FIRST

ANNUAL REPORT

OF THE

MANHATTAN BOWERY PROJECT

April, 1969

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ACKNOWLEDGEMENT

The Manhattan Bowery Project is the result of efforts by a large number of public and private agencies. Overall direction of the Project is provided by Mayor John V. Lindsay's Criminal Justice Coordinating Council and the Trustees of the Manhattan Bowery Corporation. The Council has instituted a Committee to coordinate the efforts of the Manhattan Bowery Project; members of the Committee are key persons at Project-supporting agencies. R. Palmer Baker, Jr., is chairman of both the Corporation and the Council Committee.

The staff of the Manhattan Bowery Project on the occasion of its first Annual Report wishes to acknowledge the unstinting support and assistance of these supervisory boards, the agencies represented by the members, and all of the following agencies and departments. The men and women who staff these organizations have extended themselves far beyond the normal requirements of duty to assure that the Project opened promptly and functioned smoothly.

The Office of Law Enforcement Assistance of the United States Department of Justice.

The New York State Department of Mental Hygiene

The New York State Department of Social Services

The Mayor of the City of New York

The New York City Bureau of the Budget

The New York City Community Mental Health Board

The New York City Department of Correction

The New York City Department of Hospitals

The New York City Department of Public Works

The New York City Department of Social Services

The New York City Health Services Administration

The New York City Police Department

The Corporation Counsel of the City of New York

St. Vincen't Hospital

The New York City Criminal Justice Coordinating Council

The Ford Foundation

The Urban Corps

The Vera Institute of Justice

The Women's Talent Corps

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INTRODUCTION

Skid Row and its alcoholic men have long been a subject of both curiosity and contempt in American society. Myths abound on the carefree, companionable life of "winos and bums." The fact is, of course, that most alcoholics on Skid Row are sick, desperate people, who, unable to function in the normal workaday world, have retreated to a marginal life in run-down sections of our cities.

This report is about change on Skid Row. There occurred, first of all, a change in the attitude of New York City towards its Skid Row population. Out of that changed attitude has come a medical program of alcohol detoxification for men of the Bowery, New York's largest Skid Row. This program is known as the Manhattan Bowery Project.

The first section of this report describes the Bowery and its men. The report then describes the process by which this new program came into existence, and the results of its first year of operation. In conclusion, this report considers whether the experiences of the Manhattan Bowery Project can be duplicated elsewhere.

THE BOWERY - THE PROBLEM

The Bowery is a broad, heavily travelled avenue in New York City. It extends north from Chatham Square in Chinatown to the Cooper Union Building, a distance of about one mile. Once the principal highway out of Dutch New Amsterdam to the farms (Bouweries) of mid-Manhattan, the Bowery is now a main access route to the Brooklyn Bridge. The avenue is lined with dark, shabby bars, second-hand clothing stores, decaying commercial buildings, and the outposts of religious organizations. The lofts of the commercial buildings are called "Commercial Lodging Houses" by the City's building code, and "flops" by the Bowery's residents.

And it is, of course, for its residents that the Bowery is known. On any reasonably mild day, numbers of dirty, disheveled men, some bearded, others bruised or on crutches, can be seen shuffling along, sitting on curbs or leaning against buildings. Typically, perhaps ten or fifteen men lie prone or slumped in doorways and on the sidewalks. In front of the New York City Men's Shelter, a six-storied dark brick building on East Third Street just off the Bowery, small groups of men gather and occasionally pass wine bottles to each other.

On an average winter's night, about five thousand men can be found sleeping in the Bowery's flop-houses, in doorways, or

on the street[1]. Sociologists refer to these men as "homeless"; in other words, they are adults without substantial ties to families, to permanent jobs, or to any religious, professional, military, political or other social organization[2]. They are men with little or no money or property. Even their clothes are sold off in warm weather or at times of financial hardship. Many, although by no means all, Bowery men are seriously debilitated alcoholics.

Most Bowery men face periodic health crises. Major illnesses and injuries of an obvious nature are treated in the City's municipal hospitals. Less acute ailments, such as dental and eye problems and skin infections, mainly go untreated. Bowery men are too disorganized, and too sensitive to community hostility, to endure the endless waits and frustrating referrals of the City's municipal health clinics; moreover, clinic personnel tend to be hostile to alcoholics. Virtually no Bowery men patronize private physicians.

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(1) See Bahr, Homelessness and Disaffiliation, Columbia University Bureau of Applied Social Research, 1968, p. 43. According to Bahr, the Bowery population has been declining at the rate of 500 men a year since 1963. Whether this trend will continue is unknown.

(2) See Bahr, op. cit, pp. 19-27.

By far the most acute medical need of the alcoholic Bowery man is for periodic "drying out" or detoxification. A characteristic phenomenon of advanced alcoholism is the drinking binge which culminates in the alcoholic being seriously malnourished, filthy, unable to care for himself, and in danger of death due to liver or brain damage. While drunk he may fall, or wander into the path of an automobile. If he is not to die, the man must be "detoxified"--i.e. he must stop drinking long enough for his body to eliminate all traces of alcohol and to restore itself to a reasonably normal functional level. Detoxification from a serious bender usually requires five days. Full restoration of body functions may take weeks or months. Some liver and brain damage may be irreversible. Paradoxically, cessation of drinking may bring on symptoms as unbearable as those produced by the drinking itself--severe agitation, accompanied by tremors, nausea, anxiety, hallucinations, convulsions, and, in extreme cases, death. Few alcoholics can endure severe alcohol withdrawl in an environment where alcohol is available. Medical assistance is necessary to mitigate severe withdrawl symptoms. Untreated Delirium Tremens, for instance, has a 20% mortality rate(3).

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(3) Cecil and Loeb, Textbook of Medicine (12th Edition, Philadelphia, 1967), p. 1502.

Despite the extreme disapproval with which society regards alcoholism, an alcoholic with means and/or social roots can usually find a place to dry out--a rest home, a proprietary hospital, a relative's or friend's house. A private physician albeit frequently with ill-concealed irritation, will provide medical assistance. The homeless alcoholic has no such resources. He continues to drink, and in advanced stages of his binge he drinks and deteriorates on the street for all to see.

The Skid Row alcoholic presents serious problems, not only to himself, but also to the people who live and work in the surrounding neighborhoods. Although overt violence by Bowery men against outsiders is rare, they do rob and attack each other, especially on "check days"--those days when Social Security and other pension and benefit checks arrive. Destitute alcoholics also harass the community in countless small ways. They panhandle. They lie semi-dressed in doorways and on sidewalks, where they obstruct passersby. They wander into traffic. They carry vermin and communicable diseases such as tuberculosis, influenza, and pneumonia. They urinate and vomit in the street. Left unchecked, they are a source of constant irritation, as well as a health menace, to their neighbors.

In contrast to many other cities in this country, New

York maintains a number of programs for its destitute, homeless alcoholics. At the Men's Shelter on East Third Street, the City's Department of Social Services provides meals and issues lodging house tickets to the Bowery men. The Department also runs an outpatient counselling treatment service known as Operation Bowery, and an institutional home in upstate New York called Camp LaGuardia. Until the start of the Manhattan Bowery Project in 1967, the City did not, however, sponsor any medically-oriented system for removing drunken men from the street and there was no program of medical detoxification.

Theoretically, seriously debilitated and semi-conscious men could be transported by ambulance to a hospital, but only in the most critical cases would a man suffering solely from acute alcoholism be admitted to a New York City hospital. The hospitals' refusal to detoxify alcoholics is due in part to the discouragingly chronic nature of alcoholism; a filthy, malnourished man if admitted, sobered up, and nursed back to health is reasonable certain to resume drinking shortly after he is discharged. This attitude is also due to the fact that medical authorities share, to some extent, the general scorn with which most persons regard alcoholics. Whatever the reason, the result is that scarce hospital beds are generally allocated to "more needy" cases.

Since community values will not allow these men to drink themselves to death in full public view on the street, and since community sensibilities are constantly irritated by their presence, the police are called on as the last resort to "get the bums out of the neighborhood."

