THE UNIVERSITY OF CALGARY

AN EVALUATION STUDY OF SIMON HOUSE: A RESIDENCE FOR HOMELESS MEN

by

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A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE

DEGREE OF MASTER OF SOCIAL WORK

FACULTY OF SOCIAL WELFARE

CALGARY, ALBERTA

JANUARY, 1986

ISBN Ø-315-29987-8

THE UNIVERSITY OF CALGARY

FACULTY OF GRADUATE STUDIES

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ABSTRACT

An Evaluation Study of Simon House: A Residence for Homeless Men

Donna M. Phillips

Simon House is a residence in Calgary for homeless men. Its objectives are to increase the level of physical, psychological, and social functioning of its residents by providing them with a place to live where they are given support, responsibility, and access to available resources. This evaluation study is an attempt to determine the effectiveness of the Simon House program.

A quasi-experimental pre-test/post-test design was employed to test the achievement of the objectives of Simon House. Data were collected from residents in the form of two standardized questionnaires and one unstandardized interview (N=22). Due to a high rate of sample attrition, an analysis of a subsample (N=9) was executed to evaluate pre-test/post-test differences. Additional analyses described the sample, compared program successes and program failures, and compared all subjects' social functioning before and after they entered the program.

Major findings were: (1) the sample studied closely resembled homeless alcoholic men identified in previous research; (2) the program successes and program failures were of two distinct client types differing in their levels of physical health, psychological health, and social functioning; in their reasons for entering the program; and in the amount of dependence they had on programs and institutions; (3) subjects' social functioning improved

significantly upon entering the program; and (4) subjects who stayed in the program longer than three months (N=9) showed improvement in their overall psychological functioning as well as continuing to improve in their social functioning (psychological functioning improved in terms of sociopathy, depression, and self-worth but increased in terms of dependence and boredom).

An overall assessment of the findings led to the conclusion that Simon House is meeting its program objectives and thus is successful with a particular client group whose members are characterized by their motivation to change and by their physical, psychological, and social dependence on programs and institutions. Recommendations for program development and further research are outlined in the final chapter.

ACKNOWLEDGEMENTS

Many thanks are given to the men who participated in this study, and to the staff of Simon House — the time and effort offered by all is greatly appreciated.

Special thanks are also extended to Dr. Joe Hornick, whose wisdom and superior teaching ability are met with gratitude and awe.

DEDICATION

To Sam

For the endless supply of love, support, and editorial comments.

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CHAPTER 1

Introduction

Simon House was established in late 1983 to provide a home for men on Calgary's streets. Simon House focuses on providing for inhabitants themselves rather than on converting their physical surroundings. It is also the only long-term residence in Calgary for destitute men where neither a rigid rehabilitation program nor a time limit on their stay are imposed. The philosophy of Simon House purports that by offering homeless men a place to live where they are treated with dignity, and where they are given support, responsibility, and access to available resources, they will subsequently be given the opportunity to affiliate and become contributing members of society. The purpose of this study is to specify the program objectives of Simon House underscored by this philosophy, and to measure the effectiveness of Simon House relative to the stated objectives. The implementation of this evaluation process should aid Simon House in the development of systematic, ongoing self-evaluation in the future.

The holistic philosophy underlying the goals and objectives of the Simon House program warrants a comprehensive study of the biological, psychological, and social influences of the Simon House experience on its residents. Even though a change in one area is understood to affect the others (for example, a resident's depression interplays with his being socially isolated and his physical health), these three levels of human functioning have been delineated to enable the systematic execution of the study.

Data was collected pertaining to each of these three levels of the subjects' (residents') functioning early in their stay at Simon House, and again approximately six weeks later. Information about the subjects' life situations before they came to Simon House was also collected during the pre-testing.

CHAPTER 2

Literature Review

The homeless alcoholic population has been a social problem for the western nations for over sixty years (Bahr, 1969, p. 224). In the United States and Canada in the 1920s, vagrancy was identified as the primary problem and one type of vagrant was classified as the alcoholic vagrant (Bahr, 1969, p. 223). Over the years, alcoholism superceded vagrancy as the more general disorder and some argue that the only homeless men who receive much attention today are the chronic alcoholics (Bahr, 1969, p. 223; Cook, 1975, p. 177).

Simon House caters to any homeless, destitute man; however, over 90% of its residents state they have an alcohol problem as well. Therefore, the literature related to the homeless male alcoholic and programs for him will be reviewed in this chapter.

