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ORIGINS, TREATMENT AND DESTINY OF SKID-ROW ALCOHOLIC MEN*

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This paper reports a ten-year-follow-up study of a group of indigent alcoholic men. In 1950 we established a work-oriented halfway-house program for their rehabilitation at the Boston Long Island Hospital.[1] In 1956 we evaluated 101 patients who had volunteered for this program four years previously.[2] In 1962 we re-evaluated this treatment group. For comparison, we made an extensive record search not only of these 101 patients but of an additional 108 skid-row alcoholics who entered the Hospital in 1952 but who, for one reason or another, never applied for the halfway-house treatment program. This record search consisted of gathering data from probation records, hospital records from Boston City and Massachusetts General hospital, death records and State Hospital records. In addition, we collected the social-service indexes not only of these 101 treatment and 108 comparison patients but also of their parents, wives and children, if any. Each social-service index recorded the patient's and his family's contacts with various social service agencies, such as public welfare, society for the prevention of cruelty to children and division of child guardianship and various treatment agencies. These data enabled us to obtain a 2-generation and, in some cases, a 3-generation, picture of these skid-row alcoholic men.

In this paper we shall first briefly set forth the program and then describe the background of these two groups, with particular attention to similarities and differences in their origins,

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1. D. J. Myerson, *Approach to "Skid Row" Problem in Boston,* 249 NEW ENG. J. MED. 646-649 (1953).

2. D. J. Myerson, *"Skid Row" Problem: Further Observations on Group of Alcoholic Patients, with Emphasis on Inter-personal Relations and Therapeutic Approach,* 254 NEW ENG. J. MED. 1168-1173 (1956).

marriages, work adjustment and police records. We shall then present in detail the outcome of the treatment group from 1952 to 1962. Finally, we shall discuss the treatment program, offering recommendations for broader and more preventive treatment programs.

THE PROGRAM

For many years Boston Long Island Hospital has served the needs of the city's indigent and homeless. In addition to serving patients with chronic illnesses such as arthritis and cardiac disturbances, it is one of the few hospitals to offer institutional care for the skid-row man. The Hospital has maintained a 300-bed dormitory to which the alcoholic man may come, withdraw from alcohol, stay as long as he wishes and leave at any time. In 1950 we converted one ward of the dormitory into a "halfway-house." Men who volunteered for the halfway-house program worked during the day in the city, spent nights in the ward and used weekends to re-establish family relations if any existed. To help control their drinking, they were required to take disulfiram (Antabuse) daily. They could turn to the professional staff for individual help, but for the most part the program centered about the following points: control of drinking; value of work as a means of re-establishing themselves in the community and giving them a sense of worth; and acceptance of the men by the staff and the part acceptance played in molding the ward into a structured, partially protected community.

The 101 men in the treatment group consecutively volunteered for the halfway-house program. The 108 in the comparison group were admitted to the same alcoholism section of the Hospital during the same period but did not volunteer for the halfway-house program. They knew of the program but for a variety of reasons did not choose to accept help in the manner offered. All the men in the comparison group entered the Hospital two or more times over the subsequent years, although they never entered the halfway-house program. Although obviously differing from the treatment group in motivation, both groups were similar so far as the men all entered the alcoholism section of a metropolitan hospital for the homeless and indigent for the primary purpose of detoxification.

Personal and Social Background

Both groups were similar in age, place of birth, national origin and socioeconomic position. The men ranged in age from their late twenties to their early sixties, with a median age of forty-six. The majority (53.5 per cent) were in their forties, and 29.7 per cent in their fifties. All but 4.8 per cent were native-born Americans, with 77.0 per cent Boston born. A small number (13.4 per cent) were born outside Boston but within Massachusetts, and only 4.8 per cent came from other parts of the United States.

