

Final Report.

CHICAGO'S ALCOHOLIC
TREATMENT CENTER

Final Project Narrative
OPERATION OUTREACH
LEAA Grant No. ⁶⁹⁻DF - 010

32378

READING ROOM



U.S. DEPARTMENT OF JUSTICE
OFFICE OF LAW ENFORCEMENT
ASSISTANCE

GRANTEE'S
QUARTERLY PROGRESS REPORT
FINAL PROJECT NARRATIVE Page 1

From: (Name and address of grantee)

Chicago's Alcoholic Treatment Center
3026 South California Avenue
Chicago, Illinois 60608

Grant
No. DF-010

Date of
Report March 31, 1971

Covering Period:

August 1, 1969 to September 30, 1970

To: Director, Office of Law Enforcement Assistance
Department of Justice, Washington, D.C. 20530

Submitted herewith is the grantee's progress report for the period shown above:

Project Director (Signature)

Phyllis K. Snyder
Executive Director
Chicago's Alcoholic Treatment Center

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The Project Director of "Operation Outreach" wishes to express her appreciation to the great many individuals and agencies who extended their assistance and cooperation in making this project possible.

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City Council of Chicago
Mayor's Commission for the Rehabilitation of Persons
Chicago Police Department
Chicago Comptroller
Chicago Committee on Criminal Justice

Alcoholics Anonymous
American Legion Auxiliary
Cathedral Shelter
Catholic Charities
Chicago Board of Health
Chicago Christian Industrial League
Chicago Department of Urban Renewal
Cook County Hospital
Cook County Department of Public Aid
Cortland House
Lutheran Welfare Services of Illinois
Municipal Tuberculosis Sanitarium
Pacific Garden Mission
Salvation Army, Harbor Light Center
State of Illinois Department of Mental Health
Veterans Administration Hospitals
Volunteers of America

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We are also grateful to the many individuals, families, and organizations whose generous contributions of clothing helped fulfill a great need and showed us that the people of Chicago are indeed responsible and concerned citizens.

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Phyllis K. Snyder
Project Director
March 31, 1971

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INTRODUCTION

GENERAL BACKGROUND

Recent judicial decisions, medical and psychiatric opinion, and police experience have indicated that chronic public intoxication and alcoholism are medical problems requiring appropriate remedial and prophylactic attention. Pittman (1967) stated that "The substitution of medical and social rehabilitation programs for Skid Row alcoholics, instead of the current primitive and punitive practices of the 'revolving door' of arrest, court appearance, jailing, release, and rearrest, would further shrink the population of those attached to the Skid Row way of life" (p.76).

Public concern for the overtly intoxicated Skid Row inhabitant is a relatively recent phenomenon. Prior to the beginning of the present decade it was a widespread practice to arrest and incarcerate publicly intoxicated individuals on such vague and nebulous charges as "vagrancy" or "drunk and disorderly," allowing them to spend the night and "dry out " in the "drunk tank." Such individuals were then released the next day to begin this "vicious cycle" again, thus keeping the revolving door spinning.

As noted by Bogue (1963), public knowledge of Skid Row and its inhabitants is grounded more in fiction than in fact. "Skid Row fascinates the average person. It is a street of mystery. Delegates to the many conventions in Chicago often go to Skid Row bars for an evening of adventure. The sight-seeing busses invariably pass through the Skid Row Area, hauling crowds of tourists."

Bogue attempted to destroy the myth and to define the reality of the situation. "The major finding of this study is that Skid Row life is very different from what may be the popular impression. Instead of being a care-free, anarchistic seventh heaven, life for the typical Skid Row resident is boring, insecure, and often lonely. Fear of robbery, worry and where the next meal is coming from, 'alcoholic shakes' from need of a drink, physical discomfort, shame, despondency, and self-hate are daily feelings of these men. Instead of being proudly unfettered, the homeless man suffers a perennially degraded status."

In his report to Chicago's Department of Urban Renewal, Vanderkooi (1967) supported and extended Bogue's findings. An especially relevant finding of Vanderkooi's was the recognition of the need expressed by Skid Row men for treatment and rehabilitation in the area of alcoholism. Indeed, this was the one need most often verbalized, and was endorsed by 43 percent of the 184 subjects he interviewed (p. 25). Thus, the need for a diagnostic, detoxification, and referral facility for the City of Chicago had been demonstrated. It was the recognition of this need that prompted Chicago's Alcoholic Treatment Center (CATC) to investigate the steps necessary in providing the care.

Operating under the auspices of the Mayor's Commission for the Rehabilitation of Persons, Chicago's Alcoholic Treatment Center was opened in 1957. Between May 1957 and December 1970, 7,684 male alcoholics had received residential treatment, amounting to 287,083 patient days; more than 70,452 outpatient and followup contacts were

made during that same period. Operating on a philosophy of milieu therapy and a multitherapeutic approach, CATC was the first of its kind in the country and has established a highly respected record of service, setting a number of precedents and becoming a paradigm for the development and operation of other similar institutions.

Under the provisions of the Alcoholic and Drug Addict Rehabilitation Act of 1968 (PL 90-574), an amendment to the Community Mental Health Centers Act of 1965, CATC had been preparing an application for Federal assistance for the construction and staffing of a fifty-bed comprehensive Detoxification, Diagnostic, and Referral Center. When the U.S. Congress failed to appropriate funds for the enactment of PL 90-574, preparation of Chicago's Alcoholic Treatment Center's application was temporarily suspended.

The Chicago Police Department, upon receiving notice of funds to be made available through the Special Discretionary Fund for the ten largest cities in the U.S., invited CATC to submit a grant proposal. To facilitate communication, a police official was named to act as liason man, and a personal visit was made to the Commander of Chicago's 12th Police District.

To provide for the treatment of homeless and indigent men of the Chicago Skid Row area, and to produce a pilot effort for the operation of a Detoxification, Diagnostic, and Referral Center for the City of Chicago, "Operation Outreach" was funded by the U.S. Department of Justice, Law Enforcement Assistance Agency, under PL 90-351, Title I, as specified under the conditions of the Special Discretionary Fund for the ten largest cities in the U.S.

Funded as project DF-010, the Department of Justice contributed \$70,574. This pilot program began August 1, 1969 and, following two emergency extensions, terminated on September 30, 1970.

METHODS AND PROCEDURES

GENERAL BACKGROUND: Initial Phase

CATC's third floor was rearranged to provide the ten additional beds required for Operation Outreach. Six of these beds were located in three semiprivate rooms where acutely ill patients were brought after initial medical evaluation. The other four beds, used for less seriously ill patients, occupied a large cubicle akin to those used in the ward area of CATC's ongoing rehabilitation program. All of Operation Outreach's ten beds were located close to the nurses' station, doctors' offices, program social worker's office, and street rescue personnel's office, thus allowing close observation of, and easy access to, all ten patients.

Operation Outreach was designed to exist within an established alcoholic treatment and rehabilitation facility. With this came certain advantages, one of which was the availability of a knowledgeable and experienced staff. Much of the existing CATC staff, though pressed with the demands of the ongoing 72-bed rehabilitation program, made an in-kind contribution of their professional services to the Operation Outreach patients, and served to train and guide the newly formed Operation Outreach staff.

Throughout the entire duration of the project, but particularly

during the initial phase, administrative and supervisory personnel on CATC's rehabilitation staff contributed great amounts of their time. Thus, the Executive Director, Medical Director, Chief Psychiatric Social Worker, Director of Mental Health Services, Supervisor of Nurses and the Research Psychologist spent many hours beyond the in-kind contribution requirement in establishing and maintaining the operation of the project, developing methods and procedures, supervising training, conducting meetings and discussions, providing for public dissemination of information regarding the program, and in related activities.

The nucleus of the Operation Outreach staff consisted of four Street Rescue Teams (SRT). Each team was composed of a plainclothed Chicago police officer and a Community Health Aide (CHA). The police officers (whose services were provided through the City of Chicago's in-kind contribution by the Police Department) were specifically selected for their skill and experience in handling public inebriates, first aid, and their desire to help the alcoholic. The police officer was responsible for the driving and care of the unmarked vehicle (also an in-kind contribution by the Chicago Police Department) in addition to his duties as part of an SRT.

The second member of each SRT was a recovered alcoholic who had been carefully selected and trained. Four of the five men who served in this position were former patients who had successfully completed CATC's rehabilitation program and maintained continuous sobriety for a minimum of twelve months prior to the initiation of the project.

To provide for the research and evaluation of the project, a Senior Research Assistant was hired. In consultation with the Research Psychologist and other staff of CATC, he was to be responsible for the collection and maintenance of records, information relevant to the evaluation of the project, and for designing and conducting correlative studies based on the patient data.

To fulfill the medical and social-service needs of Operation Outreach, the positions of a part-time physician and full-time psychiatric social worker were included in the staffing proposal. Because of the desire for highly qualified professionals and the shortage of applicants, these positions were not filled until October 1969. To provide the needed medical and social-service functions, members of CATC's existing staff temporarily assumed the necessary added responsibilities until those positions were filled. The staff required to make Operation Outreach functional had been hired as the project moved into the second quarter of operation.

TRAINING PROCEDURES

Under the direction of CATC's existing staff, a two-week training program was begun on August 1, 1969. The first week of training focused on the CATC philosophy and treatment of alcoholism. Training packets, containing an array of literature on alcoholism, currently operating detoxification, diagnostic, and referral centers, Skid Row studies, and on CATC, were distributed. During this first

phase of training, the new staff became acquainted with the treatment milieu at CATC by attending the same orientation sessions that new patients attend.

A typical training day during this first phase included an early-morning briefing session with the Executive Director, attendance at the patient ward meeting and staff conference of that meeting, a psychiatric orientation session, a "chalk talk" (one of a series of lectures on alcoholism given by CATC's Educational Department), a general staff meeting, and finally, a group discussion and rehash of the day's learning experience.

The second phase of the training program dealt specifically with the operational approaches and procedures of Operation Outreach. During the first three days of this phase of training the new staff was under the direct guidance of the Executive Director, the Medical Director, the Chief of Mental Health Services, the Chief Psychiatric Social Worker, and the Supervisor of Nurses. The medical and psychosocial aspects of the Skid Row alcoholic were discussed at length, and nurses-aide techniques and admission procedures were taught.

To orient the new staff to the reality of conditions existing in the Skid Row area, and to acquaint the men with agencies with which they would be dealing, visits were made to the 12th District Court (Monroe Street) of the Chicago Police Department, Holy Cross Mission, Municipal Reading Room, Cathedral Shelter, Christian Industrial League, and the Salvation Army Harbor Light Shelter.

The second phase of training culminated during the last two

days of the training period when under the supervision of the Medical Director and Chief of Mental Health Services, "dry runs" were made into the Skid Row area using the unmarked police vehicle. During these "dry runs" screening and approach procedures for prospective patients were practiced and discussed. Upon return to the Center, all procedures were reviewed and minor procedural alterations were introduced.

PHASE I:

ORIENTATION AND TRAINING SCHEDULE

Monday, August 4, 1969

- 8:30 a.m.: Briefing session and/or discussion with inpatients
- 9:15 a.m.: Ward meeting and rehash
- 10:45 a.m.: Medical Orientation meeting
- 12:00 noon: Lunch
- 1:00 p.m.: Chalk Talk
- 2:30 p.m.: Group discussion

Tuesday, August 5, 1969

- 8:30 a.m.: Briefing session and/or discussion with inpatients
- 9:15 a.m.: Ward meeting and rehash
- 10:45 a.m.: Psychiatric Orientation meeting
- 12:00 noon: Lunch
- 1:00 p.m.: Chalk Talk
- 2:00 p.m.: General staff meeting
- 3:00 p.m.: Group Discussion

Wednesday, August 6, 1969

- 8:20 a.m.: Briefing session and/or discussion with inpatients
- 9:15 a.m.: Ward meeting and rehash
- 10:45 a.m.: AA Orientation meeting
- 12:00 noon: Lunch
- 1:00 p.m.: Administrative Orientation meeting
- 2:00 p.m.: Chalk Talk
- 3:00 p.m.: Group Discussion

Thursday, August 7, 1969

- 8:30 a.m.: Briefing session and/or discussion with inpatients
- 9:15 a.m.: Ward meeting and rehash
- 10:45 a.m.: Vocational Orientation meeting
- 12:00 noon: Lunch
- 1:00 p.m.: Chalk Talk
- 2:30 p.m.: Group Discussion

Friday, August 8, 1969

- 8:30 a.m.: Briefing session and/or discussion with inpatients
- 9:15 a.m.: Ward meeting and rehash
- 10:45 a.m.: Chalk Talk
- 12:00 noon: Lunch
- 1:00 p.m.: Psychiatric Staff meeting
- 2:30 p.m.: Group Discussion

PHASE II:

OPERATIONAL APPROACHES AND PROCEDURES

Monday, August 11, 1969

8:30 a.m.: Briefing session

9:00 a.m.: Skid Row Alcoholics

1. Medical Aspects
2. Psychosocial Aspects

10:30 a.m.: Intake Procedures

1. Initial approaches
2. Intake procedures, forms, etc.

12:00 noon: Lunch

1:00 p.m.: Postadmission procedures

1. Nurses' Aide Techniques
 - a. Putting the patient to bed
 - b. Bathing and cleaning
 - c. General nursing care

Tuesday, August 12, 1969

(Same as Monday)

Wednesday, August 13, 1969

8:30 a.m.: Review session

9:00 a.m.: Medical briefing review

10:30 a.m.: Intake briefing review

12:00 noon: Lunch

1:00 p.m.: Briefing review - Nurses' Aide Techniques

Thursday, August 14, 1969

9:00 a.m.: Briefing for dry run
11:00 a.m.: Dry run
12:00 noon: Lunch
1:30 p.m.: General review of dry run

Friday, August 15, 1969

(Same as Thursday)

INTAKE METHODS

When notified by the medical staff that a bed was available, one of the Street Rescue Teams (SRTs) was dispatched to the Skid Row area located in Chicago's 1st and 12th Police Districts.

The treatment of the public inebriate began with the first contact made by the SRT. Upon observing a man who appeared to be in need of the services of Operation Outreach, the SRT approached and attempted to befriend him. Through informal conversation the Operation Outreach program for medical, nutritional, and psychosocial rehabilitative attention was explained. At the same time, gross screening of the prospective patient was done by the SRTs to rule out obvious serious medical or psychiatric conditions that would exceed the scope of the program, (i.e., patient must be ambulatory and able to voluntarily consent to treatment). SRTs looked for overt signs of psychosis or acute physical injuries such as broken bones, bleeding, and serious cuts that required emergency treatment. If emergency treatment was indicated, police were contacted to provide transportation to Cook County Hospital.