In New York City, the practice has been for the 5th and 9th Precincts' "condition men" to sweep through the Bowery with a paddy wagon twice a day. Generally the police have ignored the sickest and most deteriorated men. Those who were standing or sitting in groups, or staggering slightly, were selected for arrest on minor charges such as public intoxication or disorderly conduct. These men have usually been brought to trial a few hours after their arrest, and in most cases found guilty by the judge. Obviously debilitated men have been sentenced to ten or fifteen days, but in about 80% of the cases, unconditional releases have been granted, and the men have been back on the streets within twenty-four hours.

The police policy towards derelicts in New York thus has amounted to little more than a harrying action, which each day has removed about fifteen men from the Bowery for a few hours, but has made no real impact on either the medical needs of the men or the unsightly neighborhood conditions. Longer sentences would, of course, mean fewer men on the streets, and, in fact, during the 1965 World's Fair, judges increased sentences

so dramatically that as one patrolman reported, "The Bowery was as clean as a china plate." The practical fact is, however, that jails are ill-equipped to handle the medical aspects of withdrawl. Moreover, the process of jailing the men, far from "teaching them a lesson," seems only to reinforce their attitudes of self-contempt and self-abuse.

The practice of police harassment of alcoholics is nation-wide. Arrests of alcoholics on public intoxication charges accounts for 33.3% of all arrests in this country(4). Length of sentences varies from court to court, but most police and correction officials are anxious to turn responsibility for these men over to someone else.

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(4) Task Force Report: Drunkenness, The President's Commission on Law Enforcement and Administration of Justice, U.S. Government Printing Office, 1967, p.1. Not included in the above figure are alcoholics arrested for vagrance, disorderly conduct, and similar charges.

PLANNING FOR CHANGE

In 1966, a crisis confronted the traditional system of jailing drunks. Two Federal Court decisions, Easter v. District of Columbia and Driver v. Hinnant had held that conviction of alcoholics on charges of public intoxification was tantamount to conviction of sick persons for displaying symptoms of a disease, and consequently unconstitutional. Although a subsequent Supreme Court ruling in Powell v. Texas brought those decisions into question, it seemed at that time likely that even jails would become unavailable as detoxification centers for destitute alcoholics. Further urgency for the creation of some alternative was caused by the severe overcrowding in New York City courts and jails. Judicial and correction officials were anxious to devise some system by which the prison population could be relieved of this heavy burden.

In May, 1966, Mayor John Lindsay, in consultation with the legal and social agencies involved with Bowery men, invited the Vera Institute of Justice to plan and develop

a medically-oriented method for removing destitute alcoholics from the criminal justice system. Vera, as a private, non-profit agency, could operate outside the City's bureaucracy, unshackled by traditional chains of communication, and thereby obtain information and bring about decisions with all possible speed. The Mayor requested that relevant City departments cooperate with Vera, and assigned a key assistant to expedite the City's procedures wherever possible. The cost of Vera's planning efforts was financed by a grant from the Ford Foundation.

In searching for an alternative to periodic arrests of destitute alcoholics, Vera was forced to resolve conflicting theories of health administration and alcoholism treatment.

What Kind of Service?

Perhaps the most difficult issue which faced Vera was the question of whether, given the limited resources of New York City, priority should be given to a program stressing long-term rehabilitation or to a short-term program providing primarily medical detoxification.

After consultation with many health and social services experts, Vera decided to recommend that priority be given to establishment of a 50-bed detoxification unit in the Bowery

area. The unit would provide only five days of treatment. This recommendation was made for the following reasons:

(1) Such a program could handle large numbers of men and could thus provide a genuine alternative to detoxification in the jails.

(2) Many men would never respond for any extended period of time to any form of rehabilitation program, and would continue to require periodic detoxification all their lives.

(3) Bowery alcoholics presented such a variety of psychiatric problems that no single long-term program was deemed appropriate. Many men were schizophrenic, or suffered from irreversible organic brain damage. Others presented relatively minor disorders, and were amenable to group therapy and halfway houses. Virtually all Bowery alcoholics could use a detoxification program.

(4) Some long-term care facilities already existed, and men desirous of further help after detoxification could be referred to them. Some of these facilities admittedly offered little more than room and board for an extended period of time, but for some men even such limited help would encourage them to remain sober for substantial periods. Other facilities,

such as the alcohol treatment wards of the state hospitals, offered excellent intensive psychiatric care for men who were not too seriously brain damaged or mentally ill.

Where to House It?

Many medical experts felt that the Bowery man undergoing detoxification would present such acute physical and behavioral problems that only the intensive care ward of a general hospital would be an adequate facility. However, after many inquiries it was found that no hospital in New York City could or would relinquish space for use as a detoxification ward. It was learned that the Fourth Floor of New York City's Men's Shelter, which had housed Bowery men between 1954 and 1964, was unused, large and well-lit, had shower and toilet facilities. The feeding service of the Shelter could be used for inpatients. No other comparable adequate space existed in lower Manhattan. The Institute thus concluded that a detoxification unit for Bowery men would have to be established there or not at all.

At first the State Department of Mental Hygiene was reluctant to accept the site. Officials feared that mayhem would inevitably occur in such an unorthodox location. The proposal for a detoxification service outside jails would have

aborted at this stage had it not been for the intervention of St. Vincent's Hospital, a lower Manhattan voluntary institution with a notable record of service to the poor and destitute of the area. St. Vincent's agreed to make its beds available to Bowery men whose condition proved unmanageable in the detoxification unit at the Shelter, to analyze blood and urine samples from all patients in its laboratory, and to make its X-ray services available to Project patients. Complicated tests could be run at the hospital when necessary. This unique institutional arrangement, an independent detoxification unit operating at the New York City Men's Shelter and backed by the services of a prestigious New York Hospital, was ultimately accepted by the State Department of Mental Hygiene and other involved government agencies.

Voluntary or Compulsory?

Another question facing the Institute was whether a detoxification program for Bowery alcoholics should operate voluntarily or compulsorily. Laws do exist in New York which permit the courts to commit chronic alcoholics to public institutions, however compulsory commitment raises procedural and management problems. According to the law, the alcoholic would probably have to be run through a hearing (of dubious validity considering the man's state) prior to receiving detoxification. Locked wards, security systems, and coercion of recalcitrant patients would be necessary. On the other

hand, anyone who has ever seen Bowery men lurching down the street would well assume that they would accept no help unless compelled to do so.

The question of the practicability of a voluntary program was solved by a test which was conducted in October 1966 by Vera and the City's Police and Social Services Departments. A plain-clothes Police officer and a Bowery lodging-house clerk drove down the Bowery and approached sixteen men lying on the street. Each man was awakened, and offered the opportunity of receiving medical assistance and a place to "sleep it off." Thirteen of the sixteen men accepted, and returned with the team to the Shelter's Fourth Floor. Here they were examined by a doctor, sedated, and put to bed. One man left that night. At the experiment's end, the next morning, the twelve remaining men, not yet fully detoxified, were offered the opportunity to go to the City-run rest camp known as Camp LaGuardia, or to a mission. Eleven accepted. Throughout the experiment the men were, though intoxicated, cooperative and fully manageable. This experience convinced Vera that a voluntary program was workable and preferable to a compulsory one.

The Proposal

In November, 1966, a formal proposal was submitted to the Mayor recommending a pilot project which would operate a 50-bed alcohol detoxification center to which men could be brought on a voluntary basis by a rescue team, and which would offer

referral services to rehabilitation, residential, and medical facilities. The report received the endorsement of the Mayor, and commitments of support from the heads of all relevant agencies. Specifically:

(a) The Commissioner of Social Services subscribed to the use of the Fourth Floor of the Shelter as a detoxification facility, and said he would assign two (later four) caseworkers to the Project to handle screening and referral.

(b) The Police Department agreed to assign four men and two unmarked vehicles to the Project.

(c) The Department of Hospitals approved the loan of hospitals beds, examining tables, and other medical equipment.