Information on religion and education was available only for the treatment group. In this group of 101 men 88.1 per cent were Catholic, and 11.9 per cent Protestant. Only 1 man was Negro. Educationally, more than half the men (51.4 per cent) had less than twelve years of schooling. The educational level ranged from a few years of grade school to completion of college, with a median educational level of ten years.

The social-service index was used as an indication of the patient's and his family's socioeconomic position, community dependency and degree of family disruption. Table 1 shows the frequency of the patients' contacts with a community-agency, most often with public-welfare agencies and agencies that care for the destitute and those from broken homes. The families of both groups thus showed a high degree of poverty and family disruption. It is noteworthy that the families of the comparison group showed significantly more frequent agency contacts than the families of the treatment group. In addition, although both

Table 1. *Treatment and Comparison Groups in Relation to Frequency of Parents' Social-Service Index Contacts.*

NO. OF CONTACTS	TREATMENT GROUP		COMPARISON GROUP		TOTALS	
	Number	Percentage	Number	Percentage	Number	Percentage
Frequent (0.40+)*	21	20.8	26	24.3	47	22.6
Moderate (0.20-0.39)*	24	23.8	22	20.6	46	22.1
Infrequent (0.01-0.19)*	15	14.9	31	29.0	46	22.1
None	41	40.6	28	26.1	69	33.2
Totals	101		107†		208†	

Chi square $= 8.47$, $df = 3$, $p < 0.05$.

* No. of contacts/no. of yr. between 1st & last contacts.

† Unknowns reduce totals.

groups came from larger than average families, the groups differed significantly in the size of their original families. The median number of siblings was 4 in the treatment and 6 in the comparison group (chi square of 11.90, df of 3, p less than 0.01).

Table 2 indicates the frequency of the patients' social-service-index contacts. Only 17.2 per cent of the men were unknown to the various agencies that reported their contacts to the social-service index. In other words, when these men married they created families that, like their own, were supported by the community. It is interesting that the 114 men from both groups who married (54.5 per cent) sired 336 children, 73 (18.9 per cent) of whom are already recorded by the social-service index.

At the time of admission all the men had separated either from their original families or, if they had married, from their wives. The treatment group showed a higher marriage rate than the comparison group: 61.6 per cent of the former and 48.1 per cent of the latter had been married (chi square of 3.48, df of 1, p less than 0.10).

A most important and significant difference between the treatment and comparison groups occurred in their occupational distribution. At the time of admission to the Hospital those who were working (most of them sporadically) were working in the lowest-grade jobs. Table 3, however, is based on the highest occupational level the men had ever achieved. Of the treatment group 68.3 per cent were at least semiskilled workers whereas only 39.8 per cent of the comparison group achieved a work skill. It is clear, then, that a work-oriented treatment program might well be more attractive to the men who had work skills than to those who did not.

DRINKING HISTORY

Probation and hospital records revealed the seriousness of their drinking. Of the total group at least 93.3 per cent had been arrested 1 or more times and at least 65.1 per cent had been arrested before the age of twenty-five for drinking and other offenses.

Tables 4 and 5 show the number and frequency of arrests. At least 55.5 per cent of the men had more than 25 arrests, and at least 65.0 per cent averaged more than 1 arrest every two years from the beginning of adolescence to admission to the Hospital.

TABLE 2. *Treatment and Comparison Groups in Relation to Frequency of Patient's Social-Service Index Contacts.*

NO. OF CONTACTS	TREATMENT GROUP		COMPARISON GROUP		TOTALS	
	Number	Per-centage	Number	Per-centage	Number	Per-centage
Frequent (0.45+)*	28	27.7	28	25.9	56	26.8
Moderate (0.20-0.44)	30	29.7	37	34.3	67	32.1
Infrequent (0.01-0.19)	25	24.8	25	23.1	50	23.9
None	18	17.8	18	16.7	36	17.2
Totals	101		108		209	

* No. of contacts/no. yr. between 1st & last contacts.

The treatment and comparison groups did not differ significantly in the number and frequency of their arrests.