Individuals who were resistive to the attention of the SRT or

who refused care and attention, and who were not apparently in need of emergency medical and/or psychiatric attention, were, as the situation demanded, either transported to their place of residence, left undisturbed, or remanded to police authorities for their own protection.

If the patient voluntarily expressed a wish for treatment, he was given the necessary consent-for-treatment forms to sign and then was helped into the vehicle and transported to CATC.

Immediately upon arriving at CATC, the patient was taken to the examining room, at which time the nurse and physician made a brief preliminary medical examination to assess the patient's physical condition. A suspected condition such as tuberculosis, advanced cirrhosis of the liver, or other acute illness would mitigate against admission and the patient would then be transported to a general hospital.

If the patient was acceptable for detoxification, orders were written by the physician. Although all orders were given on an individual basis to meet each patient's specific needs, general outlines of detoxification treatment and delirium tremens treatment were included.

After the initial physical examination, the SRT brought the patient to the bathing area for cleaning and delousing. If a patient's clothing had to be destroyed, a notation was made in the patient's record and the clothing was later replaced. Following this, he was accompanied by the SRT to his room and put to bed. Doctors' orders were followed closely.

DETOXIFICATION METHODS

1. Stop all alcohol. Do not administer paraldehyde, due to ease of addiction, toxicity of the drug, and synergism with alcohol.
2. Close observation to avoid accidental injury or suicide.
3. Bed rest, up to twenty-four hours, to avoid falls and subsequent injuries.
4. Administer multivitamin capsules, one three times daily, with one-hundred miligrams of Thiamine intramuscularly daily.
5. Administer Sparine or Librium one-hundred miligrams if patient is very nervous and shaky, unless vital signs are depressed or other contraindications are present.
6. Administer twenty-five miligrams of Librium four times daily, orally, as early as four hours after initial injection. If patient is elderly, debilitated, or is a small person, administer Sparine intramuscularly in fifty-miligram dosage instead of one hundred, and orally in ten-miligram dosage instead of twenty five.
7. If patient has a history of seizures, or if course is stormy, administer Dilantin Sodium three times daily in one-hundred miligram doses.
8. Administer one three-hundred miligram capsule of Noludar at bedtime. This dose may be repeated once during the night if necessary. Withdraw this medication after one week.

9. Administer high-protein diet at all meals, including bedtime snack.
10. Administer orange juice with fifteen grams of Dextrimaltose per three-hundred cc glass, urged at frequent intervals, to help replenish the liver's store of glycogen, and to boost the patient's intake of Vitamin C, Sodium Chloride, and Potassium.
11. If urinalysis conducted at time of admission indicates presence of sugar and/or acetone, nurse will notify physician on duty.
12. Omit glucose from intravenous fluids until presence of diabetes has been ruled out.
13. Administer thirty cc of general antacids every two to four hours if needed for gastritis, heartburn, nausea, vomiting, etc.
14. Never administer medications which contain alcohol.
15. For patients manifesting delirium tremens or hallucinoses, follow procedures indicated under Treatment of Delirium Tremens.

METHOD OF TREATING DELIRIUM TREMENS

1. Delirium Tremens (DTs) are marked by elevated body temperature, restlessness, insomnia, auditory and/or visual hallucinations, illusions, disorientation, tremor, fear, and anxiety.
2. Physical and neurological examinations should be conducted to rule out presence of unconsciousness or comatose state,

head injuries, fractures, pneumonia, tuberculosis, etc. Patients so affected should be conducted to Cook County Hospital for treatment. Those patients with DTs who are not affected in the manner mentioned above should be treated in the following fashion.

- a. Stop alcohol.
- b. Provide constant supervision to avoid accidental injury or suicide.
- c. Provide bed rest for twenty-four to forty-eight hours, to prevent orthostatic hypotension while the patient is receiving tranquilizing agents, to prevent falling during a convulsion with the attendant possibility of head injury.
- d. Administer regular diet (high protein).
- e. Force fluids, by mouth if possible. Orange juice with one-half ounce of Dextrimaltose per ten-ounce glass should be urged at frequent intervals. If fluids cannot be retained by mouth, then give i.v. feedings approximately 3000 cc per day; glucose in various electrolyte forms.
- f. Administer multivitamin capsule three times a day and one-hundred milligrams of Thiamine Chloride daily i.m.
- g. Immediately administer one-hundred milligrams i.m. Sparine or Librium P.R.N., 24 hours. If possible, give Librium orally, twenty-five milligrams Q.I.D.

- h. Seven and one-half grams of Chloral Hydrate or Seconal may be administered at bedtime as needed. This dosage may be repeated during the night if necessary.
- i. Administer antibiotics for infection as needed.
- j. Administer thirty cc of Amphogel every two to four hours for gastritis and related symptoms.
- k. Use barbiturates only to control convulsions. Phenobarbital may be given every six to eight hours in .03 gram doses. If status epilepticus develops, notify physician (consultant neurologist) immediately. Large doses (.3 to .6 grams) of intravenous Sodium Luminal should be administered.
- l. If the course is stormy or if patient has a history of seizures, one-hundred miligrams of Dilantin Sodium may be given three times daily.
- m. Keep all lights on in the room at night to avoid producing shadows and to allay delirium. A nurse or attendant should be available to reassure the patient. Restraints should not be used under any circumstances. Patient should be kept under constant supervision to prevent self-injury in response to hallucinations.
- n. Urinalysis should be conducted at admission to rule out diabetes mellitus.

DIAGNOSTIC METHODS

Because each patient's condition varies, the diagnostic process was ongoing. The first few days of the treatment were, of necessity, medically rehabilitative in nature. But, since many patients thought of leaving as soon as their physical condition permitted--- and since they were not held against their wishes---the emphasis was shifted quickly to other aspects of rehabilitation.

As soon as it was appropriate to the patient's condition, initial contact was made by the project's psychiatric social worker and a social history was taken to help understand the patient's psychosocial situation, motivation for treatment, and direction for future referral plans. In addition, patients were encouraged to attend the daily open-ended group-therapy sessions with the psychiatric social worker, to round out the multitherapeutic treatment environment of the patient, to participate in Alcoholics Anonymous meetings, chalk talks, various orientation meetings, work details (according to the patients capacity) and various other CATC activities.

Staff's observation of the patient's behavior in the total milieu was considered one of the most important factors in determining the psychosocial diagnosis and direction of referral.

REFERRAL METHODS

As in all phases of treatment, the referral process was individualized to suit the needs of each patient.

Patients who were considered appropriate for continued residential treatment in a multitherapeutic milieu were encouraged to apply for admission to CATC's ongoing rehabilitation program.

Other patients, depending on their needs and their potential for rehabilitation, were referred to other agencies for continued care. Thus, some patients in need of longer-term psychiatric care, on an inpatient basis, were referred to the Illinois State Psychiatric Institute. Other patients in need of even more extensive psychiatric care were referred to one of the other State hospitals. Patients who had a job, home, or family to which they could return, on the other hand, were referred to the outpatient program at CATC, one of Chicago's Community Mental Health Centers, or some other related program. Other patients, without homes and/or families, were often referred to a halfway house or a facility operated by one of the agencies cooperating in this project.

For example, if AA help was appropriate or desired, referral to a group was made through the help of the AA Rehabilitation Representative on the staff of CATC. In addition, all of the SRT personnel were familiar with AA procedures and assisted, on an informal basis, with this phase of the referral process.

Similarly, a full-time Vocational Counselor, whose services were provided through an in-kind contribution to the rehabilitation program by the Cook County Department of Public Aid, assisted Outreach patients as needed in locating employment and obtaining financial assistance at time of discharge.

In addition, a full-time Relocation Representative, whose services were provided through an in-kind contribution by Chicago's Department of Urban Renewal, made it possible to offer departing

patients advice and assistance in residential relocation. If the patient and staff agreed that return to the Skid Row area was avoidable, this assistance was coordinated with the other referral services of the program.

METHODOLOGICAL PROBLEMS AND
SUBSEQUENT PROCEDURAL ALTERATIONS

First Quarter

Whenever a new project is initiated within an existing facility, a period of adjustment by both experienced and new staff members is anticipated. However, because of the shortage of staff during early phases of this project, this adjustment period required more time than expected. The ramifications of some staff members having to function in both programs simultaneously were multifaceted. Coordination and communication among Operation Outreach staff, and rehabilitation staff, were not firmly established. As may be expected, the patients in both the rehabilitation program and the new project felt the strain due to the shortage of staff. Rehabilitation patients felt at times that their own treatment was being pre-empted for the benefit of the newly arrived Operation Outreach patients. Some patients, as well as staff, felt that they were being intruded upon. However, as understanding of the staff situation and the extraordinary neediness of the new patients was gained, such feelings began to subside.

After the newly hired psychiatric social worker completed his training, he was appointed Project Coordinator in an effort to

establish lines of communication, relieve the already overburdened rehabilitation staff from Operation Outreach responsibilities, and to provide a centrally coordinated effort.

Various experimental modes of design for the multitherapeutic milieu have been proposed. For the first operational quarter the milieu for the Operation Outreach patients was relatively the same as that of the rehabilitation patients with one major difference. Operation Outreach patients and staff were not present at the regular morning ward meetings, spending this time instead with their counselor or in some other therapeutic activity. For purposes of experimental comparison, it was decided that Operation Outreach patients and staff would attend ward meetings during the second quarter of the project. It was hoped that in this way all patients and staff would be able to participate more actively in both projects, and that communication and cooperation would develop. It was also hoped that exposure to the ward meetings and to the rehabilitation patients would serve to augment the motivation of some of the Operation Outreach patients to a level where they would be more receptive to further treatment when indicated.

Other experimental controls were included in the Operation Outreach milieu. Because of the limited ten-bed facility and the great numbers of homeless and/or indigent Skid Row inebriates, it was necessary to continue our policy of no readmission for the first six months of the project. (After the six month period, this policy was reviewed, but no change was instituted).

To prevent disruption of both the Operation Outreach and the

rehabilitation milieu, patients discharged from the rehabilitation program were not eligible for Operation Outreach until ninety days after the date of their discharge, and vice versa. This procedure was intended to allow the rehabilitation patient population to change sufficiently so that no then-current rehabilitation patient would have been present when the incoming Operation Outreach patient was a rehabilitation resident. The need for these measures was recognized when a patient was admitted to Operation Outreach only a few days after his discharge from the rehabilitation program. His presence clearly disrupted the existing rehabilitation population which, in turn, raised questions as to the benefits that the Operation Outreach patient could gain under such circumstances.

During the first quarter it was learned that much of the effectiveness of Operation Outreach would depend on the efforts of the SRTs in the Skid Row community. They were, in effect, the foundation of the project. The gradually rising rate of voluntary acceptance of treatment was attributed in part to the increasing skills of the SRTs as the project progressed, and to the active "grapevine" in the Skid Row area. It was anticipated that as more SRT contact was made, the men of the area would spread the news of Operation Outreach, thus lessening patient resistance. (It was gratifying to note that of the 123 public inebriates contacted in the Skid Row area during the first quarter, 63 percent accepted treatment. The increment in the acceptance rate from 41 percent in August 1969, to 81 percent in October 1969, confirmed our expectations.)

A change in SRT operations in the initially proposed catchment area led to contact being made in the First as well as the Twelfth Chicago Police Department Districts. This was due to a change in Police Department zoning, making that part of the Skid Row area most densely populated with public inebriates part of the First as well as the Twelfth Police Districts.

In addition to their intake duties in the Skid Row area, added responsibilities were given to the SRTs. Since this pilot project had only a total capacity of ten beds, there were many times when the SRTs did not go into the Skid Row area to pick up new patients. Thus, to allay any boredom or impending lack of enthusiasm, and to assist patients and other staff, the SRTs became actively engaged in the transporting of referred patients, conducting AA meetings for Operation Outreach patients, data collections, continued training, and other varied responsibilities.

One of the more important responsibilities of the SRTs was the collection, care, and distribution of clothing for the patients. The degree of community awareness of this program is suggested by the donation of a great variety of used clothing from AA groups, Salvation Army, Catholic Charities, and other social, religious, business, and community organizations. Some additional surplus clothing was obtained through the General Services Administration. Because of the condition of the patients' clothing at admission in most cases it was incinerated. The SRTs played a major role in picking up donated clothing, sorting and storing it, washing it when necessary, and seeing that every patient was supplied

with adequate clean clothing within a day or two after admission. It was felt that some measure of dignity could be restored to the patient if he had appropriate clothing to call his own, particularly when being referred for a job and/or housing. The Grantee strongly urges all future projects of this nature be adequately funded or otherwise supported to insure a sufficient quantity of appropriate clothing--particularly good shoes and warm coats in the winter--for all of its patients.

A problem existed in assuring appropriate referrals for many men who were discharged from Operation Outreach. Concentrated efforts to overcome this problem were begun toward the end of the first quarter of the project and remained a concern throughout the grant period. The reasons for the difficulty in the referral procedure were numerous. First, there was a problem of fitting the men to existing agencies: Many agencies were simply not equipped to provide adequately for this type of patient. Secondly, the motivation of these men was often extremely low. Many of the patients were acclimatized to and/or entrenched in a Skid Row way of life and had not significantly responded to past treatment experiences.

The shortage of staff also prevented the referral phase of the program from operating at an optimal level. As noted earlier, the needs of the patient changed quickly from medical to social service as soon as the patient began to regain his health. Because of the shortage of social service personnel, patients could not be interviewed and referred quickly enough.

With the addition of the Psychiatric Social Worker and Relocation Representative however, steps were taken to more effectively coordinate and speed the referral procedure. The Psychiatric Social Worker attempted to counsel the patient at that moment when his motivation was optimal.

The Relocation Representative and the Psychiatric Social Worker began visiting and evaluating referral agencies in order to provide the desired calibre of postdischarge care. These steps, in conjunction with consultation from the medical and mental health staff of CATC's rehabilitation program were expected to show their effects in the next several months of Operation Outreach.

Second Quarter

It was known that homeless and indigent male alcoholics have a higher incidence of tuberculosis than that found among the general population (Bogue, 1963). For this reason the medical staff at CATC had always been alert for signs of TB among incoming Outreach patients. Late in October there was an increase in the number of patients suspected of being actively tubercular, necessitating a modification of our initial intake and screening procedures.

Starting November 1, 1969, potential patients were brought to the Center only when an X-ray technologist was present. For this reason, intake was possible at all times except from noon Fridays through noon Sundays. This modification made it possible for all incoming Operation Outreach patients to be X-rayed within twelve

hours of being brought to the ward area. If the X-ray indicated suspicion of active tuberculosis, the patient was transported to a facility equipped to deal with this specific problem.