A Profile of the Homeless Male Alcoholic

Demographic Characteristics

The following information has been gathered from studies of men living on the street, as well as men living in rehabilitation settings. These studies have indicated the homeless male alcoholic is most likely to be in his mid-forties (Blumberg, Shipley, & Shandler, 1973, p. 147; Orford & Hawker, 1974, p. 215; Wattenberg, 1954, p. 589; Young, 1973, p. 60). (Blumberg et al. found 80% of their subjects to be over the age of 45.) He is also most likely to be divorced or separated (Blumberg et al. [1973] reported 44% of their subjects to be divorced or separated, and Young [1973] reported the figure to be 62%). He is unlikely to have completed high school, according to: the Bon Accord study, in which 95% of the subjects had a grade eight education or less (Collier & Somfay, 1974, p. 12); Blumberg et al. (1973, p. 253), who found 59% of the subjects in their study had not completed grade eight; and Young (1973, p. 60), who found 90% of the subjects in his study had not completed high school. Findings indicate the homeless male alcoholic is generally of low intelligence. Blumberg et al. (1973, p. 253) found the mean IQ of their sample to be 88.5. This level is surpassed by 75% of the general population. Young (1973, p. 60) stated 59% of the skid row men he studied had a Protestant religious affiliation, whereas 38% had a Roman Catholic affiliation. Based on this descriptive data, the typical homeless alcoholic is middle-aged, divorced or separated, not well-educated, of below average intelligence, and Protestant or Roman Catholic.

Physical Health

It is well-documented that most homeless alcoholic men are in poor physical health (Report of the Greater Philadelphia Movement, 1961, p. 7; Blumberg et al., 1973, p. 113; Sutherland & Locke, 1971, p. 42). High rates of physical handicaps, tuberculosis, and appalling dental conditions have been found in this population (Bahr, 1967, p. 98; Blumberg et al., 1973, pp. 109-112). Malnutrition is also more common in these men than the general population. This has been linked to the high rate of alcoholism, as it is believed many men do not eat properly while they are drinking (Blumberg et al., 1973, p. 116).

Although many skid-row men are sick, and much of the disease is chronic and remediable, they are unlikely to seek medical care unless forced to by pain or other symptoms. If they do, their chances of following through treatment are poor. Blumberg et al. (1973, p. 116) stated that the key to control and prevention of many health problems on skid row is the treatment of alcoholism, as most are alcohol-related.

Alcoholism

There are conflicting findings relating to the extent of alcoholism in the North American homeless male population. Though alcoholism was once viewed as a problem experienced by a minority of vagrants (Anderson, 1967, p. 98), more recent studies show the percentage of alcoholics within this population to range from 25% to over 80% (Anderson, 1967, p. 6; Blumberg et al., 1973, p. 116; Bogue, 1963, p. 93; Edwards et al., 1966, pp. 1036-1037; Holloway, 1970, p. 62). The societal view of the homeless man associates him with alcohol and drug dependency, indicated by the number of services and treatment programs for homeless alcoholics.

Much of the confusion surrounding the relationship between homelessness and alcoholism arises from the lack of agreement on the definition of alcoholism. Currently, there are over 200 definitions of alcoholism, and little agreement as to which is correct (Ward, 1979, p. 55). Recent research has indicated that alcoholism may not be a single or distinct disorder, but a number of different "alcoholisms" with corresponding personality types (Collins, 1978, p. 21; Lawlis & Rubin, 1971, pp. 318-327). In practice, alcoholism and its treatment have been defined largely in terms of where the "problem drinker" is seen, be it in hospital, court, a detoxification center, or an Alcoholics Anonymous meeting. The general definition used by most treatment centers and halfway houses is based on a systems theory approach — "alcoholism is viewed as multivariant disease, having physiological, psychological, and social components" (Collins, 1978, p. 21). Thus an estimate of alcoholism rates within the homeless male population will vary with the definition accepted by the professional involved, and whether or not the client states he has an alcohol problem (the homeless man tends to inaccurately minimize his drinking problem [Bahr & Houts, 1971, pp. 374-382; Blumberg et al., 1973, pp. 243-249]). Though estimates of alcoholism rates vary, more comprehensive assessments of alcoholism within this population are being made.