The records of the Boston City and Massachusets General hospitals, the 2 largest hospitals in the City, were checked for the years 1952-1962. These records revealed that 43.5 per cent of the comparison group and 31.7 per cent of the treatment group were admitted at least once with the diagnosis of acute alcoholism. In addition, many were admitted for other medical emergencies, as well as for cirrhosis of the liver, tuberculosis and infections.

Police and hospital records confirmed our clinical observations of these men; drinking began early in their lives and continued for many decades. It was not infrequent to find that the men were still being arrested at the age of seventy.

For the married men, nonsupport charges were added to the many charges for drunkenness. The jail sentences for nonsupport were longer than those for the charge of drunkenness, and during this period in jail, their marriages, tenuous at best, were often finally dissolved. Of the men in the treatment group 49 of the 62 who were married became inhabitants of the skid-row community when their wives left them.

Of the total group, only 17.6 per cent were known to have been admitted to mental hospitals before admission to the Long Island Hospital. The most frequent mental-hospital diagnosis was acute alcoholism. This relatively small percentage of mental hospital admissions, in contrast to the 93.3 per cent with known arrest records, indicated that the community managed the chronic drunkenness through police action rather than through psychiatric methods.

TABLE 3. *Treatment and Comparison Groups in Relation to Highest Occupational Level Achieved.*

OCCUPATIONAL LEVEL	TREATMENT GROUP		COMPARISON GROUP		TOTALS	
	Number	Per-centage	Number	Per-centage	Number	Per-centage
Professional, clerical or skilled	33	32.7	13	13.0	46	22.9
Semiskilled	36	35.6	30	30.0	66	32.8
Unskilled	32	31.7	57	57.0	89	44.3
Totals	101		100*		201*	

Chi square = 16.26. df = 2. $p < 0.001$.

* Unknowns reduce totals.

TABLE 4. *Treatment and Comparison Groups in Relation to Number of Arrests before Admission to the Hospital.*

NO. OF ARRESTS	TREATMENT GROUP		COMPARISON GROUP		TOTALS	
	Number	Per-centage	Number	Per-centage	Number	Per-centage
None	11	10.9	3	2.8	14	6.7
1-24	35	34.7	44	40.7	79	37.8
25-49	25	24.8	27	25.0	52	24.9
50-74	18	17.8	18	16.7	36	17.2
75-100	5	5.0	10	9.3	15	7.2
> 100	7	6.9	6	5.6	13	6.2
Totals	101		108		209	

DESTINY OF THE TREATMENT GROUP

Three important criteria characterize the skid-row alcoholic man: the severity of his alcoholism; his social isolation; and his dependency upon the community for his subsistence and even existence. Without exception, all the men in the treatment group had severe alcoholism, as indicated by the lack of control of drinking, the variety of physical stigmas and the extreme degree of social disintegration. We emphasize these three distinguishing characteristics of the skid-row alcoholic man because they offer criteria by which we can determine the fate of the various members of this treatment group. For purposes of evaluation we have separated the men into the following categories:

Successful rehabilitation refers to a man who lives, for the most part, a sober life, works steadily and restores meaningful family relations. Even if such a man drinks occasionally, as long as his family cares for him during the episode and he is able to

return to work, he represents a complete recovery. It is important to emphasize the point that sobriety by itself is not a necessary ingredient. We do not consider the treatment a success if a man is sober but remains institutionalized. For recovery, he has to be a working member of the community and live as a member of a family. Only then has he given up his isolation and dependency upon the community. In no known case did any man who lived alone remain sober.

TABLE 5. *Treatment and Comparison Groups in Relation to Frequency of Arrests before Admission to the Hospital.*

ARRESTS	TREATMENT GROUP		COMPARISON GROUP		TOTALS	
	Number	Per-centage	Number	Per-centage	Number	Per-centage
Frequent (1.40+)*	28	27.7	41	38.0	69	33.0
Moderate (0.50-1.39)	39	38.6	28	25.9	67	32.0
Infrequent (0.01-0.49)	23	22.8	36	33.3	59	28.2
None	11	10.9	3	2.8	14	6.7
Totals	101		108		209	

* No. of total arrests/no. of yr. between age 12 & admission.