Another modification of procedures was necessitated when CATC's 72 rehabilitation beds were filled and unavailable for patients being discharged from Operation Outreach. Because of our desire to permit discharged patients every opportunity to obtain longer-term treatment, they had been allowed to occupy their Operation Outreach beds until space became available in the rehabilitation program. It became impossible to continue this practice, however, when it began to interfere with the admission of new Operation Outreach patients. It was decided, therefore, that the treated Operation Outreach patients should be discharged and referred to an appropriate halfway house or other facility and given appointments to return to CATC within a short period of time when beds would be available, and at that time to be interviewed for admission into the rehabilitation program. This procedural modification freed some of the beds for new incoming Operation Outreach patients and served to give the discharged Outreach patient a chance to demonstrate his motivation for further inpatient care by returning to CATC to be interviewed for rehabilitation admission.

Treatment and referral procedures were also modified during the second quarter. Emphasis was placed on reducing the Outreach patients' length of stay and speeding the referral process. It was hoped that this action would make it possible for a greater number of persons to benefit from the detoxification, diagnostic,

and referral services offered by Operation Outreach by making beds more readily available.

As indicated, the general multitherapeutic milieu offered to Outreach patients during the first quarter had been relatively similar to that of our rehabilitation patients, with the exception that the Outreach patients and staff had not attended the regular daily patient-government ward meetings. To improve communication and foster therapeutic relationships between the two groups of patients, complete integration of all staff and patients was attempted during the second quarter by joining the two groups in regular ward meetings. During the third quarter, the ward meetings were to be attended by rehabilitation staff and patients and during the fourth quarter we were to again completely integrate this activity with Operation Outreach patients. We hoped, by this shifting of approach, to collect data that would permit us to determine which of the two arrangements is more therapeutically efficacious.

Third Quarter

Social-service operation of the project was temporarily assumed by a member of the rehabilitation social-service staff, due to the loss of the project's Social Worker at the beginning of February. The ongoing rehabilitation program operated under some hardships each time a staff member was temporarily removed from his regular duties in order to assist in the pilot project. A new Social Worker was later hired to provide the necessary services to the Operation Outreach patients (April 1, 1970).

To assist the Social Worker, one of our Community Health Aides was advanced to the position of Rehabilitation Representative. It was felt that his skills were such that he was often able to successfully reach the indigent patients who at times had difficulty relating to conventional therapeutic attempts. The Rehabilitation Representative spent most of his time in direct contact with the patients. A replacement Community Health Aide was to begin work on April 1, 1970, at which time the Rehabilitation Representative was to begin his new duties.

The hiring of a Licensed Practical Nurse was also made possible by a grant adjustment approved during the second quarter. Beginning employment March 1, she assumed responsibility for a portion of the nursing care offered to our Operation Outreach patients. Previously this was solely the responsibility of the rehabilitation program's nursing staff. The position of Administrative Assistant was also made available to Operation Outreach through the same grant adjustment, since the need for assistance in data collection, tabulation, and report writing was most pressing.

Fourth Quarter

Procedures during this quarter were similar to those of the preceding, with the exception that Operation Outreach patients attended daily ward meetings as they had been during the second quarter of operation. Thus, during the second and fourth quarter, greater integration of the milieu of both programs was a part of the treatment focus. During the first and third quarter of operation, the milieu were integrated but not to the same degree

(i.e., Operation Outreach patients and staff were not present at morning ward meetings), thereby establishing the research design of alternating quarters of total and partial milieu integration.

A full-time Psychiatric Social Worker and an Administrative Assistant filled the staff complement permitted by special grant adjustment.

Unfortunately, upon inspection of a routine chest X ray given to all of our Street Rescue Teams, one of our Community Health Aides was suspected of having symptoms of tuberculosis. Upon further examination, this preliminary diagnosis was confirmed and he was hospitalized at the Illinois State Tuberculosis Sanitarium.

Supplementary Periods

While awaiting notification of action on a request for a one year renewal period for this project, two additional grant adjustment permitted two thirty-day extensions of operation. Surplus funds--from unexpended salaries and wages accumulated during the twelve months of operation--permitted the continuation of the project on a reduced basis.

Procedures remained essentially unchanged, with the exception of a more concerted emphasis on followup contacts by the SRTs rather than intake procedures. Upon termination of the project (September 30, 1970) two of the police members of the SRTs were permitted to remain at CATC to focus on followup procedures. Collection of followup data was terminated on January 31, 1971, and the two officers returned to their regular duties with the

Chicago Police Department.

RESULTS

Of the 343 patients treated during the fourteen months of the project, followup information was obtained for 274, or 79.9 percent of the population, within periods ranging from four to thirteen months or more after discharge from Operation Outreach. Table 1 shows in detail the number and proportion of patients contacted within this total period, in intervals of one month. It can be observed that 78.1 percent of the patients were contacted for followup within 300 days, or approximately ten months, after release from Operation Outreach.

TABLE 1. TIME ELAPSED BETWEEN DISCHARGE AND FOLLOWUP CONTACT (N=274)

INTERVALS	N	%
120-150 days	67	24.5
151-180 days	33	12.0
181-210 days	26	9.5
211-240 days	31	11.3
241-270 days	29	10.6
271-300 days	28	10.2
301-330 days	21	7.6
331-360 days	12	4.4
361-390 days	10	3.7
More than 390 days	17	6.2

To the extent possible, it was attempted to obtain followup data from the patient himself. When this was not feasible, other sources of information were used, such as the agencies serving

alcoholics, or families and friends. Table 2 shows the distribution by source of information. It can be noted that 42.3 percent of the patients were personally contacted. About a third (30.7 percent) of the followup information was obtained from an agency, and approximately 25 percent was obtained from family and friends of the patients.

TABLE 2. SOURCES OF FOLLOWUP INFORMATION (N=274)

RESPONDENT	N	%
Patient	116	42.3
Patient's family	11	4.0
Patient's friends	57	20.8
Referral agencies	84	30.7
Other	6	2.2

The following materials are divided into two parts: (1) A profile of the 274 Operation Outreach patients contacted for followup is presented in terms of psychosocial and demographic information obtained from a questionnaire they filled out during admission, and also in terms of some items covered in the followup questionnaire. The former source of information is comparable to the data reported in the four quarterly progress reports, and the reader should compare this followup profile to the earlier data. (2) Some indices of improvement or nonimprovement after Operation Outreach treatment are compared with biographical variables and with each other to determine the extent of relationships present. Specifically, these indices include:

- a. Drinking at time of followup contact.

- b. Drinking behavior since discharge from Operation Outreach Treatment.
- c. Employment status at time of followup contact.
- d. Usual employment since discharge.
- e. Affiliation with AA since discharge.
- f. Living on Skid Row after discharge.

Chi-square tests were performed to test for independence of any two variables, after which an index of relationship between them was provided by the Contingency coefficient (C). Level of statistical significance accepted was .05 or less.

General Profile

Age Distribution. Table 3 presents the age distribution of 271 patients for whom this information was available. It can be noted that 44.2 percent of them ranged in age from 41 to 50, with a mean age of 45.5 years. Although the actual age range was from 26 to 75, 85 percent of the subjects were between 31-55 years old. Inspection of Table 3 also reveals a median age of 41-45. The distribution of age is a bimodal one, peaking at the intervals of 41-45 and 46-50. Because of the coincidence of mean median and mode, it can be assumed that this distribution is an approximately normal one.

Usual Occupation. The usual occupations of the patients were classified into six categories: skilled, semiskilled, unskilled, professional, clerical and sales, and unknown or retired. Examples of skilled workers include tradesmen, electricians, firemen, telephone repairmen, and related occupations. Drivers, factory or steel workers, bricklayers, and cooks are examples of semiskilled

workers. Unskilled workers include laborers, handymen, bus boys, movers, and kindred. Professionals include managers, proprietors, pharmacists, photographers, accountants, teachers, engineers, and the like. Clerical and sale include office workers, shipping clerks, insurance agents, etc.

TABLE 3. AGE DISTRIBUTION OF 271 PATIENTS

AGE	N	%
26-30	8	3.0
31-35	27	10.0
36-40	44	16.2
41-45	60	22.1
46-50	60	22.1
51-55	39	14.4
56-60	18	6.6
61-65	9	3.3
Over 65	6	2.2

Table 4 shows that approximately half of the patients were unskilled, roughly a quarter were semiskilled, and less than twenty percent were skilled. There was a very small percentage of professionals or people in clerical and sales positions, as may be expected.

At the time of their admission only seven men were employed. Of the others who indicated their work status, 262 were not employed at the time, and two were retired (Cf. Tables 28 and 29 for information on postdischarge employment).

TABLE 4. USUAL OCCUPATION (N=271)

CATEGORIES	N	%
Skilled	52	19.2
Semiskilled	64	23.6
Unskilled	139	51.3
Professional, managerial, and related	7	2.6
Clerical, sales, and related	5	1.9
Retired, unknown	4	1.5

TABLE 5. MEANS OF FINANCIAL SUPPORT (N=271)

CATEGORIES	N	%
Regular employment	13	4.8
Day labor	151	55.7
Public welfare	17	6.3
Unemployment compensation	6	2.2
Family	5	1.9
Other	26	9.6
No response	53	19.6

It is not surprising to find that most of the patients were unemployed at the time of admission to Operation Outreach. Table 5 indicates the various means of financial support available to patients during the twelve months immediately prior to admission. Note that more than half were day laborers, and less than five percent had regular employment of any kind. A small number were receiving public welfare, and an even smaller number obtained financial support from the family. The "Other" category in the

preceding table includes social security, retirement funds, and any sources not classifiable in the alternate categories.

Educational Attainment. Inspection of Table 6 reveals that almost forty percent of the ex-patients contacted had at least a complete high school education, and more than two-thirds of that proportion had some college. Approximately one-third of the total sample went to high school, and roughly a quarter had eight years or less education. Comparing this information with Table 4 (usual occupation), it must be noted that despite the relatively high level of education, more than half of the subjects had unskilled jobs.

TABLE 6. EDUCATIONAL ATTAINMENT (N=271)

CATEGORIES	N	%
8 years or less	72	26.6
8-12 years	87	32.1
High School graduate	64	23.6
One semester of college or more	42	15.5
No response	6	2.2

Military Service. Of the 271 patients, 69 percent were veterans, 21.8 percent were not, and 9.2 percent gave no response to the question.

Place of Birth and Racial/Ethnic Derivation. Of the 271 respondents to these items, 69.7 percent were from out-of-state, and 30.3 percent were born in Illinois. From Table 7 it can be observed that most of them were white (79.3 percent), followed by Negroes (13.3 percent). American Indians and Spanish-speaking

patients form a very small percentage. These racial/ethnic proportions seem to be representative of those found in the general population.

TABLE 7. RACIAL/ETHNIC DERIVATION (N=271)

CATEGORIES	N	%
White	215	79.4
Negro	36	13.3
American Indian	11	4.1
Spanish-speaking (Mexican, Puerto Rican, etc.)	9	3.2

Religious Affiliation. From Table 8 it can be seen that Catholics comprise 44.2 percent of the sample, while Protestants of all denominations constitute 52.4 percent of the total.

TABLE 8. RELIGIOUS AFFILIATION (N=269)

CATEGORIES	N	%
Catholic	119	44.2
Protestant (all dencominations)	141	52.4
Other	3	1.1
None	6	2.2

Parentage. In general, parents of the patients were American born (79 percent), and only ten percent had both parents born in Europe (see Table 9).

Table 10 shows that 45 percent of the patients indicated that both their parents were dead. Almost thirteen percent indicated that both their parents were still living, while

roughly one third had at least one parent still alive. As seen in Table 11, the majority of patients had living siblings. However, of those who indicated how often they still saw their siblings, 73 percent stated that they saw them "never" or "rarely."

TABLE 9. BIRTHPLACE OF PARENTS (N=271)

CATEGORIES	N	%
Both American-born	214	79.0
Both foreign-born	27	10.0
One American, one foreign	3	1.1
Unknown	27	10.0

TABLE 10. DEATH OF PARENTS (N=271)

CATEGORIES	N	%
Both parents living	35	12.9
One parent living	86	31.7
Both parents dead	124	45.8
No response/unknown	26	9.6

TABLE 11. NUMBER OF SIBLINGS LIVING (N=270)

CATEGORIES	N	%
None	30	11.1
1-2	90	33.3
3-4	56	20.7
5 or more	46	17.0
No response	48	17.8

Marital Status. Table 12 shows the marital status of

followup patients. With the exception of seven who were currently married and five with common-law wives, the rest were unmarried for all practical purposes: 29.1 percent never married, while 64.6 percent were either divorced, separated, or widowed. Among those 158 separated or divorced, 80 percent of the respondents had been separated five years or more (see table 13).

TABLE 12. MARITAL STATUS(N=268)

CATEGORIES	N	%
Single	78	29.1
Married	7	2.6
Common Law	5	1.9
Separated	48	18.0
Divorced	110	41.0
Widowed	15	5.6
No response	5	1.9

TABLE 13. LENGTH OF MARITAL SEPARATION (N=140)

INTERVAL	N	%
Less than 1 year	7	5.0
1-2 years	8	5.7
3-4 years	13	9.3
More than 5 years	112	80.0

Of the 162 who answered the question on number of children (Table 14), only 24.7 percent had none. Nevertheless, many of those who did have children had either lost contact with them or

rarely saw them any more, and most of the patients (82.2 percent) considered themselves as their only dependent (see Table 15).

TABLE 14. NUMBER OF CHILDREN (N=162)

CATEGORIES	N	%
None	40	24.7
1-2	66	40.7
3-4	45	27.8
5 or more	10	6.2

TABLE 15. NUMBER OF DEPENDENTS (N=270)

NUMBER	N	%
1	222	82.2
2	7	2.6
3	22	8.2
4	9	3.3
5	3	1.1
6	5	1.8
7	1	0.4
8	1	0.4

TABLE 16. LIVING ARRANGEMENTS (N=271)

CATEGORIES	N	%
Alone	266	98.2
With family	4	1.5
With friends	1	0.4

Virtually all the patients followed up by Operation Outreach

lived alone at the time of admission. Table 17 gives the duration of their residence on Skid Row. Only 29.1 percent had lived on Skid Row for less than a year; 41.9 percent had lived there between 1-14 years, while 20.7 percent had lived on Skid Row for more than fifteen years.