(d) The Commissioner of the Department of Correction, recognizing the significant impact this program might ultimately make on the correction system, agreed to assign four of its officers to assist with record-keeping and reception duties, and to be available in the unlikely event that some disorders did occur. The Department also promised to lend recreational materials and 30 hotel-type beds for use by recuperating patients.

(e) St. Vincent's hospital, in addition to serving as the supporting hospital, and to making its laboratory services available, suggested that some of its resident physicians on their off-duty time should serve on the night shift in order to ensure 24-hour physician coverage.

(f) The Mayor's Criminal Justice Coordinating Council endorsed the proposal and agreed to lend the services of its members and staff to advising and assisting Project operations.

Mayor Lindsay then requested the Vera Institute to secure funding for the Project and to implement its operations.

IMPLEMENTATION OF THE PLAN

For those concerned with the process by which change and reform can be brought about in our society, it is worth noting that in the eleven months which elapsed between the presentation of the plan to Mayor Lindsay and the opening of the Manhattan Bowery Project's detoxification ward, affirmative decisions and actions were required by a total of eighteen distinct governmental departments and agencies(5). The unit could not have opened at all had not all these departments given prompt and affirmative attention to the applications and requests of the Vera Institute. Undoubtedly the commencement of Project operations would have been delayed interminably had it not been for the periodic intervention of representatives of the Mayor's office.

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(5) Mayor of the City of New York, Corporation Counsel of the City of New York, New York City Community Mental Health Board, New York City Department of Buildings, New York City Department of Correction, New York City Department of Hospitals, New York City Department of Public Works, New York City Department of Social Services, New York City Bureau of the Budget, New York City Fire Department, New York City Police Department, New York State Attorney General, New York State Department of Health, New York State Department of Mental Hygiene, New York State Department of Social Services, New York State Secretary of State, Office of Law Enforcement Assistance of the United States Department of Justice, Supreme Court of the City of New York.

Funding

Coincidentally, the proposal for the Manhattan Bowery Project came out almost simultaneously with the President's Commission on Crime and Law Enforcement's recommendation for the establishment of medical detoxification programs as replacements for City "drunk tanks." The newly established Bureau of Alcoholism of the New York State Department of Mental Hygiene was also committed to developing detoxification centers. The time was thus propitious for an experimental detoxification program. Ultimately, a three-way funding arrangement was worked out by which the Bureau of Alcoholism of the New York State Department of Mental Hygiene, the Office of Law Enforcement Assistance of the U.S. Department of Justice, and the City's Community Mental Health Board jointly funded the Project's first year. In the second and third years, the funding would be carried on by the Bureau of Alcoholism and the Community Mental Health Board, with the latter carrying the lion's share of the burden. These agencies not only provided funding but have taken an active role in the planning and operations of the Project.

Legal Authorization

Once commitments for funding had been secured for the pilot project it became necessary to create a legally authorized organization to run the project. A question confronting the Project organizers was, what sort of creature were they concocting; a hospital, a nursing home, a mental hospital, or what?

None of the existing categories of health service institutions seemed to fit. The Department of Mental Hygiene ultimately found that it could license the unit as an alcoholism treatment facility under a little-used section of the Mental Hygiene Law. The State Department of Health in turn agreed to relinquish any powers it might have to require the detoxification center to be licensed as a hospital or nursing home.

The next step was to create a charitable corporation which would have powers to operate the detoxification unit. Under New York State Law the Certificate of Incorporation of a charitable corporation must be approved by the State Board of Social Welfare. Representatives of the Board of Social Welfare, who had heretofore not been consulted on the considerations underlying the original recommendations, were disturbed at the prospect of an intensive care medical unit operating in a Department of Social Services center. The Certificate of Incorporation came close to being rejected by the Board, and it was only after an appeal from the from the Mayor's office to the State Commissioner of Social Welfare that consent to the Certificate of Incorporation was obtained on September 19, 1967. Once the Board of Social Welfare approval was obtained, the necessary approval of other state officials proved to be pro forma.

Renovations and Staff Training

In the last three months before the Project opened, renovations were made on the Shelter's Fourth Floor. Partitions were put up, additional plumbing installed, and walls throughout the entire floor were painted bright yellow. The City's

Department of Public Works' architect drew up the plans; once the bid was let, the Department's inspectors made constant visits to the Shelter urging the contractor to speed up completion of his work.

On November 13, 1967, the staff assembled for the first time. They totaled in all (not including the covering physicians) 33 persons. (A year later that number had increased to 47 due to additions to the nursing and casework staffs.) For the next four days the staff attended an orientation program on various aspects of alcoholism and its treatment. After a final frantic three days of scrubbing floors, assembling beds, and sorting drugs, the Project admitted its first patient at 12 noon on November 27, 1967.

The Project

From its first day the Project detoxification program has followed approximately the same routine:

Seven days a week from 9am to 9pm the Project's two-man rescue teams patrol the Bowery in the Project's unmarked police vehicles. One of the team members is a rescue aide, a recovered alcoholic, the other a police officer. When the team spots a man who is either prone or otherwise debilitated, the aide approaches him and offers him the chance to come to the Project to dry out. The plain-clothes police officer remains available to provide protection should the man become violent. In the event the man seems in grave medical danger, the police officer summons an ambulance. The Bowery man is free at all times to reject

the team's offer, or later to leave the treatment program.

If the man accepts the team's offer of help he is escorted to the Fourth Floor of the Men's Shelter where he is screened by a physician and signed into the Project by the plain-clothes correction officer on duty. The patient is showered and deloused by a team of medical aides. He is then put to bed in the Project's "acute ward"--the bed area closest to the nurses' station. The physician on duty obtains as much pertinent history as possible. He then performs a complete physical examination and orders appropriate medication. Sedation in type and amount is tailored to the needs of the patient. Intravenous feeding is sometimes needed(6). For the next three days the patient is kept under constant supervision and is given further medication to ease the symptoms of alcohol withdrawl.

Most ot the men are ambulatory after twenty-four hours. On the third day, if he seems well enough, a man is assigned a bed in the Project's "recuperative ward." Here in an area farther removed from the nurses' station, the man is given a hotel-type bed. He begins to use the recreation room where he eats, watches television, and takes part in the crafts and recreation program run by a case aide.

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(6) On the morning following admission, each patient is also given the following tests: chest x-ray, complete blood count, urine analysis, liver function blood tests and blood test for syphillis. Complicating diseases are treated when found. Psychiatrically disturbed patients are evaluated by a psychiatrist who orders specific medicine.

On his third day, the patient usually sees a caseworker and begins to make tentative plans for his aftercare. The caseworker presents the man's case at a daily staff conference which is attended by the nurses, physicians, and staff psychiatrist. Pertinent information about the man's physical and emotional condition is brought out. A tentative referral plan is suggested which the caseworker then discusses with the patient. If the patient approves the plan, the caseworker contacts the appropriate agency and tries to place the patient with the agency's program.

The Project employs a variety of referral programs. The four most frequently used are the state hospital rehabilitation units, the general psychiatric wards of Central Islip State Hospital, Camp LaGuardia, and the Project's own aftercare clinic (which is described more fully later on in this report).

Most patients leave on their fifth day. Occasionally men with severe complicating illness, or those awaiting an opening in another program, are held longer. A key task of the Project's street patrol is to transport discharged patients to their destinations whenever possible. This procedure is designed to ensure that a patient makes contact with the next agency, and also to give him a sense of continuity about his treatment.

The Project's 1968-69 operating budget is approximately $465,000 for its inpatient service. The City of New York contributes additional personnel and services worth about $170,800; thus, the

total operating budget is about $635,800. The budgeted cost per patient-day (based on an estimated annual population of 3,000 admissions and an average of 5.5 days of treatment) is $38.50. Between July 1968 and February 1969 the actual operating cost per patient'day has been $38.20.