In measuring alcoholism severity, an increasing number of researchers are finding duration of drinking, frequency of drinking, and alcohol intake to be poor diagnostic indicators, largely due to alcoholics underestimating their intake (Evenson et al., 1973, p. 1339; Wattenberg, 1954, p. 591). Rather, severity seems primarily related to an item cluster representing loss of control and advanced clinical symptoms such as blackouts plus some related consequences (Selzer, Schmidt, Sheinberg, & Rohan in Evenson, 1973, pp. 1336-1339).

There is widespread agreement that alcoholism is more prevalent in homeless men than the general population, and that significant physical and psychosocial problems result. Other aspects of the literature pertaining to alcoholism will be discussed in conjunction with the social functioning of, and programs for, the homeless alcoholic.

The purported extent of alcoholism in homeless men raises questions of cause and effect. One wonders whether these dysfunctional conditions caused the homelessness, or whether the homelessness is responsible for them. Blumberg et al. (1973, p. 190) stress that a person usually has had severe life problems before becoming an alcoholic, whereas Straus (1974, pp. 9-14) states alcohol provides a form of adjustment to skid-row life. Wiseman (1970, p. 15) notes similarly that drinking tends to obliterate the anxiety-provoking environment of skid row. Regardless of etiology, the alcoholism and social dysfunction are bound to be mutually detrimental.

Psychological Health

Two studies of homeless male alcoholics included a systematic assessment of their personalities. Blumberg et al. (1973) found the mean group score on the Psychopathic Deviation Scale (Pd) of the MMPI to be 64, which surpassed 70% of the general population. This indicates the group has a high degree of social pathology, which would be a severe hindrance to their being accepted as members of a larger community. The same study found a mean of 61 associated with the Depression scale (D). This score surpassed 82% of the general population, and indicates that these men found little happiness in their life on skid row, and experienced much dissatisfaction with themselves.

Kirchner (1974) found alcoholic males scored significantly higher on the Ego Strength (C), Boldness (H), Guilt Proneness (O), and Free-floating Anxiety (Q4) scales of the 16 PF, supporting the "alcoholic personality" as defined by the 16 PF in four other studies (Kirchner, 1974, pp. 627-635). Also supported by other findings were elevated scores on the Impulsivity (F), Suspiciousness (L), and Imagination (M) scales, indicating the alcoholic male to be more heedless, suspecting, and absent-minded than the average male. (This study did not focus on the homeless alcoholic population.)

Holloway's less systematic study (1970) found the homeless alcoholic to have an inability to cope with small problems and minor inconveniences, resentment and hatred toward parents, and a longing for affection and sympathy. Priest's study of the Edinburgh homeless found only one man in four with no psychiatric abnormality (1971, p. 198). Similar rates of psychiatric illness have been found by Wood (1979, p. 209) in his study of those at the Camberwell Reception Center; Scott et al. (1966) in his study of Edinburgh common lodging house residents; and Edwards et al. (1968, p. 1034). Thus the population of homeless alcoholics appears to be psychologically unhealthy, especially in terms of sociopathy, depression, and overall anxiety.

Social Functioning

The social functioning of homeless alcoholic men varies greatly depending upon which man is being considered, and which part of the "treatment loop" he is in at that time. The treatment loop analogy is used by Cook (1975) to explain the cyclical nature of the social functioning of skid-row men. The men repeatedly move from street life to jail or detoxification centers, then into a rehabilitation center or halfway house. They remain there, gaining strength until they are again physically and mentally able to manage on the street. Their return to street life closes the treatment loop, restarting the cycle. One might expect the social functioning of these men to be better when they are not on the street. The analogy also implies that due to this continuous cycling, these men remain "homeless" irrespective of having a temporary home.

Blumberg et al. (1973, p. 179) report that 61% of the subjects in their sample of homeless men resided in the skid-row area, leaving 39% who did not. Similarly, Orford and Hawker (1974, p. 215) found that 19% of the homeless men in a halfway house for chronic alcoholics did not live on the street for the year before they were interviewed. These findings support the theory that homeless alcoholics do not necessarily live on skid row. A consistently-made observation is that these men change their residences often (Bahr, 1973; Blumberg, 1973; Holloway, 1970; Ward, 1979). The alternative accommodations reported were: in their own home or apartment; in a halfway house; or with friends or relatives.