TABLE 17. DURATION OF SKID ROW RESIDENCE (N=251)

INTERVALS	N	%
Less than 1 year	73	29.1
1-4 years	30	12.0
5-9 years	43	17.1
10-14 years	32	12.8
More than 15 years	52	20.7
No response	21	8.4

TABLE 18. AFFILIATION WITH ALCOHOLICS ANONYMOUS (N=269)

CATEGORIES	N	%
Yes	133	49.4
No	114	42.4
No response	22	8.2

Affiliation with Alcoholics Anonymous. Almost half of the patients had been affiliated with Alcoholics Anonymous prior to Operation Outreach treatment. Of these, 45.5 percent stayed less than six months, and 23.5 percent stayed between six and twelve months (see Tables 18 and 19).

Medical History. Table 20 shows frequency of previous hospitalizations of patients for treatment of alcoholism. Of

the total followup sample, more than half of the patients had received treatment prior to being admitted to Outreach. In response to a question regarding existing body disorders or deformities, only sixteen subjects responded in the affirmative (see Table 21). This particular question was of interest to see if alcoholism could be related to the presence of any disease, disability, etc.

TABLE 19. DURATION OF AA AFFILIATION (N=132)

DURATION	N	%
0-6 months	60	45.5
6-12 months	31	23.5
1-2 years	9	6.8
2-3 years	6	4.5
3 years or more	21	15.9
No response	5	3.8

TABLE 20. PREVIOUS HOSPITALIZATIONS FOR ALCOHOLISM (N=271)

NUMBER	N	%
None	99	36.5
1	52	19.2
2	24	8.9
3	16	5.9
4 or more	47	17.3
No response	33	12.2

In exploring family history of nervousness and/or mental illness, Table 22 indicates that such disorders were rarely

reported. However, almost a fourth of the subjects indicated that some member of their family had a history of alcoholism.

TABLE 21. PRESENT BODY DISORDER OR DEFORMITY (N=271)

CATEGORIES	N	%
Yes	16	5.9
No	237	88.5
No response	18	6.6

TABLE 22. FAMILY HISTORY OF NERVOUSNESS, ALCOHOLISM, AND/OR MENTAL ILLNESS (N=271)

RESPONSES	NERVOUSNESS		ALCOHOLISM		MENTAL ILLNESS	
	N	%	N	%	N	%
Yes	21	7.8	64	23.6	10	7.8
No	218	80.4	174	64.2	228	84.1
No response	32	11.8	33	12.2	33	12.2

TABLE 23. SOCIAL DRINKING PATTERNS AND FREQUENCY OF DRINKING (N=271)

DRINKING PATTERNS	N	%
<u>Social</u>		
Drinks alone only	78	28.8
Drinks with others only	121	44.7
Drinks alone and with others	48	17.7
No response	24	8.9
<u>Frequency</u>		
Drinks Steadily	161	59.4
Drinks Periodically	82	30.3
No response	28	10.3

Drinking Patterns. Social drinking patterns of the patient before admission are presented in Table 23, together with the frequency of drinking. It can be seen that only 28.8 percent generally drank alone only, and more than half were steady drinkers.

FOLLOWUP INFORMATION

Table 24 shows that of the 164 patients referred for further help after discharge, more than half of them kept their appointments, and from Table 25 it can be seen that a great many sought voluntary treatment after discharge. Only 33.6 percent did not seek voluntary treatment after discharge, while the remainder of the subjects went to various agencies, mainly to halfway houses, CATC Rehabilitation Program, and the missions. These postdischarge treatment data seem to speak favorably of the continuing motivation for treatment, or at the very least a recognition of the need for, and availability of, additional professional assistance.

Drinking Behavior Since Discharge. Of the 273 patients contacted, 13.5 percent claimed that they had not been drinking at all since discharge, while more than half of these former patients were drinking less than before. Those unchanged or drinking more represent 31.8 percent of the total sample. At the time of the followup contact, 53.3 percent were drinking, while 46.7 percent were not (see Table 27). These data and those in Table 26, suggest some improvement in drinking behavior. That is, a substantial proportion of these former patients had either not demonstrated any further increase in alcohol consumption--i.e., their drinking

was stabilized--or had actually reduced their intake, in some cases to a zero level.

TABLE 24. PATIENTS MEETING REFERRAL APPOINTMENTS (N=274)

CATEGORIES	N	%
Yes	143	52.2
No	21	7.7
Unknown/Does not apply *	110	40.1

*Patient either refused to be referred or left CATC before referral could be arranged.

TABLE 25. PATIENTS SEEKING VOLUNTARY TREATMENT AFTER DISCHARGE (N=274)

SOURCE OF TREATMENT	N	%
None	92	33.6
CATC Rehabilitation Program	45	16.4
State facility	16	5.8
City facility	1	0.4
Veterans Administration facility	14	5.1
Private hospital	5	1.8
Mission	34	12.4
Halfway house	58	21.2
Other	9	3.3

Employment. At the time of the followup contact, 14.2 percent of the subjects were not employed, 51.8 percent were employed on a day-to-day basis, while 17.9 percent had regular or full-time jobs, and 16.1 percent had irregular forms of employment other

than day labor. These figures are presented in Table 28. Fewer than ten percent had not worked at all since discharge (see Table 29). Comparing Tables 28 and 29 with Table 5 (preadmission sources of support) and its accompanying narrative, this sphere of behavior shows a marked improvement. It will be recalled that only seven men were employed at the time of admission, whereas at the time of followup, 235 former patients were employed. Moreover, the proportion of regular or full-time employment has tripled, from a preadmission rate of 4.8 percent to a postdischarge rate of 14.2 percent.

TABLE 26. DRINKING BEHAVIOR SINCE DISCHARGE (N=273)

CATEGORIES	N	%
Total abstention	37	13.5
Drinking less than before	149	54.6
Drinking unchanged	79	28.9
Drinking more than before	8	2.9

TABLE 27. DRINKING AT TIME OF FOLLOWUP CONTACT (N=274)

CATEGORIES	N	%
Yes	146	53.3
No	128	46.7

TABLE 28. EMPLOYMENT AT TIME OF FOLLOWUP CONTACT (N=274)

CATEGORIES	N	%
None	39	14.2
Day labor	142	51.8
Regular/full time	49	17.9
Irregular employment other than day labor	44	16.1

TABLE 29. USUAL EMPLOYMENT SINCE DISCHARGE (N=273)

CATEGORIES	N	%
None	26	9.5
Day labor	157	57.5
Regular/full time	40	14.7
Irregular employment other than day labor	50	18.3

Affiliation with Alcoholics Anonymous after Discharge.

Of the 274 patients, 132 or 48.2 percent affiliated with AA, while 142 or 51.8 percent did not.

TABLE 30. LIVING ARRANGEMENT SINCE DISCHARGE (N=274)

CATEGORIES	N	%
Unknown	24	8.8
Living alone	137	50.0
Living at agency	55	20.0
Living with family	28	10.2
Living with friends	8	2.9
Other	22	8.0

TABLE 31. LIVING ON SKID ROW SINCE DISCHARGE (N=274)

CATEGORIES	N	%
Yes	153	55.8
No	119	43.4
Unknown	2	0.7

Living Arrangements. Prior to treatment, as shown in Table 16, 98.2 percent of the patients had been living alone.

At the time of followup, only half of them were living It should be especially noted that the number living with family or friends had increased considerably after discharge (see Table 30). This same trend of improvement in living arrangements is also evident when comparing Tables 17 and 31. Before treatment, the majority of patients lived on Skid Row, whereas after discharge only 55.8 percent had returned there.

Correlational Results

Selected variables, chosen as indices of improvement, were taken individually and cross classified with all the biographic and followup variables discussed in the preceding sections as a means of determining the existence of any relationships. This section presents only the statistically significant ($p < .05$) results of these cross classifications as indicated by chi-squares. Contingency coefficients are indicated in the Tables to give an index of relationship.

A. Drinking Behavior Since Discharge.

In seeking relationships between this variable and biographic items, only two were found to be statistically significant, Table 32 shows the results of these comparisons. (Note: In this and in the remaining tables, proportions summed horizontally add up to 100 percent). The number of living siblings and frequency of previous hospitalization are significantly related to drinking behavior since discharge. Inspection of percentages show that those patients with five or more living siblings had improved the most, since 78.2 percent of them were not drinking at all, or were drinking less than before. Those who had no living siblings showed the same trend. In terms of previous hospitalizations for

alcoholism, the significant relationship is accounted for by those with four or more hospitalizations. In this group, 19.1 percent were not drinking at all and 63.8 percent were drinking less than before ($X^2 = 22.43, p < .05$).

TABLE 32. DRINKING SINCE DISCHARGE VS. SEVERAL BIOGRAPHICAL ITEMS

BIOGRAPHIC ITEMS	DRINKING SINCE DISCHARGE			N
	Not at all %	Less than before %	Same or more %	
Number of living siblings				
None	3.3	66.7	30.0	30
1-2	23.3	38.9	37.8	90
3-4	12.5	53.6	33.9	56
5 or more	6.5	71.7	21.7	46
No information	10.4	62.5	27.1	48
$X^2 = 21.43, p < .01, C = .271$				
Previous Hospitalization				
None	11.1	53.5	35.4	99
One	9.6	59.6	30.8	52
Two	37.5	29.2	33.3	24
Three	6.3	56.3	37.5	16
Four or more	19.1	63.8	17.0	47
No response	6.1	54.5	39.4	33
$X^2 = 22.43, p < .05, C = .276$				
Total N	37	148	86	271
Percentage of Total	13.7	54.6	31.7	100.0

Table 33 presents the significant chi-squares when drinking behavior is related to other followup variables. As to be expected,

drinking behavior since discharge is highly related to drinking behavior at time of followup contact ($\chi^2= 64.67$, $p<.001$). That drinking behavior since discharge was related to AA membership is also shown. The figures indicate that among those affiliated with AA, a greater percentage were not drinking at all or were drinking less than before. More of those not affiliated with AA were drinking the same amount or more than before ($\chi^2= 5.99$, $p<.05$).

Those subjects working regularly or not at all since discharge were most improved as far as drinking behavior since discharge is concerned. Those doing day labor were the least improved, since among them 41.8 percent were drinking the same amount or more ($\chi^2= 105.78$, $p<.001$). The same trend can be observed when drinking behavior is compared with current employment status ($\chi^2= 94.25$, $p<.001$).

Regarding living arrangements, it is evident that those patients living with family, friends, or at an agency showed the greatest improvement. Those who were living alone were least improved ($\chi^2= 24.79$, $p<.01$). As expected, those who were living away from Skid Row were drinking less than those who had returned to the area ($\chi^2= 16.74$, $p<.001$).

B. Drinking Behavior at Time of Followup.

No relationship was found between drinking behavior at time of followup and any of the biographic information collected at time of admission. Significant relationships were found between drinking behavior at time of followup and drinking since discharge (as discussed above), affiliation with AA, usual employment since discharge, current employment status, postdischarge living arrangements and living on Skid Row. These results are shown in Table 34.

TABLE 33. DRINKING SINCE DISCHARGE VS. FOLLOWUP VARIABLES

FOLLOWUP VARIABLES	DRINKING SINCE DISCHARGE			N
	Not at all %	Less than before %	Same or more %	
Drinking at time of followup				
Yes	0.0	52.7	47.3	146
No	28.9	56.3	14.8	128
$X^2 = 64.67, p < .001, C = .437$				
Affiliation with AA after discharge				
Yes	18.2	54.5	27.3	132
No	9.2	54.2	36.6	142
$X^2 = 5.99, p < .05, C = .146$				
Usual employment since discharge				
Not at all	34.6	38.5	26.9	26
Day labor	.6	57.6	41.8	158
Regular job	57.5	35.0	7.5	40
Irregular employment	8.0	68.0	24.0	50
$X^2 = 105.78, p < .001, C = .528$				
Current employment status				
Not at all	23.1	51.3	25.6	39
Day labor	0.0	55.6	44.4	142
Regular job	51.0	40.8	8.2	49
Irregular employment	6.8	68.2	25.0	44
$X^2 = 94.75, p < .001, C = .506$				

(Continued) TABLE 33. DRINKING SINCE DISCHARGE VS. FOLLOWUP VARIABLES

FOLLOWUP VARIABLES	DRINKING SINCE DISCHARGE			N
	Not at all %	Less than before %	Same or more %	
Postdischarge living arrangement				
Unknown	0.0	62.5	37.5	24
Alone	6.6	56.9	36.5	137
At agency	23.6	47.3	29.1	55
Family	21.4	50.0	28.6	28
Friends	37.5	50.0	12.5	8
Others	27.3	54.5	18.2	22
$\chi^2 = 24.79, p < .01, C = .288$				
Living on Skid Row				
Yes	5.9	58.2	35.9	153
No	22.7	50.4	26.9	110
$\chi^2 = 16.74, p < .001, C = .241$				
Total N	37	149	88	274
Percentage of total	13.5	54.4	32.1	

TABLE 34. DRINKING AT TIME OF FOLLOWUP VS. FOLLOWUP VARIABLES

FOLLOWUP VARIABLES	DRINKING AT TIME OF FOLLOWUP		N
	Yes %	No %	
Drinking since discharge			
Not at all	0.0	100.0	37
Less than before	51.7	48.3	149
Same or more	78.4	21.6	88
$\chi^2 = 64.67, p < .001, C = .437$			

(Continued) TABLE 34. DRINKING AT TIME OF FOLLOWUP VS. FOLLOWUP
VARIABLES

FOLLOWUP VARIABLES	DRINKING AT TIME OF FOLLOWUP		N
	Yes %	No %	
Affiliation with AA			
Yes	43.9	56.1	132
No	62.0	38.0	142
$X^2 = 8.94, p < .01, C = .178$			
Any employment since discharge			
Not at all	42.3	47.7	26
Day labor	71.5	28.5	158
Regular job	17.5	82.5	40
Irregular employment	30.0	70.0	50
$X^2 = 53.83, p < .001, C = .405$			
Current employment status			
Not at all	41.0	59.0	39
Day labor	73.2	26.8	142
Regular job	24.5	75.5	49
Irregular employment	31.8	68.2	44
$X^2 = 49.54, p < .001, C = .391$			
Postdischarge living arrangement			
Unknown	91.7	8.3	24
Alone	62.8	37.2	137
At agency	36.4	63.6	55
Family	39.3	60.7	28
Friends	37.5	62.5	8
Others	18.2	81.8	22
$X^2 = 39.38, p < .001, C = .354$			

(Continued) TABLE 34. DRINKING AT TIME OF FOLLOWUP VS. FOLLOWUP VARIABLES

FOLLOWUP VARIABLES	DRINKING AT TIME OF FOLLOWUP		
	Yes %	No %	N
Living on Skid Row			
Yes	70.6	29.4	153
No	31.1	68.9	119
$X^2 = 41.95, p < .001, C = .366$			
Total N	146	128	274
Percentage of total	53.3	46.7	100.0

Table 34 also indicates that among those men who affiliated with AA after discharge, a greater percentage was not drinking at the time of followup contact. Among those who did not affiliate an even greater percentage was drinking ($X^2 = 8.94, p < .01$).

