Agency	-	-
Self-Referral	-	-
Other	-	-
4. Mode of Contact	137	100
Client approached by rescue team	136	99
Client referred by other agency	1	1
Client brought to facility by third party	-	-
Client refers self to facility	-	-
Other	-	-
5. Where is Contact Made?	137	100
Inside Facility	1	1
On Street	136	99
6. Sex	137	100
Male	133	97
Female	4	3
7. Estimated Age	137	100
Under 30	24	17
30-39	39	28
40-49	41	30
50-59	24	18
60+	9	7
8. Estimated Economic Status	137	100
Middle Class	2	1
Working/Lower Class	28	20
Skid Row	107	78

	#	%
9. Ethnicity	137	100
White	64	47
Black	55	40
Hispanic	17	12
Other	1	1
10. English Language Ability	137	100
Fluent	100	80
Some English	25	18
Little or no English	2	1
11. Is Client Coherent?	137	100
Fully	35	26
Partly	96	70
No	6	4
12. Is Client Known?	137	100
Prior treatment	49	36
Prior verbal contact	14	10
Previously spotted	17	12
Unknown	57	42
13. Client's Activity When Contacted	137	100
Walking	69	50
Sitting/Leaning	61	45
Sleeping/Lying	7	5
14. Is Client Drinking and/or is Bottle Visible?	137	100
Yes	79	58
No	58	42
15. Company	137	100
Alone	87	64
With one or two others	45	33
In larger group	5	4
16. Physical Appearance/Condition[a]	137	100
Orderly	34	25
Orderly, but unshaven	4	3
Unshaven and/or clothing mussed, soiled, or missing	97	71
Shaky	15	11
Hallucinating	5	4
Other	-	-

[a] Categories may sum to more than loo per cent because of multiple coding.

	#	%
17. Degree of Intoxication	137	100
Severe	14	10
Moderate	113	82
Mild or none	10	7
18. Physical Condition	137	100
Good	16	12
Fair	111	81
Poor	10	7
19. Client Attitude	137	100
Friendly	109	80
Neutral	20	15
Hostile	6	4
No Data	2	1
20. Does Client Express Interest in Detox?	137	100
Yes	92	67
No	45	33
21. Is Client Willing to Stay Full Term?	137	100
Yes	91	66
No or not relevant	46	34
22. Does Client Decide to Detox?	137	100
Yes	89	65
No	48	35
23. Total Number of Clients Brought to a Facility by Rescue Team	89	65 (% of total approaches
24. Does Client Take Regular Medication?	89	100
Yes	10	11
No	78	88
No Data*	1	1
25. Does Client Abuse Drugs?	89	100
Yes	-	-
No	88	99
No Data	1	1

*One woman was not coherent and spoke little English. Rescue Aide unable to get information in most questions.

	#	%
26. Number of Clients with Medical Problems[a]		
Epilepsy	7	8
Heart Disease	1	1
Diabetes	4	5
High blood pressure	2	2
Recent Injury	4	5
Other	6	7
None	67	75
27. Health Insurance	89	100
Medicaid	42	48
Medicare	2	2
Blue Cross/Blue Shield	-	-
Other	1	1
None	44	49
28. Previous Detoxifications	89	100
In hospital only	51	58
In sobering-up station only	2	2
In non-medical setting only	13	15
In hospital and non-med	3	3
In hospital and SUS	1	1
In non-med and SUS	-	-
In hospital, non-med, and SUS	-	-
Other	1	1
Never detoxified	17	19
No Data	1	1
29. Most Recent Detoxification	88	100
Less than 1 month ago	10	11
1-2 mos. ago	22	25
3-6 mos. ago	20	23
More than 6 mos. ago	19	22
Never detoxed before	17	17
No data	1	1
30. Where is Initial Referral Made?	89	100
S.S.A.T.C.	57	64
Hospital	32	36
Sobering-up station	-	-
Other	-	-
31. Is Client Admitted?	89	100
Yes	80	90
No	9	10

[a] Categories may sum to more than 100 per cent because of multiple coding.

	#	%
32. If not, why not?	9	
Medical problem	4	
No available bed	-	
Client refused assistance	1	
No third party payor	-	
Does not meet time requirement	3	
Other	1	
33. Is Client Referred Elsewhere?	9	
Yes	4	
No	5	
34. Where?		
S.S.A.T.C.	1	
Hospital	3	
Other	-	

APPENDIX B

TO: All Staff

FROM: Janet Quint

SUBJECT: Procedures for the Experiment

Our experiment to measure the impact of social setting detoxification will begin July 5th. As you probably know, this experiment is part of the evaluation of S.S.A.T.C. required by our funding agencies, the N.I.A.A.A. and the New York State Department of Mental Hygiene. For the month of July, this experiment will affect all day shift personnel -- Rescue Team members, S.S.A.T.C. staff, and research people. However, I think (and hope!) we have designed the experiment in a way that will be minimally disruptive of normal operations.

1. Only clients admitted to a facility by the Rescue Team would participate in the experiment. Walk-ins and persons referred from social agencies would not participate.

2. Until the end of the month, the experiment will be "on" every day.

3. Clients who would participate in the experiment include only those who:

a) are judged by the Rescue Team to be able to detox at S.S.A.T.C. (All people who would normally be detoxified in a hospital, or would be screened for possible hospital treatment, will continue to be detoxed in a hospital during the course of the experiment.)

b) have not detoxed within the past 60 days

c) agree to detox in either a hospital or a social setting

c) are covered by Medicaid.

4. All such clients would be brought to S.S.A.T.C. for further screening.

5. Potential subjects would be asked to sign a form expressing consent to participate in the experiment and to be interviewed.

6. Using a random assignment procedure, Kathy Schaffer would assign clients to either Beth Israel Hospital or to S.S.A.T.C. for treatment.

7. Once a client has been selected for treatment at Beth Israel Hospital, Rescue Team staff will phone the hospital to ascertain whether a bed is open. If the bed is open, they will "reserve" the bed. If the bed is not open (and if hospital staff do not expect any openings in the remainder of the day), the client will be admitted to S.S.A.T.C. but can be considered a subject for the experiment.

If S.S.A.T.C. has no available beds but the client meets the criteria set out above, he will be referred to Beth Israel and will be considered a subject for the experiment.

8. Intake data on both clients to be treated at S.S.A.T.C. and those to be treated in hospitals would be collected by S.S.A.T.C. staff. These data consist of Questions 1-28 and 35-41 on the new Client Information form.

9. Counselors of clients to be treated at S.S.A.T.C. will complete the remaining items on the Client Information form during the client's stay. (Research staff will complete those items for patients treated at Beth Israel Hospital.)