About one-fifth of the Project's budget is allocated to physician costs. At least one physician is present at the Project twenty-four hous a day, seven days a week. This round-the-clock physician staffing makes it possible to keep patients who are quite ill at the Project. By contrast, some other American detoxification programs transfer patients with Delirium Tremens, or other serious problems, to a hospital and use physicians only a few hours a day. The cost of these nursing programs is consequently lower than those of the Manhattan Bowery Project. Since the Project's operation costs less than that of a typical hospital ward, and transfers many fewer men to hospitals than do nursing programs, the overall costs of detoxifying homeless men may not be substantially different under either system.

RESULTS OF ONE YEAR OF OPERATION

Admissions

In its first year of operation, the Manhattan Bowery Project admitted 2,387 patients. In the first quarter of 1968, the average number admitted weekly was 30.8. By the last quarter of the year, the average weekly admission rate was 60.2. 599 (25%) of the 2,387 admissions were referred to the Project by other agencies, or walked onto the detoxification ward voluntarily and persuaded the staff to admit them. The remaining 1,788 were recruited by the street patrol.

The voluntary approach by the street patrol was effective about 67% of the time. Of 2,966 men approached by the patrol, 1,788 (60%) agreed to enter the detoxification program. Ambulance calls or other special assistance was provided in 7% of the cases. 1,008 (33%) refused all help.

During the summer of 1968 it became apparent that Negro Bowery men, for reasons not altogether clear, refused the assistance of the street patrol more frequently than did Caucasians (Negro refusals ran about 50% as opposed to Caucasian refusals of about 20%). The Project street patrol was consequently instructed to make extra efforts to seek out Negro men and to explain the Project's aims with special clarity.

As a consequence, the percentage of Negro men admitted to the Project rose from 9.5% in the first six months of the year to nearly 25% in the last six months of the year.

Medical and Psychiatric Results

The experiences in this first year tended to substantiate the belief that these men suffered from many undiagnosed and untreated diseases. A sample of the medical charts prepared showed that Project patients presented the following medical problems:

Neurological diseases were found in 23.5% (11.5% had a history of seizure disorders).

Pulmonary diseases were found in 63.5%. Included in this figures is an inactive tuberculosis rate of 28.0%, an active tuberculosis rate of 1.0%, and pneumonia in 4.5%.

Gastro-intestinal diseases were found in 9.5%, peptic ulcer, cirrhosis, and gastritis predominating.

Cardiovascular disease was found in 9.0%.

Dermatological disease was found in 22.5%.

(A detailed table of medical complications of Project patients is included in the Appendix.)

Few of the patients were receiving regular medical care at the time of their admission.

The psychiatric problems presented by these men were no less severe. Analysis of the charts of the first 200 patients

admitted shows that 33% were diagnosed as schizophrenic; 38% suffered from personality disorders: 8.5% had anxiety neurosis; 17.5% suffered from depression: and 35.5% had associated chronic brain syndrome. Many of the men suffered from more than one condition, which accounts for psychiatric problems of 134%. A more detailed analysis is provided in the Appendix.

Despite the severe medical and psychiatric problems presented by these men, management of patients on the treatment floor proved surprisingly easy. Only 2% of the cases treated at the Project had to be transferred to local hospitals with acute medical or psychiatric problems prior to completion of detoxification. A few additional men were sent to hospitals after detoxification for routine surgery or medical care. One man died at the Project of apparent Cardiac Arrhythmia. Delirium Tremens developed in about 2% of the cases. Considering the intoxicated and highly disordered condition of these men, they were, for the most part, quite cooperative with the staff. Walk-outs against medical advice occured in 79 instances, or 3.3% of all admissions. Use of restraints to control patients undergoing psychotic episodes was necessary in fifteen cases, usually only for several hours.

Use of appropriate drug therapy was undoubtedly a key element in this relatively trouble-free operation. As shown above, the psychiatric evaluation of a sample of these men displays an extraordinarily high degree of mental disorders, and without effective use of medication the stress of alcohol withdrawal would have undoubtedly precipitated many more psychotic episodes than in fact occurred. Phenobarbitol has

been the drug of choice for alcohol withdrawl. If necessary, as much as 150 to 240 mg (2 1/2-3 grains) of intramuscular phenobarbital is given every two hours. If the patient shows alcoholic hallucinosis or alcoholic paranoid reactions, phenothiazines are used in place of phenobarbital. Chlorpromazine and trifluoperazine are the preferred phenothiazines. As much as 1 to 1.5 grams of chlorpromazine or 40 to 60 mg of trifluoperazine has been used per day. Intravenous pentobarbital has been used for Delirium Tremens in doses of 30 to 200 mg (1 1/2 - 3 1/2) grains).

Social and Economic Profile of Project Patients

A profile of the first 200 patients treated by the Project showed that they ranged in age from 21 to 72 hears, with the greatest number in their middle forties. 88% were Caucasian; 9.5% were Negro, 1.5% were American Indian, and 1% were Puerto Rican(7). About 61.5% were Catholic; the rest were Protestant (largely Southern Baptist or Methodist). Since its inception, the Project has treated (as of 3/31/69) three Jews, two Moslems, and one Buddhist. Most men had been Skid Row drinkers for about twenty years.

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(7) Due to increased Negro admissions in the later half of the hear, the ethnic breakdown for the entire year was: white 81%, Negro 17.5%, Puerto Rican 1%, North American Indian 1%, unknown 5% (based on a random sample of 268 men). The increase in Negro patients may affect other social and economic statistics.

They were wine drinkers, and they supported themselves by sporadic spot jobs. Approximately 25% completed the 8th grade or less, 25% attended high school, and 27% had a high school diploma or one to three years of college. 4% of the men were college graduates, and some had professional or graduate training. The educational level of the other 19% was unknown. 25% had job skills, 62% were unskilled or semi-skilled, 8% had professional or semi-professional training. The job-skill level of the other 5% were unknown. Half of the men were veterans; 3% of the men were currently married, 45% were single, and the remainder were divorced, separated or widowed. Most were born in New York, or neighboring states, while 26% were from Southern states.

Two significant areas of Project experience cannot be easily reduced to statistics. The first is the development of a skilled and effective staff; the second is the Project's role in developing and planning after-care and rehabilitation services.

The Staff

An effective Project staff did not develop without considerable effort and strain. The problems of the early months of operation can be attributed partially to the inefficiencies of any new organization, but primarily the cause lies with the peculiar problems presented by the alcoholic personalities of the Project patients

The alcoholic has, for a number of reasons, low stress tolerance. He demands immediate gratification of his desires. He has tremendous anxiety which, in his sober periods, he copes with by constant demands for things and attention. Because he so desperately wants to escape his anxiety and tensions, he is constantly on the lookout for excuses to drink. Often he sets up "rejection situations" which justify his drinking. At the Project, this takes the form of intensified demands for instant service, needling, and veiled insults. The unconscious hope is to provoke a staff member to rage or cold dismissal which will give the patient an excuse to walk out and drink.

Other frustrating characteristics of these alcoholic men are their inability to make decisions and their rejection of after-care for frivolous reasons. It is the rare alcoholic who admits that he prefers to return to drinking. Even after having decided to accept some form of after-care, the patients generally need constant reassurance that their decisions are indeed wise. On the morning of transfer to another program a man may change his mind four or five times, and, despite repeated intervention by the staff and other concerned patients, finally walk out of the door to the nearest bar.

For the nurses and doctors whose training has been "cure-directed" a final frustrating characteristic is the recidivism of so many of these men. Strenuous medical care, much counselling, careful referral, all seem to come to naught when so many men resume drinking.

The staff, particularly the nurses and medical aides who must be in continual contact with these men, respond in a variety of understandable ways: in a few (remarkably few) instances, they rise to the bait, lose their tempers, and tell the patient off. More typically, they try to meet each and every patient's demands. Their efforts to satisfy the patients' insatiable needs leads the staff to resist administrative pressures for full occupancy and rapid referral. Men may be deemed "too sick" to leave the acute ward area, thus creating a shortage of intake beds. The street patrol may be told to "hold off rounds until we let you know." In fairness, genuine crises do indeed develop which make additional admissions impractical, and at times the staff does undertake admissions under truly heroic conditions; nevertheless, it is an understatement to say that the staff would not object to a reduction of patient turnover.