A much greater percentage of those who were doing day labor, or had been in some form of day labor since discharge, were found to be drinking at the time of followup contact, as compared with those who were regularly employed, irregularly employed at other than day labor, or not working at all ($X^2 = 49.54, p < .001$).

In contrast to those living in some form of social or familial setting (family, friends, agency, or other), significantly more of those living alone were found to be drinking at the time of followup contact ($X^2 = 39.38, p < .001$). More of those men living on Skid Row were also drinking at time of followup ($X^2 = 41.95, p < .001$).

C. Affiliation with AA After Discharge.

Table 35 reveals that affiliation with AA after discharge is related to the following biographic variables: number of children,

previous AA affiliation, education, and usual means of support.

Examination of the Table indicates the following trends:

1. Those with one or two children are more likely to affiliate with AA than the others ($X^2= 12.61, p<.01$).

2. Those previously affiliated with AA are more likely to affiliate again ($X^2= 7.51, p<.05$).

3. The more education one has, the greater the probability of affiliating with AA after discharge ($X^2= 14.54, p<.01$).

4. A greater percentage of those whose means of support was derived from regular jobs or unemployment compensation before admission affiliated with AA than did patients with other means of support ($X^2= 13.71, p<.05$).

TABLE 35. AFFILIATION WITH AA AFTER DISCHARGE VS. SEVERAL BIOGRAPHIC ITEMS

BIOGRAPHIC ITEMS	AFFILIATION WITH AA		N
	Yes %	No %	
Number of children			
None	50.0	50.0	40
1-2	59.1	40.9	66
3-4	26.7	73.3	45
5 or more	30.0	70.0	10
$X^2= 12.61, p<.01, C= .270$			
Previous AA affiliation			
No answer	54.5	45.5	22
Never	38.6	61.4	114
Affiliated	55.6	44.4	133

$X^2= 7.51, p<.05, C= .165$

(Continued) TABLE 35. AFFILIATION WITH AA AFTER DISCHARGE VS.
SEVERAL BIOGRAPHIC ITEMS

BIOGRAPHIC ITEMS	AFFILIATION WITH AA		N
	Yes %	No %	
Education			
8 years or less	36.1	63.9	72
Some high school	42.5	57.5	87
High school graduate	54.7	45.3	64
Some college	69.0	31.0	42
No response	66.7	33.3	6
$\chi^2 = 14.54, p < .01, C = .226$			
Means of Support			
Regular job	76.9	23.1	13
Day labor	49.0	51.0	151
Relief	23.5	76.5	17
Unemployment compensation	66.7	33.3	6
Family	20.0	80.0	5
Other	34.6	65.4	26
No response	54.7	45.3	53
$\chi^2 = 13.71, p < .05, C = .219$			
Total N	131	140	271
Percentage of total	48.3	51.7	100.0

Among the followup variables, significant chi-squares were obtained on the following: drinking since discharge, drinking at time of followup contact, usual employment since discharge, current employment status, postdischarge living arrangements, and

source of information. A summary of these data is presented in Table 36.

Drinking behavior since discharge and its relationship to AA affiliation has been discussed previously.

In relation to employment pattern, those who had had regular jobs or were currently holding one had a greater proportion of AA affiliation ($X^2= 21.00, p<.001$). The pattern was reversed for those who were not employed or who were working at day labor only.

A greater percentage of those living at agencies or with friends were affiliated with AA ($X^2= 25.77, p<.001$). Those men living with their families were evenly distributed, while a smaller percentage of those staying alone had affiliated with AA after discharge.

Significant relationships with source of information are indicated by the figures showing that when the followup information was obtained from an agency, a greater percentage of men were reported as being AA members ($X^2= 24.07, p<.001$).

TABLE 36. AFFILIATION WITH AA AFTER DISCHARGE VS. FOLLOWUP VARIABLES

FOLLOWUP VARIABLES	AFFILIATION WITH AA		
	Yes %	No %	N
Drinking since discharge			
Not at all	64.9	35.1	37
Less than before admission	48.3	51.7	149
Same or more	40.9	59.1	88

$X^2= 5.99, p<.05, C= .146$

(Continued) TABLE 36. AFFILIATION WITH AA AFTER DISCHARGE VS.
FOLLOWUP VARIABLES

FOLLOWUP VARIABLES	AFFILIATION WITH AA		
	Yes %	No %	N
Drinking at time of followup			
Yes	39.7	60.3	146
No	57.8	42.2	128
$X^2 = 8.94, p < .01, C = .178$			
Usual employment since discharge			
Not at all	30.8	69.2	56
Day labor	42.4	57.6	158
Regular job	77.5	22.5	40
Irregular employment	52.0	48.0	50
$X^2 = 19.33, p < .001, C = .257$			
Current employment status			
Not at all	30.8	69.2	39
Day labor	43.0	57.0	142
Regular job	75.5	24.5	49
Irregular employment	50.0	50.0	44
$X^2 = 21.00, p < .001, C = .267$			
Postdischarge living arrangement			
Unknown	8.3	91.7	24
Alone	44.5	55.5	137
Agency	67.3	32.7	55
Family	50.0	50.0	28
Friends	62.5	37.5	8
Others	59.1	40.9	22
$X^2 = 25.77, p < .001, C = .293$			

(Continued) TABLE 36. AFFILIATION WITH AA AFTER DISCHARGE VS.
FOLLOWUP VARIABLES

FOLLOWUP VARIABLES	AFFILIATION WITH AA		
	Yes %	No %	N
Source of information			
Patient	44.8	55.2	116
Family	54.5	45.5	11
Friends	31.6	68.4	57
Agency	66.7	33.3	84
Others	0.0	100.0	6
$X^2 = 24.07, p < .001, C = .284$			
Total N	132	142	274
Percentage of total	48.2	51.8	100.0

D. Usual Employment Since Discharge.

Table 37 shows the significant relationships between usual employment since discharge and several biographic items: racial/ethnic background, previous AA affiliation, social drinking pattern, and frequency of drinking. The following trends can be noted:

1. As a rule, the greatest percentages in each row are always found under the "day labor" column, since this group is the largest in terms of frequency. Comparing racial/ethnic groups and usual employment since discharge, it can be seen that a smaller percentage of whites than blacks have been working at day labor since discharge. More whites have had regular or irregular (other than day labor) jobs ($X^2 = 27.47, p < .01$).

2. A greater percentage of those who were affiliated with AA

had regular or irregular (other than day labor) jobs since discharge ($X^2= 14.0$, $p<.05$).

Among the periodic drinkers, a greater number had regular jobs than those who drank steadily. Those who drank alone, or both alone and with others, represent a greater proportion of regular employment ($X^2= 16.97$, $p<.05$).

Among the followup variables shown in Table 38, usual employment since discharge is related to drinking since discharge, drinking at time of followup, affiliation with AA after discharge, current employment status, postdischarge living arrangements, return to Skid Row, and source of information. Relationships with the first three variables have been discussed previously under those respective headings.

As expected, a very strong relationship was found between current employment status and usual employment since discharge. The slight difference represents shifts from regular or irregular jobs to day labor. For example, among those who were not working at time of followup contact, 23.1 percent have had day work and 10.3 percent irregular (other than day labor) jobs. Among those who were regularly employed at time of followup, 12.2 percent were in day labor, 81.6 percent have had regular jobs since discharge, and 6.1 percent had irregular (other than day labor) employment prior to their regular employment.

Postdischarge living arrangements were related to usual employment ($X^2= 58.73$, $p<.001$). A greater percentage of those men living at agencies or with friends had regular jobs than those who stayed alone or with family. Among those who were currently living with the family, a greater percentage had

irregular (other than day labor) employment than any other type of work arrangements.

More of those men who had returned to Skid Row were day laborers than those who were not on Skid Row. More of those who had regular or irregular (other than day labor) employment were not living on Skid Row ($X^2= 35.20, p<.001$).

TABLE 37. TYPE OF EMPLOYMENT SINCE DISCHARGE VS. SEVERAL BIOGRAPHIC ITEMS

BIOGRAPHIC ITEMS	TYPE OF EMPLOYMENT SINCE DISCHARGE				N
	Not at all %	Day labor %	Reg.emp %	Irreg.job %	
Racial/Ethnic background					
White	11.2	50.2	17.7	20.9	215
Negro	5.6	86.1	5.6	2.8	36
American Indian	0.0	72.7	0.0	27.3	11
Spanish speaking	0.0	100.0	0.0	0.0	9
$X^2= 27.47, p<.01, C= .303$					
Previous AA affiliation					
No answer	0.0	81.8	4.5	13.6	22
Never	11.4	61.4	9.6	17.5	114
Affiliated	9.8	49.6	21.1	19.5	133
$X^2= 14.0, p<.05, C= .222$					
Social drinking pattern					
Drinks alone	14.1	46.2	21.8	17.9	78
Drinks with others	9.1	63.6	11.6	15.7	121
Both alone and with others	8.5	48.9	14.9	27.7	47
No response	0.0	80.0	8.0	12.0	25
$X^2= 16.97, p<.05, C= .243$					

(Continued) TABLE 37. TYPE OF EMPLOYMENT SINCE DISCHARGE VS.
SEVERAL BIOGRAPHIC ITEMS

BIOGRAPHIC ITEMS	TYPE OF EMPLOYMENT SINCE DISCHARGE				N
	Not at all %	Day labor %	Reg.emp %	Irreg.job %	
Drinking pattern: frequency					
Steadily	11.2	57.8	9.9	21.9	161
Periodically	9.8	51.2	24.4	14.6	82
No response	0.0	75.0	14.3	10.7	28
$X^2 = 15.06, p < .02, C = .229$					
Total N	26	156	40	49	271
Percentage of total	9.6	57.6	14.8	18.1	100.0

TABLE 38. TYPE OF EMPLOYMENT SINCE DISCHARGE VS. FOLLOWUP VARIABLES

FOLLOWUP VARIABLES	TYPE OF EMPLOYMENT SINCE DISCHARGE				N
	Not at all %	Day labor %	Reg.job %	Irreg.emp %	
Drinking since discharge					
Not at all	24.3	2.7	62.2	10.8	37
Less than before admission	6.7	61.1	9.4	22.8	149
Same or more	8.0	75.0	3.4	13.6	88
$X^2 = 105.78, p < .001, C = .528$					
Drinking at time of followup					
Yes	7.5	77.4	4.8	10.3	146
No	11.7	85.2	25.8	27.3	128
$X^2 = 53.83, p < .001, C = .405$					

(Continued) TABLE 38. TYPE OF EMPLOYMENT SINCE DISCHARGE VS.
FOLLOWUP VARIABLES

FOLLOWUP VARIABLES	TYPE OF EMPLOYMENT SINCE DISCHARGE				N
	Not at all %	Day labor %	Reg.job %	Irreg.emp %	
Affiliation with AA after discharge					
Yes	6.1	50.8	23.5	19.7	132
No	12.7	64.1	6.3	16.9	142
$\chi^2 = 19.33, p < .001, C = .257$					
Current employment status					
Not at all	66.7	23.1	0.0	10.3	39
Day labor	0.0	100.0	0.0	0.0	142
Regular job	0.0	12.2	81.6	6.1	49
Irregular employment	0.0	2.3	0.0	97.7	44
$\chi^2 = 617.05, p < .001, C = .832$					
Postdischarge living arrangement					
Unknown	4.2	91.7	0.0	4.2	24
Alone	6.6	69.3	10.2	13.9	137
Agency	9.1	40.0	25.5	25.5	55
Family	14.3	32.1	14.3	39.3	28
Friends	0.0	37.5	37.5	25.0	8
Others	31.8	31.8	22.7	13.6	22
$\chi^2 = 58.73, p < .001, C = .420$					
Living on skid row					
Yes	7.2	73.2	7.8	11.8	153
No	12.6	37.8	22.7	26.9	119
$\chi^2 = 35.20, p < .001, C = .338$					

(Continued) TABLE 38. TYPE OF EMPLOYMENT SINCE DISCHARGE VS.
FOLLOWUP VARIABLES

FOLLOWUP VARIABLES	TYPE OF EMPLOYMENT SINCE DISCHARGE				N
	Not at all %	Day labor %	Reg. job %	Irreg. emp. %	
Source of information					
Patient	12.1	49.1	19.8	19.0	116
Family	9.1	36.4	18.2	36.4	11
Friends	7.0	52.6	8.8	31.6	57
Agency	6.0	76.2	11.9	6.0	84
Others	33.3	50.0	0.0	16.7	6
$X^2 = 32.94, p < .001, C = .328$					
Total N	26	158	40	50	274
Percentage of total	9.5	57.7	14.6	18.2	100.0

E. Current Employment Status.

Three biographical items were found to be significantly related to current employment status as shown in Table 39: racial/ethnic background, frequency of drinking, and usual means of support before admission to Operation Outreach. As with other employment-related variables, more of the whites had regular jobs than the others. The Spanish-speaking subjects were either day laborers or not working at all ($X^2 = 21.0, p < .02$).

There was also a difference in status of current employment related to frequency of drinking. Periodic drinkers were more likely to find regular jobs than were the steady drinkers ($X^2 = 12.86, p < .05$).

Those whose regular means of support before admission came from holding a regular job did better in finding employment after discharge,

since more of them held regular jobs again. Only 7.7 percent did not find any job at all. Those whose usual support had come from relief or welfare were either not working or doing day labor at the time of followup. 55 percent of those who used to do day labor were still doing the same thing, although 33.7 percent had found regular or irregular (other than day labor) employment ($\chi^2= 29.11, p<.05$).

Relationships with followup variables are the same as those noted in previous discussion of usual employment since discharge. Similar trends were found here, as presented in Table 40.