Homeless male alcoholics are largely unskilled, unemployed, or performing menial labor if they are employed (Blumberg et al., 1973, p. 181; Collier & Somfay, 1974, p. 12; Holloway, 1970, p. 62; Report of the Greater Philadelphia Movement, 1961, p. 7; Ward, 1979, p. 50). Thus this population largely has a destitute existence. In fact, the reason most residents applied to enter Bon Accord Farm (a work farm in Ontario) was that they had no money (Collier & Somfay, 1974, p. 62). Both Ward (1979, p. 50) and Holloway (1970, p. 62) described over 35% of their subjects as being on public assistance. (Ward comments that collecting welfare forces the homeless man to become more sedentary and bored than do petty thieving, panhandling, junk collecting, and other such occupations.) It is certain that conventional employment for the homeless male alcoholic requires either improving his education level or his accepting and maintaining menial jobs. (Young [1973, p. 60] found 90% had not completed high school and Blumberg et al. [1973, p. 253] reported 59% had less than a grade eight education.) Blumberg et al. have stated that because of these problems, employment is an unrealistic early goal for skid-row alcoholics. Emotional support and protection from facing ordinary life situations are far more necessary (Blumberg et al., 1973, p. 184).

Other studies of homeless alcoholics have revealed well over half had been convicted of a criminal offence: Holloway (1970) found 50% were ex-prisoners; Collier and Somfay (1974) found 65% had a criminal record; and Orford and Hawker (1974) found 66% had been convicted of a criminal offence. This indicates a significant proportion of this population has, at some point, committed a crime, and has consequently been involved with the legal system. This confirms the finding that this group is abnormally sociopathic (Blumberg et al., 1973).

When homeless alcoholics are in a rehabilitation setting, the structuring of their leisure time presents a problem. Wiseman (1970, p. 2) finds these men lose the ability to plan their time. Archard (1979, p. 147) explains how the residents of Rathcoole, a halfway house, were required to structure their time, and how staff evaluated the subjects' progress based on this. Negative ways of structuring time were those "from which the resident gained no inner satisfaction" (1979, p. 147), such as watching TV, sleeping, reading the newspaper, and betting. Levine (in Cook, 1975, p. 89) stated that his view of appropriate use of leisure time differed significantly from the men's view; however, the need for them to structure their own leisure time is paramount.

Disagreement exists as to whether or not the homeless alcoholic can build a supportive social network from "street" relationships. Ward (1979, p. 36) found friendships on skid row to be long-lasting — 57% of the men he surveyed had their friends for over four years. Archard similarly did not find the men in his study to be isolated, but having a network of relationships that were socially meaningful to them. Conversely, other researchers have termed the relationships of these men superficial and not emotionally supportive (Blumberg et al., 1973, p. 181; Collier & Somfay, 1974, p. 12). However, it is agreed that homeless alcoholic men do not have long-term relationships with women, nor do they have close, consistent contact with their families of origin (Blumberg et al., 1973, p. 253; Collier & Somfay, 1974, p. 12; Young, 1973, p. 60). Holloway (1970, p. 66) found many subjects to display resentment and hatred toward their parents while longing for affection and sympathy.

Regardless of whether or not the homeless alcoholic's degenerating social functioning remits while he is in a halfway house, he can be characterized by: frequent changes of residence; poor education; unemployment; criminal behavior; inability to structure leisure time; a limited social network; loose family ties or denial of close ones; and an inability to sustain intimate relationships. All of these problems have been, at some point in the literature, related to alcoholism.

Programs for the Homeless Male Alcoholic

It has often been suggested that treatment for homeless alcoholics has never been a priority of society; therefore programs are inevitably fraught with defects (Al-Issa, 1984, p. 96; Blumberg et al., 1973, p. 314; Report of the Greater Philadelphia Movement, 1961, p. 7). Presently, there are a number of different treatment approaches:

(1) rehabilitation on the streets — where the change agent works and lives with members of the homeless community (Blumberg et al., 1973, pp. 236-238).

(2) Salvation Army — a Christian missionary program seen by many men as exploitable, hypocritical, and stagnating (Wiseman, 1970, pp. 171-181).

(3) hospital programs — which usually do not treat homeless alcoholics unless they have an accompanying medical problem (Bahr, 1973, p. 246).

(4) prison programs — of which there are few in existence (Bahr, 1973, p. 246).

(5) long-term residential centers (larger than residential homes) — of which there are few that have formally stated goals (two are: Camp La Guardia in New York City [Bahr, 1973, p. 255], and Bon Accord Farm in Ontario [Collier & Somfay, 1974]).