Another response has been the resignation of some staff. At some point virtually every staff member finds himself or herself overwhelmed by a sense of helplessness and inability to cope with the demands of the patients. Those who can't take it get out; those who can, take a vacation. The turnover rate seems highest among the R.N.s who must cope not only with the patients, but also mediate between the demands of the floor staff, the physicians, and the Project administrators.

The staff has gradually evolved a series of techniques for handling the stress imposed by Project patients and operations: one of the most important is constant communication and exchange of views. Prior to the daily case conferences, the casework supervisor posts a list of all patients on their third day, and caseworkers are expected to present those cases and tentative referral plans at that day's conference. At the daily conference, a review is made of all patients who have been in the acute ward three or more days and in the program as a whole over five days. If the referral can be expedited or (in the case of an acute ward patient) the treatment handled on the recuperative ward, appropriate steps are taken(8).

The nursing, casework and street patrol supervisors meet regularly with the medical and administrative directors to review admission and discharge goals and to resolve other difficulties. Medical and casework staff meetings are held every few weeks. At a monthly meeting, attended by all staff members, a lecture is given by a Project worker or a visitor.

The staff has also found that a key element for successful Project operation is the selection of personnel on the basis of flexibility--a willingness to adjust tasks and work schedules

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(8) The hiring of a supervisor of street patrol and transportation operation, who coordinates transportation of outgoing patients with intake procedures, has also greatly expedited admissions and referrals.

to the patients' needs and an ability to accept informal cooperative relationships. The staff believes that the response of Bowery men to the Project results in large part from the friendly atmosphere on the ward and the enthusiasm of Project personnel.

Examples of the kind of flexibility and cooperation desired are the caseworkers who will serve a meal tray or hold an intravenous pole; the medical aide who sits down with a patient to discuss a possible referral with him; a police officer who tells a nervous out-going patient "you look just great, take care of yourself;" and a secretary who accompanies a patient to St. Vincent's Hospital and sits with him in the x-ray department until 9 o'clock at night.

In general, the fact that an applicant for a job at the Project is a recovered alcoholic does not in itself guarantee selection or rejection. It has been found that many recovered alcoholics are extremely compassionate and dedicated. At the same time they do feel particularly frustrated and threatened by the recidivist patient. The staff has also found that alcoholics with a record of under a year's sobriety have generally been unable to bear up under the demands of the Bowery patients and the staff. Alcoholics with a good history of sobriety do make a useful contribution, provided they are reasonably stable and confident. At present all of the civilian members of the rescue team are recovered alcoholics, and they have functioned extremely well in this capacity. Four of the nursing and medical aide complement of twenty-four are also recovered alcoholics.

The police and correction officers have adapted with ease to the voluntary and medically-oriented program. They have on frequent occasions proved most helpful in assisting the staff with emergencies such as psychotic episodes and epileptic seizures. They have consistently demonstrated interest in, and concern for, Project patients. It is significant that in the entire first year of operation not a single arrest has been made by the Project police or correction officers. Major changes in working routines are handled directly through the commanding officers of the Correction and Police Departments and men assigned to the Project are not asked to undertake tasks which diverge too far from their professional training and skills.

Planning and Developing Aftercare Services

At the start of the Project it was recognized that few, if any, men would achieve substantial improvement in their long-term alcoholism problems after only five days of detoxification. It was further assumed that few existing aftercare programs were equipped to bring disabilities of Bowery alcoholics.

To some extent, these gloomy expectations have been borne out. Of the 2,387 admissions during the first year, 1,480 (62%) were first admissions, 473 (20%) were second admissions, 194 (8%) were third admissions and 240 (10%) were fourth or more admissions. In a very preliminary study of 100 men three months after their discharge it was found that 17% were still known to be sober and either working or in some organized program.

However, the Project has found, during this first year, that Bowery men, despite their limitations, can profit from certain programs; these findings have led to the planning of several further services, and to the actual implementation of two programs.

It was found that the number of men prepared to accept some form of after-care plan rose steadily with each passing month. In August, 1968, 33% of the men admitted accepted a referral. In October, 1968, the percentage was 48, and in January, 1969, the percentage was 57. This increase was undoubtedly due in part to the fact that with colder weather the men were less able to obtain jobs or function adequately on their own. At the same time it seems quite likely that the casework staff has gained expertise in convincing patients to accept further help; moreover, the Project staff have been able to open up increasingly attractive referral services for the men. Initially, for example, the state hospital alcoholism units were most reluctant to accept presumably hopeless Bowery men. At present, however, the Project is able to send a substantial number of its less seriously disturbed patients to the alcoholism units. Similarly, the Reiss Psychiatric Pavillion at St. Vincent's Hospital has begun to accept a few selected Bowery men as patients. A detailed list of the referral sources used by the Project is provided in the Appendix of this report.

Despite their frequent setbacks, it thus seems clear that a substantial number of Bowery alcoholics are willing to seek further help provided a sufficiently attractive plan is presented to them by an experienced caseworker.

The staff has also observed that on successive admissions a man frequently shows improvement not only in physical health but also in emotional attitudes. Periodic intervention by the Project thus often seems to prevent further brain damage, liver damage, and such progressive disabilities. The staff has the impression that many men on their first admissions who rejected referrals, have on subsequent admissions become amenable to some program. "It is," one caseworker says, "almost as if they are testing you to see what you will do if they fail. If you don't hate them for drinking and tell them you still believe they can make it, they will get up the nerve to make some effort to change." Equally gratifying, the caseworkers report, are the number of men who, despite repeated slips, do continue to make genuine efforts to improve, to get a job, to stay sober, and to start making friends.

The Meaning of "Rehabilitation"

Their experiences with Bowery patients over these past months have led the staff to revise their definitions as to what "rehabilitation" means and what methods should be employed to help the men achieve it. Rehabilitation for many Bowery men

cannot be measured in absolute terms of permanent sobriety and of acquisition of jobs, families, property, and other social ties. On that broad measure, given the age, the extent of disability, and the tremendous monetary cost, "rehabilitation" is unobtainable for a substantial number of these alcoholics. On the other hand, even very deteriorated men are often motivated to undertake some change in their life and (equally important) there are many relatively substantial forward steps a Bowery man can make on a less absolute scale. He can lengthen his average time between benders from a few weeks to months. He can obtain better paying jobs for longer periods of time. He can make better use of the City's health resources and obtain regular medical and dental attention. He can, through use of medically prescribed tranquillizers and other drugs, combat periods of stress by means other than alcohol.

The Necessary Services

In order to achieve these practicable, if somewhat limited goals, the staff believes that three types of continuing services must be provided:

First of all, congregate living facilities should be available to that proportion of homeless alcoholics who are probably incapable of re-entry into society as fully independent persons. Such men could function reasonably well outside institutional settings if adequate living programs were available

to them. Congregate living facilities would consist of apartments or dormitories where the men lived more or less permanently. The program would be supervised by a resident manager who would ensure that sanitation and behavior standards be maintained. A counsellor would be available to assist the men in obtaining jobs, health-care and pensions. Where appropriate, the counsellor would encourage a man to transfer into a more intensive rehabilitation or medical treatment program. Men living in such facilities would almost certainly leave them periodically to go on a drinking spree. With the assistance of a detoxification program, however, they could return to congregate living once their benders were over.

There is also a need for institutions to care for older or brain-damaged men. A certain number of Bowery men have lost the capacity to function on their own. They will need to spend the rest of their lives in an institutional setting.

Finally there should be therapeutic programs whose goal is to help a man re-enter society. A small proportion of the men treated at the Project seem amenable to such intensive rehabilitation efforts. For them, the inpatient alcoholic treatment units of the state hospitals are an excellent resource. These men also need a halfway house program following such treatment. Halfway houses should have a resident manager and supporting counselling services, as well as evening and weekend recreational programs. The function of a halfway house would be to serve as a temporary living program for several months

to assist a man who is trying to re-enter normal working society. On leaving, he should have out-patient clinic care available to him.