TABLE 39. CURRENT EMPLOYMENT OF OPERATION OUTREACH PATIENTS VS. SEVERAL BIOGRAPHIC ITEMS OBTAINED BEFORE ADMISSION

BIOGRAPHIC ITEMS	STATUS OF CURRENT EMPLOYMENT				N
	Not at all %	Day labor %	Reg.emp %	Irreg.emp %	
Racial/Ethnic background					
White	13.5	46.0	21.4	19.1	215
Negro	13.9	77.8	5.6	2.8	36
American Indian	18.2	54.5	9.1	18.2	11
Spanish-speaking	22.2	77.8	0.0	0.0	9
$\chi^2= 21.0, p<.02, C= .268$					
Drinking pattern: frequency					
Steadily	18.0	50.3	13.7	18.0	161
Periodically	9.8	48.8	26.8	14.6	82
No response	3.6	67.9	17.9	10.7	28
$\chi^2= 12.86, p<.05, C= .213$					

(Continued) TABLE 39. CURRENT EMPLOYMENT OF OPERATION OUTREACH VS. SEVERAL BIOGRAPHIC ITEMS OBTAINED BEFORE ADMISSION

BIOGRAPHIC ITEMS	STATUS OF CURRENT EMPLOYMENT				N
	Not at all %	Day labor %	Reg.emp %	Irreg.emp %	
Means of support					
Regular job	7.7	23.1	46.2	23.1	13
Day labor	11.3	55.0	15.2	18.5	151
Relief	23.5	58.8	0.0	17.6	17
Unemployment compensation	16.7	33.3	33.3	16.7	6
Family	20.0	20.0	60.0	0.0	5
Others	26.9	38.5	23.1	11.5	26
No response	13.2	58.5	17.0	11.3	53
$X^2 = 29.11, p < .05, C = .311$					
Total N	38	140	49	44	271
Percentage of total	14.0	51.7	18.1	16.2	100.0

TABLE 40. CURRENT EMPLOYMENT STATUS VS. FOLLOWUP VARIABLES

FOLLOWUP VARIABLES	CURRENT EMPLOYMENT				N
	Not at all %	Day labor %	Regular %	Irregular %	
Drinking since discharge					
Not at all	24.3	0.0	67.6	8.1	37
Less than before admission	13.4	53.0	13.4	20.1	149
Same or more	11.4	71.6	4.4	12.5	88

$X^2 = 94.25, p < .001, C = .506$

(Continued) TABLE 40. CURRENT EMPLOYMENT STATUS VS. FOLLOWUP
VARIABLES

FOLLOWUP VARIABLES	CURRENT EMPLOYMENT				N
	Not at all %	Day labor %	Regular %	Irregular %	
Drinking at time of followup					
Yes	11.0	71.2	8.2	9.6	146
No	18.0	29.7	28.9	23.4	128
$\chi^2 = 49.54, p < .001, C = .391$					
Affiliation with AA after discharge					
Yes	9.1	46.2	28.0	16.7	132
No	19.0	57.0	8.5	15.5	142
$\chi^2 = 21.00, p < .001, C = .267$					
Usual employment since discharge					
Not at all	100.0	0.0	0.0	0.0	26
Day labor	5.7	89.9	3.8	.6	158
Regular job	0.0	0.0	100.0	0.0	40
Irregular job	8.0	0.0	6.0	86.0	50
$\chi^2 = 617.05, p < .001, C = .832$					
Postdischarge living arrangements					
Unknown	12.5	83.3	0.0	4.2	24
Alone	8.0	65.0	13.1	13.1	137
Agency	16.4	32.7	34.5	16.4	55
Family	17.9	32.1	14.3	35.7	28
Friends	0.0	37.5	37.5	25.0	8
Others	50.0	13.6	22.7	13.6	22
$\chi^2 = 73.24, p < .001, C = .459$					

(Continued) TABLE 40. CURRENT EMPLOYMENT STATUS VS. FOLLOWUP

FOLLOWUP VARIABLES	CURRENT EMPLOYMENT				N
	Not at all %	Day labor %	Regular %	Irregular %	
Living on Skid Row					
Yes	9.2	69.9	9.8	11.1	153
No	21.0	28.6	27.7	22.7	119
$X^2 = 46.40, p < .001, C = .382$					
Source of information					
Patient	15.5	46.6	23.3	14.7	116
Family	9.1	27.3	27.3	36.4	11
Friends	14.0	47.4	8.8	29.8	57
Agency	11.9	65.5	16.7	6.0	84
Others	33.3	50.0	0.0	16.7	6
$X^2 = 28.60, p < .001, C = .307$					
Total N	39	142	49	44	274
Percentage of total	14.2	51.8	17.9	16.1	100.0

F. Living on Skid Row.

None of the biographic items were found to be related to living on Skid Row after discharge from Operation Outreach. As seen in Table 41, the first four variables related to living on Skid Row after discharge have already been discussed under those respective headings.

Among those men who lived alone after discharge, 72.8 percent had returned to Skid Row. Among those whose postdischarge living arrangements were made with an agency, family, or friends, a greater percentage had not returned to Skid Row ($X^2 = 65.51, p < .001$).

More of the patients personally contacted were living on Skid Row at the time of contact. This is also true of patients for whom followup information was obtained from an agency. Where information was obtained from friends or family, patients were generally living outside the Skid Row environment.

TABLE 41. LIVING ON SKID ROW VS. FOLLOWUP VARIABLES

FOLLOWUP VARIABLES	PRESENTLY LIVING ON SKID ROW		
	Yes %	No %	N
Drinking since discharge			
Not at all	25.0	75.0	36
Less than before admission	59.7	40.3	149
Same or more	63.2	36.8	87
$X^2 = 16.74, p < .001, C = .241$			
Drinking at time of followup			
Yes	74.5	25.5	145
No	35.4	64.6	127
$X^2 = 41.95, p < .001, C = .366$			
Employment since discharge			
Not at all	42.3	57.7	26
Day labor	71.3	28.7	157
Regular job	30.8	69.2	39
Irregular employment	36.0	64.0	50
$X^2 = 35.20, p < .001, C = .338$			
Current employment status			
Not at all	35.9	64.1	39
Day labor	75.9	24.1	141
Regular job	31.3	68.8	48
Irregular employment	38.6	61.4	44
$X^2 = 46.40, p < .001, C = .382$			

(Continued) TABLE 41. LIVING ON SKID ROW VS. FOLLOWUP VARIABLES

FOLLOWUP VARIABLES	PRESENTLY LIVING ON SKID ROW		
	Yes %	No %	N
Postdischarge living arrangements			
Unknown	87.5	12.5	24
Alone	72.8	27.2	136
Agency	41.8	58.2	55
Family	14.3	85.7	28
Friends	37.5	62.5	8
Other	14.3	85.7	21
$X^2 = 65.51, p < .001, C = .441$			
Source of information			
Patient	55.7	44.3	115
Family	27.3	72.7	11
Friends	35.1	64.9	57
Agency	73.5	26.5	83
Other	83.3	16.7	6
$X^2 = 25.96, p < .001, C = .295$			
Total N	153	119	272
Percentage of total	56.3	43.8	100.0

DISCUSSION

Several points must be clarified at the outset of this discussion of the recently concluded project. It should be noted, first, that it has been the experience of the Grantee that law enforcement and health agencies, and their respective personnel are capable of working in complete harmony and cooperation toward the fulfillment of mutual goals. Coordination of efforts, effective communication, and mutual understanding of one another's methods and objectives can result in a flexible and efficient multidisciplinary approach to resolution of problems of alcoholism that can benefit not only the target population, but those individual agencies involved and society as a whole as well.

One example of this approach was the apparent change in attitudes on the part of a good proportion of the residents of Chicago's major Skid Row area and the Chicago Police Department. It is not condemnation or indictment of either of these two dissonant groups to state that there often existed some degree of mutual hostility, resentment, suspicion, and misunderstanding between Skid Row alcoholics and police. As the project progressed and word was passed along the "grapevine" it became evident that, where as Skid Row men had initially suddenly disappeared at the sight of the unmarked--but somehow identifiable--project vehicle, they later welcomed the SRTs' visits. They often gathered around the car, or the SRTs when on foot, to exchange greetings, pass information, inquire about the health of old friends, and ask for information about admission.

It is the Grantee's contention and firm conviction that such opportunities for friendly and helpful contact not only furthers the goals of law enforcement and health care, but could in itself constitute a worthwhile Community-involvement project among police departments all over the country. It may be wise to consider, along these same lines a wider application of brief but intensive specialized training of law enforcement personnel on the pathology and dynamics of alcoholism and the "care and handling" of public inebriate, as is currently being done in Chicago by the Grantee's Executive Director.

Another rather important qualitative conclusion derived from the Grantee's experience in this project is that with appropriate screening of applicants, relevant training, and adequate supervision, recovered alcoholics can be most useful service personnel in this type of project. Recovered alcoholics, having "been there" themselves, have proven to the Grantee's satisfaction, that they can function as empathic, sympathetic, and highly effective paraprofessionals in the field of alcohol addiction. This is not to imply that all recovered alcoholics would be satisfactory workers in this field--selection errors recognized by the Grantee preclude the generalization--but the Justice Department may be well advised to consider training programs and job placement opportunities for rehabilitated alcoholics. Such programs, operated in conjunction with local law enforcement agencies, would have at their disposal a ready pool of manpower intimately familiar with the problems and life styles of Skid Row habitues, as well as providing meaningful and socially useful

employment for at least a portion of what is now a neglected and often abused segment of the population. It has been the Grantee's experience in this project that law enforcement agents who are themselves rehabilitated alcoholics are also most effective in this type of operation.

The Grantee would share with the readers of this report other of its considered opinions and experiential observations, some of which will be covered in greater detail in a consideration of the quantitative data presented in the preceding section of this paper.

Although mistakes are unavoidable and problems cannot always be anticipated, it is decidedly erroneous and shortsighted to initiate a project such as this one without a full complement of adequately trained and competent staff. Many of the procedural problems and disappointments discussed earlier may have been avoided had such a policy been possible.

Moreover, established agencies deciding to undertake a project such as this one would be well advised to be aware of possible dissidence and resistance on the part of existing-facility staff. It was the Grantee's experience that, although most problems were worked out as Operation Outreach progressed, the initial phases of the project were made difficult by faulty communication, dissatisfaction with procedures, hidden resentments, and other forms of resistance.

A final caveat to the reader before going on to discuss the data: It is not always possible to be assured of the validity of the data collected in the followup study herein reported, for a

variety of reasons: the general transiency of the population, the unwillingness of respondents to be totally truthful--often because they do not wish to disappoint the agency--the desire of the respondents to protect one another, etc. Therefore the reader is urged to consider this report with some degree of guarded optimism. Those points at which the data are particularly dubious, or on the other hand wholly valid and reliable, will be so indicated in this narrative.

In regarding the data reported under Results it should be first noted that at least some source of information was available for almost 80 percent of all patients processed through the project; although the total followup period excuded one year, it is obvious that the majority (57.3 percent) of the respondents were contacted within a six-month followup period (see Table 1). As one might reasonably expect, the greatest single period of successful followup contacts were made during a postdischarge interval of 120-150 days, with the proportion of contacts showing a fairly regular decrease throughout all other intervals.

The reader should not presume, however, that the frequently discussed anonymity and mobility of the Skid Row man is a myth, since inspection of Table 2 indicates that less than half (42.3 percent) of the followup contacts were made with patients themselves. And in those cases where patients' families (4 percent), friends (20.8 percent), and referral agencies (30.7 percent) were the respondents, it was not always true that the patient and the respondent were in contact at the time of followup. Thus, for example, families interviewed by SRTs sometimes responded, "Well,

when I last saw X two months ago he was sober," friends would often preface their responses with similar qualifiers, and agency records were sometimes dated many weeks prior to the actual followup visit. Whereas this was not always the case, and family, friend, and agency responses were often immediate and current, only when the patient himself was the respondent can we, and the reader, be certain of the immediacy of the contact. The Grantee contends nonetheless that even the 42.3 percent direct patient contacts represents a higher than usual proportion of successful followup.

The six indices of general improvement discussed in Results represents the four major life-areas that would be generally considered as significant variables, viz: drinking behavior, employment, AA affiliation, and return to Skid Row. A fifth, and highly important index, comparison of preadmission and postdischarge arrest ratios, will be discussed separately, since this index involves totally different sources of information and standards of validity and reliability.

Tables 3-23, and their accompanying text, represents the profile of the patients at the time of admission. Since most of these data were reported and discussed periodically in the Operation's quarterly reports, an extensive or detailed discussion here would be redundant. Only those significant profile variables--those for which a postdischarge comparison is available--will be discussed here. All of these Tables, however, are of value insofar as they indicate the nature of Chicago's Skid Row alcoholics and serve to inform other cities and their law enforcement and health care agencies of the characteristics they may expect to

find among their own indigent public inebriates. Such surveys are not often conducted, and what information is generally available (e.g., Bogue, 1963) may be outdated. The reader is reminded, however, that data contained in Tables 3-23 are representative only of those men who voluntarily consented to enter the project, and it is possible that this sample of volunteers is not truly representative of the population from which it was drawn. For those cities and agencies contemplating similar voluntary programs, however, these data can be considered pertinent.

If one were to construct a composite Outreach patient, one would expect him to be approximately forty-five years old, occupationally unskilled and supporting himself by day labor (but not working on the day of his admission). Such a patient is unlikely to have completed high school, is probably a veteran, and was probably born outside of the state in which he is currently located. He is apt to be a white Protestant of American-born parents who are both deceased. The patient will probably have one or two living siblings with whom he has little or no contact, and although he is likely to have been married, he can be expected to have been divorced or separated for more than five years. Although the patient may have children, he is likely to have little or no current contact with them and does not contribute to their support. Our composite individual lives alone, and has been living on Skid Row for at least one year but probably not longer than ten years. He has probably affiliated with AA in the past, but rarely for longer than six months. He has more than likely been treated for

alcoholism previously and, although not healthy he is probably free from serious disease or deformity. It is possible that there has been some history of alcoholism in his family. The composite patient is more likely to be a social individual, preferring to drink with others rather than alone, and most often he will drink regularly rather than sporadically.

Such a composite is, of course, an abstraction and does not presume to be definitive. There is too much variance within the data to allow us to draw a conclusive picture of the "Skid Row alcoholic." One can expect to find great divergence among indigent public inebriates, and geographic locations of Skid Rows will to some extent dictate racial and ethnic characteristics of its inhabitants and contribute further to divergent psychosocial, medical, cultural, and historic data. Nor do we wish to develop or perpetuate a stereotype; there is however, sufficient consistency among our voluntary patients to permit the generalizations indicated, so long as the reader bears in mind the magnitude and range of variance indicated in the data.

Turning now to a discussion of the followup information, the reader is again reminded that these data cannot be presumed to be wholly valid or reliable. The nature of the patient and the sources of information must be borne in mind throughout.

Regarding Table 24, it may be accepted as valid and reliable that 52.2 percent of the sample kept their postdischarge referral appointments. It was the common practice of the SRTs, and a policy to be followed whenever possible, to use the project vehicle to transport the dischargée to the location of his appointments.

It is a firmly held conclusion, and one that is recommended to other agencies attempting similar projects, that this method assures that the dischargée will arrive safely at his destination. It also has the effect of covertly communicating to the patient the idea that our interest and concern for him does not end when he leaves Outreach. Moreover, it indicates to the referral agency that the cooperating institutions are serious in their intent to promulgate a continuity of care and treatment.