(6) detoxification centers — which offer short-term medical care, and are often an alternative to jail. In Calgary, two are in operation: Alpha Center and Renfrew Recovery Center.

(7) halfway houses — which try to reintegrate marginal alcoholics back into society. Few have been available to homeless alcoholics, and there is some evidence that they are more effective for middle-class men than lower-class men (Bahr, 1973, p. 267).

(8) small residential houses for the homeless alcoholic — which are similar to conventional halway houses, but have flexible admitting policies; few are in existence (Cook, 1975, p. 78) (one is Kiwanis House in Kamloops, B.C. [Al-Issa, 1984, p. 98]).

(9) Alcoholics Anonymous (AA) — which is reputed to be one of the most effective programs for alcoholics; however, its characteristics of anonymity make it difficult to study. AA has been accused of being more suitable for a middle-class person. de Hoog (1972, pp. 135-136) states "AA's glorious return to sobriety and a successful career is a far cry from [the homeless alcoholic's] reality of, at best, a menial job."

Problems related to these programs vary. Some experts argue that programs should have a minimum of structure (i.e., rules, expectations, etc.) (Al-Issa, 1984, p. 96; Holloway, 1970, p. 68), whereas others argue that the men need strict, clear guidelines to provide the control that is lacking in their personalities (Collier & Somfay, 1974; Young, 1973). Levin (in Cook, 1975, p. 80), Collier and Somfay (1974), and Bahr (1973, p. 280) advocate that, regardless of the structure of a program, the men should be allowed a considerable amount of input into the development and implementation of program policies.

Small, residential houses for up to twelve homeless men are currently seen as the most appropriate rehabilitation setting (Archard, 1979, p. 133; Cook, 1975, p. 78). It is thought that as residents gain insight into their problems, and increase their confidence in, and ability to handle, tasks and relationships of everyday life, they will progress through various stages of supported accommodation, each characterized by increased autonomy and indpendence. Levin argues that these stages serve mainly to alleviate short-term problems, but do not address the long-term problems of: poor employment prospects; poor literary standards; social or emotional isolation; low self-sufficiency and confidence; or other problems inhibiting the resident from coping in our complex society (Cook, 1975, p. 78). It appears that, until programs are able to effect and measure improvement in these areas of a homeless man's life, they will not be a priority of society.

Program Evaluation

Program evaluations are vital to test the assumptions upon which activities are based, and to increase a program's accountabilities to funding sources. Still, evaluation studies of programs for homeless alcoholics have generally been supplementary to the program instead of being included in its development. Therefore, no baseline data is collected, there is no proper assignment to control groups, and a number of systematic biases remain uncontrolled. Due to the transient population studied, another major problem is data loss, or sample attrition (Ogborne & Cook, 1977; Sanchez- Craig, 1982, pp. 5-6).

With the many problems these homeless men have, it is difficult to determine which would be the most appropriate to focus on for outcome measurement purposes. Evaluation studies have used a number of different definitions of "success". Some have associated it solely with sobriety (Bahr, 1973; Blumberg et al., 1973; Ogborne & Clare, 1979). This strategy has been criticized because drinking is not considered a useful predictor of overall social adjustment (Bahr, 1973, p. 279; Collins, 1978, p. 30). In fact, a follow-up study of 46 patients at the Cincinnati Alcoholism Clinic found no difference between abstinent ex-patients and drinking ex-patients in physical and mental health, interpersonal relationships, or vocational adjustment (Bahr, 1973, p. 279). Blumberg et al. (1973, p. 150) used decreased arrests and convictions as the indicator of success in their study. (If a man was not arrested or convicted for two years after discharge from treatment, he was termed a "success".) Gillis and Keat used drinking patterns, employment record, quality of interpersonal relationships, and residential mobility as the criteria for analyzing their data on 747 alcoholics (Collins, 1978, p. 24). Being married, living at home, and being regularly employed are indicators of social stability often viewed as prognostic of treatment outcome (Collins, 1978, p. 24). These multiple measurements are more accurate than one, but a larger volume of data must be collected and analyzed.

Success has also been directly related to length of stay in a rehabilitation residence (i.e., the longer the homeless man stays in this environment, the more likely he is to become and remain "normal"). Rubington (1970) found that stays of over three months in a rehabilitation home were associated with improved outcome, and Katz (1966) found the same with stays of over four months. Orford and Hawker (1974) stated a minimum of three months was needed for the men to achieve the goals of their home for homeless alcoholics. They identified "failures" as those with stays of less than seven weeks, or discharges back to the street. The remaining subjects were identified as "successes".