Partial success refers to improvement in drinking and working patterns, but failure in ability to maintain family relations and to renounce dependency upon the community resources. The model of such improvement is the man who achieves sobriety for months but works steadily only as long as he resides within the structured hospital community. He neither succeeds in his attempts to live in the city nor demonstrates ability to establish a sustained relation with family members. When he tries to live in the city he lives alone, sooner or later becomes depressed and returns to his prior drinking way of life. Typically, he then goes back to the hospital for another six to twelve months. Only during this period does he return to productiveness and sobriety, which are dependent upon his stay within the hospital community. We consider the results a partial success if such a pattern can be observed over this ten-year span.

Failure is indicated when a man volunteers for this program any number of times but can neither work, overcome his isolation nor attain any degree of sobriety. The treatment is considered a failure even if he achieves a long period of sobriety but gives no evidence of self-sufficiency. In the men who demonstrate improvement during the first few years of the program

but return to their drinking way of life during the last few years the results are deemed failures. On the other hand, in the men who begin as failures but show improvement in recent years, the results are considered partially successful or successful.

Twenty men died before 1962, and we classified them in terms of adjustment up to the time of their death. Of the original 101 men in the treatment group we lost complete contact with 1. Of the remaining 100 men we considered 22 (22 per cent) successfully rehabilitated. They maintained significant improvement, not only in terms of their drinking but also in their work habits and family reintegration. These men did not drink, or a few of them only drank sporadically. They found jobs and maintained work over the years. They either returned to various family members or married, had children and founded new families (2 men).

Twenty-four men (24 per cent) in whom we called the results "partially successful" improved as far as their drinking and work habits were concerned. In varying degrees, however, they sustained this improvement only as long as they remained in contact with the hospital. They never managed to establish permanent family ties; therefore, they were considered to have attained only partially successful adjustment over the years.

The failure group of 54 men (54 per cent) represented the majority. Not all continued their drinking. Ten men "retired" to the hospital. They never drank, but they never worked and their contacts with family members were at a minimum. One man was serving a long sentence for murder, and 2 men were patients in State chronic-disease hospitals. Many of the rest continued to try the program sporadically but could not seem to work for more than two or three months a year, at best.

The differences that occurred among the successful, partially successful and failure groups were similar to the differences that appeared between the treatment and comparison groups. Table 6 indicates that 90.9 per cent of the men with successful results had been married whereas only 54.1 per cent of those with partial successes and 52.8 per cent of those considered failures had ever been married. Although the age, educational and occupational differences between the groups were not statistically significant the directions of the tables indicated that the men with

results considered successes and partial successes were younger, more highly educated and more occupationally skilled.

Table 7 shows that the successes occurred in men who came from families that were least dependent upon the community, and these patients, in turn became least dependent upon the community. Apparently in association with this dependency independency upon the community, Table 8 indicates that the successes were less involved with the police. They were arrested and jailed less frequently.

A picture of the men in the Hospital and in the treatment program emerges. Those who came from the most educated, occupationally skilled backgrounds and from more self-sufficient families, and who were able to get married, entered the treatment program. Of these men, those who ranked highest on these same characteristics had the greatest potential for rehabilitation.