That 7.7 percent of discharged patients failed to keep their referral appointments can also be taken as a valid datum. More important, however, is the observation that 40.1 percent of the sample either refused all referrals or left Outreach before appropriate referral could be arranged. This finding supports the widely held contention (see, for example, Catanzaro, 1968) that as detoxification proceeds successfully and the patient is restored to a modicum of physical health, the impulsive behavior of the alcoholic leads him to leave the program before psychosocial rehabilitation can begin in earnest. While this may argue for a compulsory program or a legally binding judicial decision that the alcoholic must remain in treatment for some stipulated period of time or else face a jail sentence, there are other variables to be considered. The inability to supply immediate referral consistent with the patients' needs is indicative of the need for greater number and variety of medical, psychosocial, and other agencies for the provision of continued care of the public inebriate. This is perhaps one of the greatest obstacles to successful treatment, and a well-regulated network of interacting

facilities is required to meet this need. Then too, there remains the question of whether it is possible to treat a patient who does not wish treatment beyond that of his immediate medical and nutritional needs.

It is encouraging, however, to note in Table 25 that two thirds of all discharges from the project did seek some form of additional care or treatment. The largest single contributor of such aftercare was the halfway houses, and the Grantee's observations indicate that if more such facilities were available, the rate (21.2 percent) of admission to halfway houses would be proportionately higher. The halfway house could very well be one of the integral links in the above-mentioned network of interacting facilities.

That CATC's rehabilitation program attracted 16.4 percent of the discharged patients suggests that a reasonable proportion of the men recognized their need for longer-term treatment whose major focus is psychosocial rather than predominantly medical. Moreover, the Grantee observed that had more rehabilitation beds been immediately available to discharged Outreach patients, a proportionately greater number of men would have entered the rehabilitation program: The number of applicants far exceeded the number of available beds, and interviews and admission sometimes required a waiting period of up to thirty days.

These observations again support the conclusion, and recommend the appropriate development that successful treatment of the indigent Skid Row alcoholic depends on the integration of a total treatment program that merely begins with detoxification,

diagnosis, and referral (Catanzaro, 1968; Chafetz, 1970; and Pisani, 1969). The Grantee again emphasizes the need for a comprehensive, continuous network of care that proceeds from the Outreach-type of voluntary induction, to longer-term psychosocial therapy, to occupational and/or educational training and placement, to residential relocation (in halfway houses or other supportive settings), to followup contacts and continued care in a variety of ways.

It will be recalled from the Operation's quarterly reports (and from the Introduction of this report) that one experimental variable to be manipulated during the course of the project was the alternating periods of total integration and partial integration of Outreach patients into the rehabilitation milieu. The alternation was a quarterly one of the ABAB type, and the quarterly reports indicated a higher proportion of Outreach patients entering the rehabilitation program during the quarters when integration was not total. In the fourth quarterly report it was speculated that total integration represented to the Outreach patient a potential source of threat, in the form of increased personal and group responsibility, social pressures, etc. On closer inspection, however, the value of that hypothesis is doubtful, particularly in view of the data (discussed below) on employment and living arrangements. It would seem, rather, that too many variables were operative to permit a firm conclusion. Employment records indicate that a shift in personnel--the presence of two different social workers--coincided with the shifts in referrals, as did the mean age of the patients, the general attitude of rehabilitation

staff and patients, etc. The Grantee is unable to conclude, therefore, that total integration is superior to partial integration, or vice versa.

Drinking behavior, one of the major indices of change following discharge, is indicated in Tables 26 and 27. These data, moreso than any others, must be viewed with cautious optimism due to the questionable validity and subjective nature of the reports. For example, a man who had been drinking two quarts of wine per day before admission but was drinking only one quart of whiskey per day after discharge, could honestly respond at followup that he was "drinking less." Nothing is said, however, about the toxicity of the beverage, only the quantity of intake. Then too, it is not inconceivable that patients wished to please the SRTs, families and friends wished to "protect" the patient, etc., which could lead to distorted, if not actually falsified, reports.

With these qualifications in mind, inspection of the data does indicate that better than half the respondents reported less drinking after discharge, 13.5 percent reported total abstinence, 28.9 percent reported no noticeable change, and 2.9 percent reported accelerated drinking. These data, if valid, could represent a "successful" result of Operation Outreach and represent sufficient justification of a continued, expanded program. An indication of the degree of validity of Table 26 is provided by Table 27, which indicates that 53.3 percent of the respondents reported no drinking at the time of followup. Recalling that Table 2 shows that 42.3 percent of the

respondents were the patients themselves, one can extrapolate to the point that 42.3 percent of those who reported no drinking at time of followup were, in fact, not drinking according to the reports of the SRTs who made the followup contact. The 30.7 percent of the responses provided by referral agencies can also be accepted with a greater degree of reliability, as can the 2.2 percent "other" respondents, usually employees. Regardless of how small the proportion of reduced, stabilized, or abstemious drinking behavior, these data should be gauged against the fact that virtually all of the patients were intoxicated at the time of admission.

Employment represents another major index of change, and the data represented in Tables 28 and 29 are of great importance. The Grantee sees little reason to question the validity of these data, and they can be viewed as relatively straightforward replies on the part of the respondents. These two Tables should be compared to Tables 4 and 5, and to the fact that only seven men were employed at admission. Thus, rate of employment at time of followup (Table 28) was 85.8 percent, as compared to approximately 0.3 percent at admission. Day labor at time of followup and as the reported source of income since discharge shows only slight changes over usual source of income at time of admission: In the former case a decrease of 3.9 percent, in the latter case an increase of 1.8 percent.

Quite encouraging, however is the 17.9 percent reported full-time employment at time of followup, and the 14.7 percent full-time employment since discharge; contrast those two figures with the 4.8 percent reporting regular employment at the time of

admission and a 300 percent increase is apparent. It is suggested by the Grantee, therefore, that future projects of this nature include intensive vocational and occupational placement as a major focus, especially since, as will be discussed later, employment status is closely related to changes in drinking behavior.

Postdischarge affiliation with AA after discharge shows little change over preadmission patterns. Whereas 49.4 percent of the patients had been AA members before admission, 48.2 percent affiliated afterwards.

Postdischarge living arrangements were also considered major indices of change, and the data shown in Tables 30 and 31 are viewed with guarded optimism. At the time of admission 98.2 percent of the sample lived alone, and presumably 100 percent lived on Skid Row. Examination of Table 30 shows that only half the men were living alone at followup and only 55.8 percent had returned to Skid Row (Table 13; the relationships between living arrangements and other postdischarge variables are discussed below). More than 10 percent of the men had returned to their "families" and 30 percent were living with friends or at agencies. Since most of these followup contacts were conducted at the patients' place of residence, these particular data may be considered relatively valid and reliable.

Based on these living arrangement data, and the related chi-square and correlational analyses which follow, the Grantee would tentatively conclude that an effective program for the treatment of indigent public inebriates must focus on appropriate residential

relocation as a major aspect of pre-discharge planning. Effective cooperation with halfway houses, departments of public housing, departments of urban renewal, and related municipal authorities is essential to a meaningful and comprehensive treatment program.

Examination of the chi-square and correlational data (Tables 32-41) indicate the significant findings among the admission and followup information. In all cases a probability level of .05 or less was accepted as statistically significant.

Table 32 indicates that patients with five or more living siblings showed the greatest improvement in terms of reduction of drinking: 6.5 percent were not drinking at all, and 71.7 percent were drinking less than before. The probability of this distribution occurring by chance is less than .01. Paradoxically, patients with no living siblings showed a similar trend, although not to the same extent. The Grantee would recommend further investigation of this variable.

Table 33 indicates a significant ($p < .05$) relationship between number of previous hospitalizations for alcoholism and postdischarge reports of drinking behavior. Patients with four or more past hospitalizations reported drinking less, or not at all, at a rate significantly higher than that for patients with fewer hospitalizations. The Grantee would speculate, then, that perhaps several hospitalizations or periods of treatment may be necessary before the revolving door cycle is broken and drinking behavior is altered. The Grantee would also tender the suggestion, however, that if the earlier hospitalizations had been appropriate, or had been part of a continuous-care program with sufficient post-

hospitalization followup treatment, later hospitalizations may not have been necessary. The Grantee concludes and strongly recommends that all future programs of this nature be a part of a continuous-care network of agencies and facilities integrated to provide for the needs of the patient. A comprehensive treatment program is obviously a necessity, with detoxification as only a first step, not merely a drying-out operation from which the patient is released after restoration of physical health, only to be returned again and again. In this sense, detoxification per se, without adequate supportive agencies and services, may itself perpetuate revolving door alcoholism.

In examining the statistical data in Table 33 it is not surprising to note that a statistically significant proportion of those patients who were not drinking at time of followup reported no drinking since discharge, and the entire Table shows a significant ($p < .001$) relationship between drinking behavior since discharge and drinking behavior at the time of followup. The contingency coefficient (C) of the chi-square (X^2) indicates the degree of relationship in the 3 x 2 matrix of drinking since discharge (3 categories) x drinking at followup (2 categories).

As reported in numerous publications our data also indicates that a statistically significant ($p < .05$) proportion of men who affiliated with AA after discharge reported no drinking or less drinking, whereas nonmembers were drinking at the same level or more ($p < .05$).

Table 33 also supports the frequent contention that regular employment since discharge is associated with reduced drinking

($p < .001$), whereas day labor is associated with no improvement or deterioration ($p < .001$). Paradoxically, however, those men who had had no employment at all since discharge also reported significant improvements in drinking behavior. It can be speculated that the reduction in drinking in this case, however, may be attributable to not having sufficient funds to purchase drink, but additional research is needed to clarify this variable. The same relationship and level of significance ($p < .001$) is noted in the relationship between current (at time of followup) employment status and drinking since discharge.

Nor is it surprising to note in Table 33 that patients living alone showed the least improvement in drinking behavior since discharge ($p < .01$). Relatedly, those men who had returned to Skid Row showed a significantly ($p < .001$) lower proportion of improved drinking since discharge.

In drawing conclusions from the X^2 and C data in Table 33, the following summary can be made: Patients who are not drinking at time of followup, have affiliated with AA after discharge, have had a full-time regular job (or no job at all), are currently employed at a regular job, do not live alone, and have not returned to Skid Row, are significantly more improved in terms of reduction of drinking after discharge. The conclusions that can be drawn from these data are obvious and, although they have been mentioned earlier, bear repeating: A truly effective program of treatment for the public inebriate must focus on all aspects of rehabilitation, including medical detoxification as a preliminary step--not as an end in itself--followed by longer-term psychosocial rehabilitation,

occupational and residential placement, and followup visits.

Since return to Skid Row is inimical to reduction of drinking (i.e., improvement), the Grantee believes that these data militate against a detoxification facility located in the Skid Row area. It is apparent that removing the patient from the undesirable environment, or therapeutically precluding his return to that area, represents an important variable in altering postdischarge drinking behavior. This matter is taken up again later in the Discussion.

The data displayed in Table 34 relate drinking behavior at the time of followup contact to those same variables displayed in Table 33. Because of the significant relationship between drinking since discharge and drinking at time of followup, the information in the two Tables are similar and lead the Grantee to similar conclusions. That is, patients who were not drinking at followup showed significant improvements in drinking since discharge ($p < .001$), more AA affiliation ($p < .01$), improvement in employment status ($p < .001$), less solitary living ($p < .001$), and lower rates of return to Skid Row ($p < .001$).

One cannot infer a causal relation from these data, but one can clearly conclude that all of these indices of improvement consistently cluster together, both in terms of postdischarge behavior and behavior at time of followup. It is again made apparent, therefore, that projects such as Operation Outreach can succeed if they focus on attempting to simultaneously reduce drinking, encourage AA participation, and provide occupational and residential placement. It is quite clear that living alone,

return to Skid Row, and re-entry into the day labor market are inimical to any reduction in alcohol consumption. The Grantee believes that it is this total pattern of behavior, or life style, that must be altered rather than merely any of the individual components. The overall total pattern is greater than the sum of its parts, and the pattern of alcoholism and chronic public intoxication must be attacked as a unitary problem; it will not suffice to focus on the individual maladaptive or socially disruptive components.

Table 35 displays those admission data that were related to postdischarge affiliation with AA. As discussed above, AA participation is an aspect of the "improvement syndrome," and it is significantly related to several variables. Patients with one or two children, previous AA affiliation, more education, and either regularly employed or collecting unemployment compensation, are significantly more likely to affiliate with AA after discharge.

The followup data (Table 36) that bear a significant positive relation to postdischarge AA affiliation include: reduction of drinking since discharge, no drinking at time of followup, regular or irregular (other than day labor) employment since discharge and at time of followup, and living at agencies or with friends. It is interesting to note that men living with their families were evenly distributed between AA affiliation and nonaffiliation. Perhaps the family provides much the same function as AA. It is also interesting to note the effect of source of information on reported AA affiliation, since a significantly ($p < .001$) greater proportion of men were represented

as AA members when the information came from an agency.

Looking at patterns of employment since discharge as related to biographic admission data (Table 37), a significantly ($p < .01$) greater proportion of nonwhite patients became involved in the day labor market, whereas whites were more frequently able to find regular or irregular employment outside of day labor. On the basis of this datum the Grantee would tentatively conclude that in future projects more attention be paid to occupational placement for nonwhites. Note especially that although there were only nine Spanish-speaking people in the sample, 100 percent of them were day laborers during the followup period.

The positive relationship between preadmission AA affiliation and occupational status is also apparent, as significantly ($p < .05$) fewer nonaffiliates later found employment in jobs other than day labor. Again, no causal relation is implied, but the correspondence of the two variables is noteworthy.

Affiliative drinkers (i.e., those who drank with others only) showed, overall, the poorest record of postdischarge employment, having the highest rate of unemployment and day labor, and the lowest rate of regular and irregular employment (with the exception of those who did not indicate their preferred drinking patterns). Perhaps group-drinking is conducive to a continuation of the preadmission pattern of maladaptive behavior. Not at all surprising is the observation that periodic drinkers found significantly ($p < .02$) more regular employment than did the steady drinkers.

Usual employment since discharge was found to be related to

those now-familiar components of the "improvement syndrome," and the expected pattern emerges clearly (see Table 38). Day laborers had the lowest rate of reported abstinence and the highest rate of increased drinking, while regularly employed patients had the highest rate of abstinence and the lowest rate of increased drinking after discharge. This latter group also had the lowest rate of reported drinking at the time of followup.