At the present time, New York City can provide reasonably adequate institutional services for Bowery alcoholics at Camp La Guardia, city nursing homes, and the state hospitals(8). As noted above, the State Department of Mental Hygiene's Bureau of Alcoholism runs a number of excellent in-patient alcohol treatment facilities throughout the State. More such facilities are needed. There are virtually no halfway houses or congregate living facilities available. There is also a shortage of out-patient clinics. Until all these facilities are easily available services to homeless alcoholics will be fragmentary and incomplete.

The Manhattan Bowery Project staff has discussed these findings with State and City officials. It has also undertaken some very preliminary consideration of establishing halfway houses and congregate living facilities under its own supervision. Staff members also work on various citizens' groups which work for the creation of more alcoholic services.

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(8) It should be noted that chronic alcoholics are generally regarded as problem patients on the wards of the general psychiatric units of public hospitals. When there is a need for beds for more "needy patients" these men are the first encouraged to leave.

The Project's After-Care Clinic

In order to meet at least some of the unfulfilled needs of its former patients, the Project has, of necessity, established its own after-care clinic. The clinic assists two types of men--those who are unable or unwilling to enter rehabilitation or institutional programs and those who have been discharged from such programs and have no out-patient clinics or halfway houses available to them.

The clinic operates as informally as possible to insure that these disorganized men make maximum use of its services. No requirements are imposed as to regular attendance or frequency of visits. At present, the clinic operates in a tiny office located in the recuperative ward. Two nurses staff the clinic an average of ten hours a day. Patients are free to come back to the ward at any time of the day or night. In the absence of the after-care nurses, the men are seen by a nurse on the detoxification ward.

Antabuse (a drug which causes a violent physical reaction to alcohol intake, and thus inhibits drinking), vitamins, and tranquillizers are available daily to these men on a Project physician's prescription. Men who are depressed or unusually agitated are seen by a psychiatrist. Men with job, housing and other concrete problems are assisted by a caseworker. As on the ward, a primary task of the staff is to listen to the out-

pourings of men who have not had anyone to tell their troubles to for much of their adult lives.

The clinic sees about 90 different men a day, six days a week. The case load is at present held at about 100. The one requirement imposed on the men using this flexible, informal service, is that they must be sober when they come to the clinic. About 10 men drop out of the case load each week; on the other hand, over 80 men have been coming regularly to the clinic for a month or more. In the absence of other long-term treatment facilities, the clinic seems a promising and useful step towards helping these men achieve improved health, income, social contacts, and sobriety.

The "Deck"

There is still another program which evolved from the Project's contact with Bowery men and the staff's growing awareness of their untreated medical and social problems. This is an emergency medical clinic which operates on the First Floor of the Men's Shelter and is available to any client of the Men's Shelter.

This new program, operated by St. Vincent's Hospital, resulted from a study (conducted by the Mayor's Criminal Justice Coordinating Council, and the Manhattan Bowery Project's Nursing personnel) of the medical problems of Bowery men who use the First Floor Waiting Area (called "the Deck" by the men) as a place to sit, lie or sleep (see Appendix for complete breakdown of medical problems presented).

When the report of this study was presented to the Department of Social Services and to the Project's Board, there was general agreement that because Bowery men are so highly disorganized, and because they do not receive normal home health care, minor medical problems such as colds and cuts often burgeon into major ones like pneumonia and skin ulcers. An easily accessible medical service, staffed by one nurse, two medical aides, and one physician, which provided services comparable to a military sick bay, would do as much to alleviate the health problems of Bowery men as a more massive rehabilitation operation. When these recommendations were presented to St. Vincent's Hospital along with commitments by the Department of Social Services to provide funding for such a program, St. Vincent's with the cooperation of the Project agreed to assume responsibility for a medical clinic, which opened its doors on April 14, 1969.

Once the First Floor medical program is in full operation, it is hoped that street patrol efforts can be stepped up. The First Floor would then screen sicker men for admission to the detoxification unit. The Police Department has tentatively agreed to discontinue large-scale arrests of derelicts in the Bowery area and has assigned two men to the clinic to operate a rescue team for it along the lines of the Bowery Project's rescue teams. Thus it is hoped that within a few months, a completely voluntary and medical program will replace police processing of Bowery alcoholics.

CONCLUSION

In its first year of operation, the Manhattan Bowery Project's primary goals were to test (1) whether Bowery alcoholics would accept a voluntary program of alcohol detoxification: (2) whether such a program would be workable in a non-hospital setting; and (3), whether on completion of detoxification, the men would accept referral to other types of programs for on-going care.

The results so far indicate that the majority of debilitated alcoholic Bowery men approached by a medically-oriented street patrol, voluntarily agree to detoxification. Once in such a program, virtually all the alcoholics stay until completion of treatment. The Project has also found that Bowery men undergoing detoxification are manageable from both a medical and a behavioral standpoint in a well-staffed, non-hospital facility. Finally, experience indicates that at the completion of detoxification the majority of the patients are willing to seek further treatment.

The experience of the Manhattan Bowery Project raises the question of whether its results can be duplicated in detoxification programs elsewhere.

Regarding the voluntary aspects of the Project, the staff believes that this approach <u>can</u> be successful in other adequate facilities. The staff also feels that the voluntary approach is preferable to a compulsory program of detoxification. A

patient would probably be more cooperative when he is undergoing voluntary treatment; moreover, a compulsory program would create a number of management problems. It would, for example, be difficult to prevent secret drinking. Alcoholics in a compulsory setting would also resist on-going care. Such a program also requires legal safeguards which are unnecessary in a voluntary situation.

The staff also believes that its detoxification program could be duplicated in comparable non-hospital settings, provided, of course, that the physical plant was structurally safe, the program adequately staffed, and provision made for sanitation and meal services. Buildings which could be used for this purpose are nursing homes, hotels, or schools. Naturally, the more a facility diverges from orthodox institutional settings, the more difficult it will be to meet licensing and certification requirements, and the more the support of a Mayor or other executive will be needed to obtain such licensing and certification.

The staff feels, however, that the Manhattan Bowery Project is only one of a number of alternative settings in which alcohol detoxification could be provided. Detoxification could be managed, for example, in a special ward of a hospital, or in a nursing care unit which transferred unusually sick patients to a hospital. Alcoholic patients could also be detoxified in general medical wards. Each of these solutions presents advantages and disadvantages in terms of therapeutic environment, cost, and access to specialized treatment and laboratory

resources. The Manhattan Bowery Project's staff feels that the advantages its program offers are: that it can treat many men who would otherwise require hospitalization; that its staff is trained for, and oriented towards, the handling of the difficult alcoholic personality; that it has greater flexibility of operation than is found in a hospital or other more traditional setting; and that the staff's high level of professional training assures skilled evaluation and effective after-care planning. The program is, of course, more costly than a nursing program; conversely, it is less expensive than an in-patient hospital program.

Finally, while many destitute alcoholics desire on-going care, the extent to which other detoxification centers could succeed in persuading their patients to seek after-care programs would depend in part on the skill of the staff in evaluating and encouraging the men; but successful referrals also depend on the availability of suitable resources. Insofar as society is prepared to provide these programs (not all of which must be expensive or long-term), the problems of homeless alcoholics could be mitigated, and Skid Rows themselves could gradually disappear.

APPENDIX

CONTENTS

BUDGETED PERSONNEL POSITIONS FOR MANHATTAN BOWERY PROJECT

Fiscal Year 1968-69

In-Patient Detoxification	Number of Positions
Medical Director (Half-time)	1
Psychiatric Director (10 hours a week)	1
Staff Physicians (24-hour a day coverage, equivalent of 6 full-time positions)	-
Nursing Supervisor	1
Assistant Nursing Supervisor	1
Registered Nurses	8
Licensed Practical Nurses	5
Medical Aides	8
Ward Manager	1
Rescue Aides	3
Street Patrol Supervisor	1
Casework Supervisor	1
Caseworkers*	4
Case Aides	2**
Administrative Director	1
Assistant Administrative Director	1
Project Secretary	1

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* On loan from the New York City Department of Social Services

** The Women's Talent Corps placed several trainees with the the Project. The two case aides are graduates of this program who were taken on as full time staff members. The Project has also profited from the periodic assignment of Urban Corps workers.