RECOMMENDATIONS

This ten-year study of a group of skid-row alcoholic men from the Boston Long Island Hospital reveals that the vast majority of the patients were native-born Bostonians. Feeney et al.,[3] Jackson and Connor[4] and Pitman and Gordon[5] have described similar groups from other large cities. In this Boston group 70 per cent came from families that in varying degrees knew poverty, had been dependent on public welfare for support, and were served by diverse social-service agencies, indicating family disruption and inability to care for the children. As a group, then, these patients came from families in which the parents were unable to support the children, usually because of the father's alcoholism. Men, much like the fathers of the men in this study, have been described in earlier studies by Moore and Gray[6] and Stearns and Ullman.[7] These families, like those in the present study, were

3. F. E. Feeney, D. F. Mindlin, V. H. Minear, & E. E. Short, *The Challenge of the Skid Row Alcoholic: Social, Psychological and Psychiatric Comparison of Chronically Jailed Alcoholics and Cooperative Alcoholic Clinic Patients,* 16 Q. J. STUDIES ON ALCOHOL 654-667 (1955).

4. J. K. Jackson & R. Connor, *Skid-Row Alcoholic,* 14 Q. J. STUDIES ON ALCOHOL 468-486 (1953).

5. D. J. PITMAN & C. W. GORDON, THE REVOLVING DOOR: A STUDY OF THE CHRONIC POLICE INEBRIATE (1958).

6. M. Moore & M. G. Gray, *Alcoholism at Boston City Hospital,* 221 NEW ENG. J. MED. 45-49 (1939).

7. A. W. Stearns & A. D. Ullman, *One Thousand Unsuccessful Careers,* 105 AM. J. PSYCHIATRY 801-810 (1949).

TABLE 6. *Success in Treatment Program in Relation to Age, Education, Marital Status Achieved and Highest Occupational Level Achieved.*

CRITERION	SUCCESS		PARTIAL SUCCESS		FAILURE		TOTALS		CHI-SQUARE VALUE
	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.	
Age:									
< 40 yr.	5	22.7	2	8.3	8	14.8	15	15.0	
40-49 yr.	13	59.0	15	62.5	34	62.9	62	62.0	
50 + yr.	4	18.1	7	29.1	12	22.2	23	23.0	2.286†
Totals	22		24		54		100		
Education:									
< 8 yr.	7	33.3	6	27.2	19	35.8	32	33.3	
9-11 yr.	2	9.5	4	18.1	13	24.5	19	19.7	
12 + yr.	12*	57.1	12*	54.5	21*	39.6	45*	46.9	3.497†
Totals	21		22		53		96		
Marital Status:									
Never mar.	2	9.0	11	45.8	25	47.1	38	38.3	
Ever mar.	20	90.9	13	54.1	28*	52.8	61*	61.6	12.762‡
Totals	22		24		53		99		
Occupation:									
Skilled	8	36.3	9	37.5	16	29.6	33	33.0	
Semiskilled	9	40.9	10	41.6	16	29.6	35	35.0	
Unskilled	5	22.7	5	20.8	22	40.7	32	32.0	4.154†
Totals	22		24		54		100		

* Unknowns reduce totals.
† $p > 0.10$
‡ $Df = 2$, $p < 0.01$.

stricken with recurring crises in which various community agencies played an important part, aiding either through financial support or by investigating whether or not the parents were able to continue to care for their children.

By the time they reached adolescence the records of the men under study clearly indicated failure of adjustment as self-sufficient citizens. With a small number of important exceptions—these men did not develop work skills. Instead, at adolescence they began their careers of drinking and arrests. Many came into contact with the police and the courts for delinquent acts in adolescence, and by the time they reached their twenties, the records showed frequent arrests for drinking, which continued off and on for the rest of their lives. Their extensive arrest records indicated how the police and court officers became central figures in their lives.