The relationships between employment since discharge and employment at followup are not unexpected, but deserve special attention here. The reader's attention should be drawn to the datum indicating that 100 percent of those whose usual employment since discharge was day labor, remained as day laborers at the time of followup--sometimes an interval of 390 days. All of the relationships between these two variables, in fact, lead to the conclusion that unless a patient receives adequate and appropriate job placement initially, there is virtually no probability of an improvement in status.

Excluding the postdischarge living arrangement categories of "others" and "unknown," it can be inferred that living with friends is least conducive to total unemployment; on the other hand, patients living with their family had the highest rate of unemployment, possibly because family members contribute to their support. Living alone and living on Skid Row obviously contributes to entering the day labor market, or vice versa.

Table 39 relates biographical admission date to employment status at time of followup, and indicates the employment difficulties of the racial and ethnic minorities. All of the

Spanish-speaking patients were either day laborers or totally unemployed, and again the Grantee would emphasize the need for special attention to this group in job placement as part of the overall therapeutic effort. Day labor was least common among whites, even though more than half of the white sample were numbered among the unemployed and day laborers.

Not unexpectedly, those patients who had been periodic drinkers before admission had significantly ($p < .05$) higher rates of regular employment at the time of followup. The pattern of employment at followup vs. usual means of support prior to admission again indicate relatively little change, particularly in terms of upward mobility, and the day labor market continues to claim more than half of all discharged patients.

Table 40 details the relationship between employment at time of followup and the familiar constellation of postdischarge variables. The "improvement syndrome" should be anticipated by now: Regular employment is significantly and consistently related to a reduction in drinking, particularly total abstinence; no drinking at time of followup; postdischarge affiliation with AA; regular employment since discharge; a social living arrangement, particularly with friends or at an agency; and removal from Skid Row. This pattern remains consistent!

Since return to Skid Row was unrelated to any of the biographical admission data, Table 41 focuses on the postdischarge correlates of return to the area. The "improvement syndrome" (reading down the column headed "No," i.e., did not live on Skid Row at time

of followup) is positively related to the following variables: reduction in drinking, particularly total abstinence; no drinking at time of followup; and social (nonsolitary) living arrangement. Living on Skid Row is negatively related to working in day labor jobs; i.e., those patients living away from the area reported the lowest frequency of day labor.

Before going on to discuss the police records, the Grantee must once more emphasize what may very well be the single most important inference that can be drawn from this project: The consistent pattern of interrelated variables should dictate the future of projects such as this one. Detoxification by itself will not be sufficient to eradicate the enormous problem now facing law enforcement agencies throughout the country. Detoxification by itself is no panacea. Our data indicate over and over again that drinking behavior, employment, living arrangements, and removal from Skid Row must be approached as a whole--a total problem of the total person that exceeds mere public intoxication. Detoxification is only a first step, one that must be followed by steps to rehabilitate the individual in all major spheres of living and prepare him to return to society as a useful contributor to his own welfare and that of others.

ARREST RECORDS

With the termination of the project scheduled for September 30, 1970, a survey of the official arrest records of the Chicago Police Department was begun on September 10, 1970. All arrests

CONTINUED

1 OF 2

recorded after that date were eliminated from the sample.

As of September 10, 1970, 316 men had been discharged from Operation Outreach. Of these, eight were dropped from the population because of death or duplication of records, leaving a sample of 308. The sample was further reduced by thirteen percent when it was found that 39 men had no record of arrests for drunk and/or disorderly conduct. A sample size of 269 remained. All recorded offenses that did not specifically deal with being "drunk and disorderly in the public way" were discarded (e.g., auto theft, robbery, sexual offenses, etc.) since there was no concrete indications that such offenses were committed under the influence of alcohol, nor could it be certain that such crimes would or would not have been committed irrespective of the individual's drinking behavior.

Regarding preadmission data, the number of arrests ranged from 0 to 290 per person, with a mean of 32.16 arrests per patient. The time intervals between the date of each subject's first recorded arrest and the date of his admission to Operation Outreach ranged from nineteen days to 14,445 days (39.57 years).

Visual examination of raw data indicated that comparison of frequency and number of arrests would not accurately represent the actual situation because of the variance of time intervals. It was therefore determined that the ratio: $PA = \frac{An}{Ta - Tl}$ would be most accurately descriptive, in which An = number of arrests, Tl = date of first recorded arrest, and Ta = date of admission to Operation Outreach. Performing the appropriate calculations would result in a preadmission ratio (PA) showing the number of

arrests per unit time.

Thus, PA's ranged from .0000 to .1583, representing a rate ranging from 0 arrests/per year to 47.778 arrests per year. The mean ratio was .0204, or 7.446 arrest/per year/per patient. Thus, the 269 patients included in the sample accounted for approximately 2,003 arrests/per year, and a grand total of 9,908 arrests.

Regarding postdischarge arrest information, the following formula was used to determine the rearrest ratio (PD):

$$PD = \frac{An}{Tf - Td}$$

in which An = number of arrests, Tf = date of followup arrest survey (September 10, 1970 in all cases), and Td = date of discharge. Again, the resulting figures would indicate the number of arrests per unit time. Using such PA and PD ratios permit the comparison of number of arrests during two non-equivalent time intervals. For both PA and PD the number of arrests per year could be determined by multiplying the ratio by 365 days.

Within the sample of 269 patients, 94 (35 percent) had no recorded postdischarge arrests. The time interval covered during this zero-arrest period ranged from 40 to 385 days after discharge, with a mean of 182.5 days. These 94 patients were among the 171 patients (64 percent of total sample) who showed overall decreases in PD arrest ratios. The range of such decreases was -.0002 to -.1434, representing decreases ranging from -.073 arrests/per year/per patient to -52.341 arrests/per year/per patient. The mean of such decreases was -5.621 arrests/per

year/per patient, for a mean total of -961.191 arrests per year.

Ninety-eight patients (36 percent of the sample) showed postdischarge arrest ratio increases ranging from +.0002 to +.0951. These ratios represent increases from a minimum of +.073 arrests/per year/per patient to a maximum of +34.712 arrests/per year/per patient. The maximum followup interval for this group was 366 days.

Whereas the overall pattern and rate of PD ratios is favorable and can be utilized as an index of success, the Grantee recommends that these data also be viewed with guarded optimism. There are, for example, several variables that could skew the data in a positive direction: Those men with no postdischarge arrests may have left Chicago; the use of aliases could affect the PD ratios; a change in Police Department attitude toward public intoxication could reduce arrests, and all of these variables could contribute additively to distort the facts.

The most important aspect of this project remains, therefore, the recurrent overall pattern referred to as the "improvement syndrome," with its indicators of beneficial change in the general configuration of behavior: reduced drinking, increased employment, and social living arrangements.

PROJECT SUMMARY

Methods and Procedures

Under the conditions of the Special Discretionary Fund for the ten largest cities in the U.S., established by Title I of Public Law 90-351, Chicago's Alcoholic Treatment Center (CATC) was granted \$70,574 from the Law Enforcement Assistance Agency of the U.S. Department of Justice to fund "Operation Outreach," a detoxification, diagnosis, and referral project for the treatment of public inebriates from Chicago's Skid Row area. Intended as a twelve-month pilot project for the establishment of a ten-bed unit within an existing alcoholic-treatment facility, two budget adjustments from LEAA permitted the project to operate for fourteen months.

Four rehabilitated alcoholics and four plainclothed Chicago police officers formed two-man Street Rescue Teams (SRTs) who were specially trained by the CATC staff in paramedical and nurses' aide techniques, psychosocial aspects of alcoholism, the psychodynamics of alcoholism, interviewing and data collection, and related matters, prior to the admission of patients. Additional training and education was ongoing throughout the project. A psychiatric social worker, part-time physician, nurse, rehabilitation representative (Alcoholics Anonymous), relocation counselor (Department of Urban Renewal), and research assistant were hired and, when necessary, appropriately trained to staff the project.

SRTs, nucleus of the pilot project, had three major functions: intake, ongoing inpatient contact, and followup. Operating in an unmarked Police Department vehicle on a twenty-four hour basis, the SRTs worked within the 1st and 12th Police Districts, which encompass the city's major Skid Row area. Publicly intoxicated indigent men were approached on foot, the purpose and nature of the project was explained to them, and if the prospective patient desired treatment and signed the voluntary consent for treatment form, he was transported to CATC. Men who refused care, or those who apparently needed emergency medical and/or psychiatric attention beyond the scope of Outreach were, as appropriate, either left alone, taken home, taken to Cook County Hospital, or remanded to regular police officers for protective custody, all on a voluntary basis. Coercion, arrest, or other involuntary procedures were never utilized.

Appropriate prospective patients transported to CATC were given medical examinations upon arrival and if admitted were bathed, deloused, and put to bed. X-ray, urine and blood analyses, and other lab tests were conducted within twelve hours after admission. Medical detoxification and physical and nutritional care were initiated immediately and modified forms of psychosocial therapies tailored to the patients' needs and capacities were begun as soon as patients were sufficiently healthy to respond and participate. SRTs assisted in medical care, feeding, toileting, clothing, etc., and supplemented the multitherapeutic milieu, all under appropriate supervision and in conjunction with medical and mental health staffs.

Included in the 7-10 days as Operation Outreach patients, was a shift in focus from medical to psychosocial services.

Patients were counseled by social workers, psychologist and/or psychiatrist, rehabilitation representative, occupational counselor, and residential relocation representative, to determine further course of treatment. As appropriate, patients were referred to CATC's rehabilitation program, State hospitals, Community Mental Health Centers, other hospitals, halfway houses, welfare and public aid agencies, and other social and religious agencies such as Salvation Army, Cathedral Shelter, Catholic Charities, Christian Industrial League, etc. SRTs, whose functions were ongoing during treatment, provided transportation to referral agents and conducted followup contacts and visits.

RESULTS

1. Population profile at time of admission. Data shown in the summary below were collected by SRTs and social workers during the admission period and several days thereafter. Patients were the respondents, except for arrest data, which were provided from the records of the Chicago Police Department. Additional data are reported in full in the body of the report.

Number of men contacted	364
Number of men who accepted treatment	343
Average length of stay	10.74 days
Number of patient days	3,683
Men referred to CATC rehabilitation program	24%
Men referred to other agencies	48%
Medical referrals	04%
Men who left before referral could be made	09%
Men who refused all referrals	15%
Average age	45 years
Marital Status:	
Married	04%
Separated	17%
Divorced	38%
Single	30%
Widowed	07%
Unknown	02%
Birthplace:	
Illinois	31%
Out-of-State	69%
Religious Affiliation:	
Protestant (all denominations)	53%
Roman Catholic	42%
Other	05%
Average education	10.35 years
Occupation:	
Unskilled	52%
Semiskilled	22%
Skilled	18%
Professional, technical, proprietors, and kindred	03%
Clerical, sales, and kindred	03%

Employment:

Marginally employed at admission	02%
Unemployed at admission	94%
Unknown	04%
Average time lived on Skid Row	4.66 years
Average number of arrests on charges associated with drinking behavior prior to admission	36.33 per patient

Notes:

- (1) Percentages may deviate from 100 due to rounding.
- (2) The above data represents the patient population admitted during the period August 18, 1969 through September 30, 1970.

2. Postdischarge followup information. Of the 343 patients admitted to the project, followup information was collected by the SRTs for 274 men (79.9%). The followup intervals ranged from 120 days to 390 days or more. Additional data are available in the body of the report, but a summary of some typical major findings are listed below.

A. Source of followup information:

Patients	42.3%	Referral agencies	30.7%
Patients' families	4.0%	Miscellaneous sources	2.2%
Patients' friends	20.8%		

B. Patients keeping referral appointments 52.2%

C. Patients seeking additional voluntary care 66.4%

D. Drinking behavior:

Total abstention	13.5%	Unchanged drinking	28.9%
Reduced drinking	54.6%	Increased drinking	2.9%

E. Employment:

Unemployed	14.2%	Day labor	51.8%
Regular, full-time employment			17.9%
Irregular or part-time employment other than day labor			16.1%

F. Living Arrangements:

Living alone	50.0%	Living at agency	20.0%
Living with family	10.2%	Living with friends	2.9%
No information	8.8%	Other arrangements	8.0%
Returned to Skid Row	55.8%	No return to Skid Row	43.4%
No information	0.7%		

Extensive correlational analyses and chi-square tests revealed a consistent and highly significant ($p < .05 < .001$) pattern of reduced drinking accompanied by improved employment status, social rather than solitary living arrangements, and remaining out of the Skid Row area. Recognizing the questionable validity and reliability of the followup data, the Grantee's major conclusion is that detoxification without integration in a continuous network of aftercare is futile, and a total rehabilitation effort must focus on the three inter-related areas of behavior: drinking, employment, and living arrangements.

Preadmission and postdischarge arrest records were checked and collated by the Chicago Police Department for 316 patients. Deaths, duplication, and absence of official records reduced the final sample to 269. Preadmission (PA) and postdischarge (PD) arrest ratios were formulated by dividing the number of relevant arrests by the time

interval between a patient's first recorded arrest and his date of admission (PA), or by the time interval between the day of his discharge and September 10, 1970 (PD). Both ratios can be multiplied by 365 to arrive at the number of arrests per year (interpolated or extrapolated).

PA ratios showed arrest rates ranging from 0/per year/per patient to 47.778 arrests/per year/per patient, and the PA intervals ranged from 19 days to 14,445 days. The mean PA rate was 7.446 arrests/per year/per patient.

PD ratios showed both increases and decreases over PA ratios. These data for 269 patients are summarized below, and additional information is discussed in the body of the report.

- | | |
|--|----------------|
| 1. Patients with PD arrest decreases | 64% * |
| 2. Followup interval for patients with no PD arrests | 40-385 days |
| 3. Range of PD arrest decreases per year/per patient | -.073 - -52.31 |
| 4. Mean PD decrease per year/per patient | -5.62 |
| 5. Patients with PD arrest increases | 36% |
| 6. Range of PD arrest increases per year/per patient | +.073 - +34.71 |
| 7. Followup interval for patients with PD arrest increases | 40-366 days |

* 35% of this group had no PD arrests

The Grantee has concluded that: (1) rehabilitated alcoholics who are appropriately selected, properly trained, and adequately supervised function well in this sort of program; (2) police and health agencies should cooperate fully for optimal effectiveness; (3) for best results, staffing should be complete and comprehensive before beginning such a project; (4) data must be viewed with guarded optimism as validity is not unquestionable; (5) overall pattern and rate of postdischarge arrest data is favorable; (6) a major constellation emerged to indicate that such programs must focus on three major life areas that are consistently related: reduction of drinking, improved employment status, and social living arrangements away from the Skid Row area.

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END

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