In-Patient Detoxification	Number of Positions
Receptionist-typists	3
Correction Officers*	4
Police Officers**	4
Research Assistant	1
Independent Research Consultant	1

After-care Unit	
Psychiatric Nurse	1
Registered Nurse (half-time)	1
Psychiatrist (10 hours a week)	1

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* On loan from the New York City Department of Correction

** On loan from the New York City Police Department

THE DAY

by A Manhattan Bowery Project Rescue Aide

8:00 Signed in.

8:15 Made "blood run" and returned night M.D. to St. Vincent's Hospital. Took blood, urine, and sputum specimens to Laboratory and brought back yesterday's analyses. Nice people.

8:40 On run for 9:00 a.m. pickup, saw elderly white man lying in doorway near Houston and Bowery. Legs in retracted position, bloody head wound. Soaking wet, chilled, shaking, had laid there all night through storm. Patrolman Lihack helped, got him to wagon. Patient unable to walk when got to shelter, wheelchaired him in. Weeping, thanking us, turned out to be 68 years old and second-timer. Had maintained himself during 6-month interim between admissions. Was my first Jewish admission, first whose temperature remained below 95 for five hours. Took aides 2 hours to straighten legs. Critical condition. Good candidate.

9:30 Delivered 35-year-old white man to Kings County Hospital alcoholic wards. Hostile as hell, damned Project and City of New York. "Gimme a cigarette". Waited while he was interviewed, surprised somewhat when he was accepted. 17-bed ward, lucky. What nice guy did he deny a bed to? Psychiatrist must have insight that I don't.

11:15 Delivered patient to St. Vincent's emergency room for X-rays. He'll have a good lunch -- a switch -- and try for a repeat tomorrow. Don't blame him.

12:00-
12:30 LUNCH

12:45 Only 2 medical aides on so showered Olson, cantankerous Norwegian brought in by other team. He didn't want any of his clothes and none was usable, destroyed all. He'll bitch tomorrow about loss of 85-dollar topcoat. Said "Je elsker deg", all I know, to him and he stopped grumbling long enough to smile. Emerging clean from shower with rags, smell, lice and grime gone, looks totally different. Hope feels it.

1:30 Approached Negro sprawled against side of One Mile House, forbidden territory -- Southerners' bar. He looked up and before I could say anything ran down street -- "I ain't goin' to no jail." First time for this reaction, must be getting to look like cop. He looked like a jack-roller. Guilty conscience.

2:00 Led staggering Puerto Rican out of traffic near Bowery and Kenmare. Refused help adamantly. Negro sitting against building heard conversation, asked to go -- if we'd let him take one more drink. We did, and he gave bottle to Puerto Rican. No jackroller, according to Lihack, not hostile, not fearful, wanted help. Good to find. Asked on way, "Can you all <u>really</u> help me?" "Really" threw me, but answered affirmatively.

2:05 Saw Sullivan lying on street. Helluva time waking him. Just discharged a week ago, might be refused.

2:15 Both admitted, Sullivan on condition that he accept referral. Fourth admission. He won't go anywhere: feels that his disability pension will kill him before he's 50. "To hell with AA." Four years to go.

2:30 Man to St. Vincent's Surgical-Diagnostic Clinic. Picked up patient delivered this morning for X-rays. Praised lunch, good-looking nurses. Justified.

3:15 Filled out daily tab sheet. Total for both teams, 8 -- 3 Negroes, 4 whites, 1 Puerto Rican. Four virgins, four re-admissions. Getting hard to find first-timers. Feel good about two of our three -- Sullivan's prognosis, after 4 admissions and with his AA-be-damned attitude, depresses me.

3:45 Went to ward to talk with three men we brought in 4 days ago about AA and referrals. Two are accepting, one is going out tomorrow on own plans. Back to booze. Hope for two out of three, batting .666. Pretty decent.

4:00 Finis. Good day.

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ADMISSION AND STREET PATROL STATISTICS

November 27, 1967-November 30, 1968

Total admissions		2,387
(1) Admitted through Street Patrol Operations	1,788 (75%)	
(2) Referred from other agencies	599 (25%)	
Total offers of assistance made by Street Patrol		2,996
(1) Refused help	1,008 (33%)	
(2) Given other assistance	178 (6%)	
(3) Ambulance cases	22 (1%)	
(4) Accepted admission to Manhattan Bowery Project	1,788 (60%)	

Re-admissions

Of the 2,387 admissions, 38% were of men treated at the Project one or more times previously:

1,480 admissions (62%) were first admissions

473 (20%) were second admissions

194 (8%) were third admissions

240 (10%) were fourth or more admissions

1,480 different men account for the 2,387 admissions

MEDICAL COMPLICATIONS

Presented by the First 200 Patients Admitted to the Manhattan Bowery Project's Detoxification Ward*

(Prepared by Dr. Robert Morgan and Dr. Charles Goldfarb, March 2, 1969)

Neurological Diseases - 23.5%

Cerebellar Ataxia	0.5%
Parkinson's Disease	0.5%
Late latent Syphillis	4.0%
Convulsive Seizure Disorder	11.5%
Peripheral Neuritis	7.0%

Pulmonary Disease - 63.5%

Chronic Lung Disease (not T.B.)	25.0%
Inactive Tuberculosis	28.0%
Active Tuberculosis	110%
Pneumonia	4.5%
Influenza	2.5%
Pleural Effusion	1.0%
Pleurisy	0.5%
Pneumothorax	0.5%
Bronchitis	0.5%

*The data listed above should be read as tentative results. A follow-up evaluation, presently under way, indicates that men admitted over the summer presented more numerous and more severe medical problems. Note also that some men presented more than one medical complication, thus accounting for a total of more than 100%.

Gastrointestinal Disease - 9.5%

Gastritis	3.5%
Hiatal Hernia	1.0%
Diarrhea	1.0%
Malnutrition	4.0%

Liver Disease - 23.0%

Pancreatitis - 0.5%

Cardiovascular Disease - 9.0%

Arteriosclerotic Heart Disease	4.0%
Hypertensive Heart Disease	2.0%
Rheumatic Heart Disease	1.0%
Cardiomegaly	0.5%
Myocardial Infarction	0.5%
Pericarditis	0.5%
Varicose Veins	0.5%

Dermatological Disease - 22.5%

Skin ulcers	14.0%
Lacerations and Contusions	5.5%
Lice and/or Scabies	2.0%
Psoriasis	0.5%
Gonorrhea	0.5%

PSYCHIATRIC DISORDERS

Presented by the First 200 Patients Admitted to the Manhattan Bowery Project's Detoxification Ward*

(Prepared by Dr. Charles Goldfarb, and Carolyn Stevens, March 2, 1968)

Schizophrenia	65	33.0%
Chronic Undifferentiated	14	7.0%
Simple	16	8.0%
Paranoid	21	10.5%
Catatonic	8	4.0%
Pseudo Psychopathic	6	3.0%
Hebephrenic	1	0.5%
Personality Disorder	76	38.0%
Passive Aggressive	70	35.0%
Schizoid	4	2.0%
Cyclothymic	1	0.5%
Sociopathic	1	0.5%
Anxiety Neuroses	17	8.5%
Depression	35	17.5%
Seizure History	22	11.0%

*This data should be regarded as tentative results. A follow-up evaluation presently under way indicates that men admitted during the summer months presented more frequent and more severe disorders. Note also that some men present more than one problem; thus the total percentage exceeds 100%.