TABLE 7. *Success in Treatment Program in Relation to Frequency of Parents' Social-Service Index Contacts, Frequency of Parents' Welfare-Agency Contacts, and Frequency of Patients' Social-Service Index Contacts.*

CRITERION	SUCCESS		PARTIAL SUCCESS		FAILURE		TOTALS		CHI-SQUARE VALUE
	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.	
Parents' Social-service index contacts:									
Frequent (0.40+)*	5	22.7	5	20.8	11	20.4	21	21.0	
Moderate (0.20-0.39)	3	13.6	5	20.8	16	29.6	24	24.0	
Infrequent (0.01-0.19)	1	4.5	3	12.5	10	18.5	14	14.0	
None	13	59.1	11	45.8	17	31.5	41	41.0	
Totals	22		24		54		100		7.177†
Parents' Welfare-agency contacts:									
Frequent (0.25+)*	3	13.6	8	33.3	9	16.6	20	20.0	
Moderate (0.10-0.24)	3	13.6	0	0.0	17	31.5	20	20.0	
Infrequent (0.01-0.10)	3	13.6	4	16.6	9	16.6	16	16.0	
None	13	59.0	12	50.0	19	35.2	44	44.0	
Totals	22		24		54		100		13.844‡
Patients' soc.-ser. index contacts:									
Frequent (0.45+)*	5	22.7	2	8.3	21	38.8	28	28.0	
Moderate (0.20-0.44)	6	27.3	9	37.5	15	27.7	30	30.0	
Infrequent (0.01-0.19)	5	22.7	6	25.0	14	25.9	25	25.0	
None	6	27.3	7	29.1	4	7.4	17	17.0	
Totals	22		24		54		100		13.064£

* No. of contacts/no. of yr. between 1st & last contact.
† $p > 0.10$.
‡ $Df = 6$, $p < 0.05$.
£ $Df = 6$, $p < 0.10$.

About 50 per cent of the group married. Their inability to provide for their families forced the wives to turn frequently to public welfare for assistance. In general, the more children they had, the more agencies were involved. Judging from the social-service indexes, those who married usually chose women from similar poorly organized families. These women were unable to turn to their own families for assistance when their husbands failed to support them. To gain financial support, they often brought warrants against their husbands on the grounds of

TABLE 8. *Success in Treatment Program in Relation to Number and Frequency of Arrests.*

ARREST HISTORY	SUCCESS		PARTIAL SUCCESS		FAILURE		TOTALS		CHI-SQUARE VALUE
	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.	
No. of arrest:									
0	2	9.0	2	8.3	1	2.0	5	5.3	
1-24	12	54.5	6	25.0	17	35.4	35	37.2	
25-49	3	13.6	11	45.8	10	20.8	24	25.5	
50-74	5	22.7	2	8.3	11	22.9	18	19.1	
75-99	0	0.0	3	12.5	2	4.1	5	5.3	
100+	0	0.0	0	0.0	7	14.5	7	7.4	
Totals	22		24		48†		94†		22.709‡
Frequency of arrests:									
Frequent (1.40+)*	3	13.6	6	27.2	19	39.5	28	30.4	
Moderate (0.50-1.39)	9	40.9	10	45.4	19	39.5	38	41.3	
Infrequent (0.01-0.49)	8	36.3	5	22.7	10	20.8	23	25.0	
None	2	9.0	1†	4.5	0†	0.0	3†	3.2	
Totals	22		22		48		92		11.336£

* No. of contacts/no. of yr. between 1st & last contact.
† Unknowns reduce totals.
‡ Df = 10, $p < 0.02$.
£ Df = 6, $p < 0.10$.

nonsupport. In this way, the law-enforcement agencies controlled the fathers by jailing them, and the welfare agencies supported the wives and children. The women with many children had the most difficult time and often became mentally or physically ill, drank heavily themselves and were unable to provide adequate care for their children. Under these circum-

stances, other agencies, such as the society for the prevention of cruelty to children and the division of child guardianship, entered the picture, broke up the family and helped care for the children with whatever social facilities were available.

Often, it was this incarceration for nonsupport that precipitated the final dissolution of the failing family. When the men were released from jail, they usually lived the skid-row way of life. By the time they had reached their forties, they sought out various hospital institutions, such as the Boston Long Island Hospital, to live a partially institutionalized life. When they were acutely ill, injured or suffering from delirium tremens, they were brought, often by the police, to the large metropolitan hospitals. By their fifties, a number had died, and many others had accepted institutionalization with only an occasional excursion to the city.