Alcoholic Hallucinosis	9	4.5%
Alcoholic Paranoid Reaction	3	1.5%
Homosexuality	3	1.5%
Narcotics Addiction	3	1.5%
Delirium Tremens (impending)	1	0.5%
Delirium Tremens	3	1.5%
Chronic Organic Brain Syndrome	71	35.5%

ECONOMIC, SOCIAL AND ETHNIC PROFILE

Of the First 200 Patients Admitted to the Manhattan Bowery Project Detoxification Ward.

(Prepared by Dr. Charles Goldfarb and Carolyn Stevens, March 2, 1968)

Age		
20-29	4	2.0%
30-39	31	15.5%
40-49	76	38.0%
50-59	55	27.5%
60-69	29	14.5%
70-79	4	2.0%
Unknown	1	0.5%
Race*		
Caucasian	176	88.0%
Negro	19	9.5%
American Indian	3	1.5%
Puerto Rican	2	1.0%

*A random sample of 268 men admitted during the entire first year (from Nov. 27 1967 - Nov. 26 1968) indicates that the racial breakdown was as follows:

White	210 (78.3%)
Negro	49 (18.3)
Puerto Rican	4 (1.5%)
North American Indian	1 (0.4%)
Unknown	4 (1.5%)
Total:	268 (100%)

The increase of 9% in the Negro patients may affect the other statistics presented in this article.

Religion		
Catholic	123	61.5%
Protestant	74	37.0%
None	1	0.5%
Unknown	2	1.0%
Education*- (Last Grade Completed)		
8th Grade or Less	38	25.0%
1-3 Years, High School	38	25.0%
High School Graduate	27	18.0%
1-3 Years, College	13	9.0%
College Graduate	6	4.0%
Unknown	28	19.0%
Family Contacts*		
None	71	47.0%
Poor	12	8.0%
Some	11	7.0%
Good	4	3.0%
Unknown	52	35.0%
Marital Status*		
Single	67	45.0%
Separated	39	26.0%
Divorced	26	18.0%
Married	5	3.0%
Widowed	5	3.0%
Unknown	8	5.0%

* Of first 150 admissions.

Place of Birth*		
New York City	46	31.0%
South	40	26.0%
East Coast	36	24.0%
Mid-West	12	8.0%
Foreign	13	9.0%
Unknown	3	2.0%
Job Skills*		
Unskilled	54	36.0%
Semiskilled	39	26.0%
Skilled	38	25.0%
Professional/Semiprofessional	12	8.0%
Unknown	7	5.0%

*Of the first 150 admissions.

AFTER-CARE PLANS

of Patients Admitted to the Manhatttan Bowery Project between November 27, 1967 and November 30, 1968

(Prepared by Elaine Palusci)

Accepted Referral to Agency:	Number of Men
A. A. Sponsor	4
Accept	3
Beekman Downtown Hospital	1
Bellevue Hospital	27
Bowery Mission	73
Bridge House	19
Brooklyn State Hospital Alcoholism Unit	6
Camp Challenge	1
Camp La Guardia	323
Catholic Worker	1
Central Islip State Hospital:	
(a) Alcoholism Unit	62
(b) General Units	182
Columbus Hospital	7
Creedmore State Hospital Alcoholism Unit	16
Fountain House	1
Graymoor	57
Grasslands Hospital	2
H.A.R.P.	3
Holy Name Center	18

Kings County Hospital:	
(a) TB Unit	7
(b) Alcoholism Unit	24
Marine Hospital	1
Manhattan Bowery Project - Aftercare Clinic	150
Mobilization for Youth	1
Mount Carmel Guild	9
McAuley Water Street Mission	5
Operation Bowery of the N.Y.C. Dept. of Social Services	9
Pilgrim State Hospital Alcoholism Unit	42
Quaker Assistance Program	2
Reiss Pavillion of St. Vincent's Hospital	1
Rikers Island TB Unit	2
Rockland State Hospital	1
Salvation Army:	
(a) Memorial Hotel	8
(b) Men's Social Service Centers	75
St. Vincent's Hospital	58
Triborough Hospital TB Unit	3
Veterans' Administration Hospitals	23
Village Nursing Home	3
Volunteers of America	26
Welfare Centers, Department of Social Services	10
Total Accepting Referrals	1,266 (53.0%)

Left Against Medical Advice:		
Prior to completion of admission procedures:	25	
After completion of admission procedures:	54	79 (3.3%)
Did not return from Day Pass		47 (2.0%
Left to accept a job at completion of treatment		32 (1.3%)
Left on own plans at completion of treatment		882 (37.0%)*
Unknown:		
(a) Destination not noted in discharge record	39	
(b) Discharge not noted in discharge record	42	81 (3.4%)
Total Admissions:		2,387 (100%)

* This figure is undoubtedly higher than was actually the case since the Project's Aftercare Clinic was begun on an informal basis and early referrals to this Clinic were not carefully recorded.

RESULTS OF A MEDICAL SURVEY

Conducted on the "Deck" (First Floor Waiting Area) of the Men's Shelter on March 26, 27 and 28, 1968

(Prepared by Nancy Dubler and Elizabeth Kiernan.)

A total of 150 men were interviewed by Manhattan Bowery Project Nursing personnel on these dates between the hours of 8:00 a.m. and midnight.

The nurses were equipped with a medication and treatment cart, a set of standing orders signed by the Project's Medical Director, and a set of nursing questionnaires. The cart was stocked with bandages, dressings, cleaning solutions, ointments, necessary instruments, disinfectants, and water. Men entering the "Deck" area were invited to talk with the interviewing nurses about their medical problems and to obtain either first aid or referral to other agencies.

About 150 men were interviewed by the nurses during the three-day period. Seventy-nine of these men presented relatively minor complaints, such as cuts, colds, and the like, and drifted away after receiving a few minutes of attention. Seventy-one men, however, presented problems sufficiently serious as to require referral either to the emergency room or clinic of a hospital or to the Men's Shelter casework unit on the Third Floor.

The most frequent problem presented was acute alcoholism compounded by the fear of impending Delirium Tremens. The next two most frequently presented problems were heavily infected leg

ulcers and seizure disorders. Some patients presented more than one problem and were thus noted twice. The complete classification of the medical problems presented was as follows:

Problems Encountered Frequently:	Cases
Alcoholism and impending Delirium Tremens	21
Leg Ulcers	12
Seizure Disorders	5
Upper Respiratory Infections	4
Burns	3
Stomach Problems (Ulcer Syndrome)	3
Head Pains	3
Infected Hand	3
Shortness of Breath	2
Psychosis (Overt)	2
Arthritis	2

Individual Cases Presented:

Severe Bleeding
Bleeding from Mouth
Swollen Lip
Pruretus (Genital)
Hoarseness
Sore Throats
Hernia
Vomiting
Eye Pain
Paralysis of Face
Earache
Stitches needing Removal
Cut Lip
Cyst on Nose
Chest Pain
Puncture or Wound of Heel
Paralysis of Hand
Fracture of Jaw

A Project doctor was called three times during the three days to aid the nurses in making the appropriate referral. He was summoned once to evaluate heavy bleeding and twice to evaluate the possibility of hepatitic coma. The following referrals were made:

1 case transferred to the Bellevue Psychiatric Ward by ambulance for a severe psychotic reaction

1 case transferred by ambulance to Bellevue Hospital general admission for severe vomiting of blood

5 cases referred to the Bellevue emergency room for severely infected leg ulcers or possible fractures

5 cases referred to St. Vincent's emergency room with severe breathing difficulties

6 cases admitted to Manhattan Bowery Project in need of medical assistance for acute intoxification

12 cases referred to clinics at St. Vincent's and Columbus Hospitals (for which they possessed clinic cards) for seizure disorders, cuts and bruises, and leg ulcers

19 cases referred to the Third Floor of the Men's Shelter for a Meal and Lodging House ticket

22 cases referred to clinics at Bellevue Hospital for seizure disorders, cuts and bruises, and leg ulcers.

The Rescue team of the Manhattan Bowery Project was available during the experiment to transport patients to the clinics and emergency rooms. During the three days, they transported 16 patients, not merely to the building, but to the appropriate line or waiting room at each facility. More patients could have benefited from this assistance had the team been available during the evening hours.