Those who, in a sense, accepted their dependency on the institution became less dependent upon other community facilities. The treatment group spent twice as much time living at the hospital as the comparison group. Our records further indicated that the treatment group had significantly less contact with other community agencies than the comparison group, fewer and less frequent arrests and fewer hospitalizations for acute alcoholism.

In this study there were exceptional men who did learn work skills in their late adolescence. These men completed more schooling and had at one time worked as welders, electricians, machinists, fish cutters and the like. Over the years their skills became submerged in their drinking way of life.

The same men, those with results considered successes and partial successes, came from families less dependent upon the community, and they themselves, in turn, became less dependent upon the community. More of this group were able to marry, and their drinking did not lead to as many arrests or incarcerations. Under the protection and encouragement of the halfway-house treatment program, the men who possessed the greater education and work skills and who attained a more stable social, and familial level of functioning were those who constituted the successes. The value of the treatment program was to offer men who, at one time, were able to care for themselves another chance to do so. Those who were never able to achieve adequate school-

ing or training, and who never achieved sufficiently stable functioning, did not shift from the aimless and helpless skid-row way of life.

The following conclusions and suggestions for further therapeutic attempts are warranted. There should be greater coordination between existing alcoholism clinics, welfare agencies, social-service agencies and the police. As Jackson and Connor point out, and as this study verifies, the skid-row alcoholic patient is not necessarily an irretrievable derelict. Programs such as the one in the present study, and that presented by Fox,[8] for example, are beneficial in rehabilitating the middle-aged skid-row man.

Even though such rehabilitation programs are useful, a coordinated therapeutic approach should exist earlier in the lives of these men. This longitudinal survey of their life patterns reveals several opportunities for earlier treatment, but only with a co-operative effort of community agencies. For example, the police and the court officer who come into first contact with youthful alcoholic patients must recognize the grave prognosis for many of them. Any young man or woman who has 3 or more arrests for drinking within a given year should be referred to an alcoholism clinic. A certain number of these patients can be best treated on a voluntary basis, but for many, the extra control afforded by a probation officer is a useful adjunct to the treatment program. Many youthful alcoholic patients from disrupted families are willing to accept this control provided it has a therapeutic aim.

Another critical time for therapeutic intervention occurs when the alcoholic male is arrested for non-support. Under this circumstance the entire family is so seriously incapacitated that at least several community agencies become involved. Although the community has for many years assumed responsibility for the prevention of starvation and gross physical neglect of the children, it is also feasible to offer therapeutic services. Co-ordinating the efforts of the various community agencies and offering appropriate counseling or psychotherapy can go a long way toward improving the emotional status of the family and preventing the serious effects of potential family disruptions.

8. A. D. Fox, Day Patient Hospital for Alcoholics 28-33 (North American Association on Alcolholism Programs, Selected Papers, 1963).

In its totality this problem is not solely a psychiatric or even a public-health one, but one for the community at large. In general, these men come from a group whose lives are so poorly organized in childhood that they ultimately end up totally unprepared for life as it exists in contemporary society. Their lack of work skills indicates this failure. Perhaps one can never prevent alcoholism, but at least he can minimize its social effects by developing a more meaningful educational system specifically designed for this group of youngsters from the lower socioeconomic groups. Above and beyond the dual educational goals, schools should be oriented specifically toward the development of adequate work habits and skills designed to help these youngsters to develop as more self-sufficient citizens. The schools are the only organization that can reach large numbers of these children and provide the necessary supports that they do not receive from their disorganized parents.

There are many encouraging signs that individual communities are increasingly aware of the problem and are making plans for school programs designed to meet the complicated needs of children from these deprived groups in society. The hope is that such a reorientation in schools, as it is applied effectively over the coming years, may help decrease the large numbers of poorly prepared citizens who become dependent upon the community.

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