Bahr (1973, p. 273) states that program evaluation in the field of alcoholism is still in its infancy, and that there is a pattern emerging whereby researchers conclude that more research is needed when the evaluations are proven ineffective. The evaluation research in this area is sketchy, and riddled with methodological shortcomings; therefore, the following summary of evaluation research results must be viewed with caution.

A number of studies found poor outcomes in terms of their designated criteria for success. Orford and Hawker (1974) found homeless men in their program had a high rate of undesirable discharge, as did Ogborne and Cook (1977). Sanchez-Craig and Walker (1982) found poor outcomes in terms of drinking behavior, employment, and social stability. Bahr (1973, p. 273) states there is little evidence that any programs for chronic inebriates are successful, although he cites one in which a preliminary evaluation showed 31% of the men to be abstinent and 60% to be temporarily not drinking at follow-up, 11 months post-discharge (Bahr, 1973, p. 249).

A study by Ogborne and Clare (1979) reported an increase in detoxification center admissions in the year following residence in a home for homeless alcoholics. They attributed this increase to both the subjects' greater trust of community services, and their improved ability to identify when they needed detoxification. Annix and Liban (1979, p. 68) also found the halfway house they studied integrated men into the health care network, and encouraged them to seek services on their own.

In general, research indicates programs for homeless alcoholic men are not very effective. Rather than aiming at rehabilitation, limited goals involving long-term, caregiving services have been suggested as a more realistic approach to meeting the needs of these men (Annis & Liban, 1979).

CHAPTER 3

Program Description

Simon House is a private, voluntary, non-profit organization dedicated to helping the homeless men (of any faith, race, or background) who live on the streets of Calgary. Although most of the residents have chronic drug and/or alcohol problems, this is not a requirement of admission to the program. Men with severe mental illness are excluded from entering Simon House.

This program parallels the small, residential houses for homeless alcoholic men discussed by Cook (1975) and Archard (1979) in its admission leniency, purpose, and philosophy. However, it does not have the physical capacity or funding to implement the various stages of supported accommodation discussed by Archard (1979, p. 13). The philosophy of increased autonomy and independence is implemented in other ways. For example, as a resident becomes more able to cope with tasks and relationships, he may be given the responsibility of being the house representative. The long-term problems Levine (in Cook, 1975) argues are not dealt with in these residential houses (i.e., poor employment prospects, poor literary standards, social or emotional isolation, low self-sufficiency and confidence) have a greater chance of being dealt with at Simon House, as no limitation on length of stay is imposed — some residents stay for over one year.

Simon House consists of two adjacent residences which provide accommodation for 20 men. They have been operating at full capacity since their opening. Four staff are on the payroll of Simon House — a director, an evening supervisor, a night supervisor, and a weekend supervisor. A number of activities are pursued by these staff, including: (1) designing and implementing plans for each resident's rehabilitation; (2) giving attention to residents' physical health problems; (3) supervising work programs devised for residents; (4) assisting in arranging social activities; (5) providing informal counseling; (6) arranging referrals to outside agencies; (7) maintaning records; and (8) enforcing house rules. These activities are pursued in an environment where the men are accepted as unique individuals, and a minimum number of rules are is existence, yet it is made clear to the residents that they must be responsible for, and deal with, the consequences of their actions.

There are three major differences that hold Simon House distinctly apart from conventional halfway houses (Bahr, 1973, p. 267): (1) its pragmatic approach to providing a service to all homeless men, whether they have an addiction problem or not; (2) its provision of a very unstructured program which oversees unique individualized plans developed and implemented for each resident; and (3) its focus on the lower rather than the middle-class man.

Program Goals, Objectives, and Activities

Figure 3.1 presents an outline of the goals and objectives of Simon House. The column on the right attempts to delineate the activities undertaken by Simon House staff in their attempts to meet these objectives.

Figure 3.1

Program Goals, Objectives, and Activities

Goals:
(1) To help the residents achieve personal fulfillment.
(2) To help the residents become responsible, contributing members of society.

Objectives	Activities
1.1 To improve their biological functioning. 1.1 To improve physical health. 1.2 To increase interest in grooming, self-care, and exercise.	-providing access to medical care. -providing food, clothing, shelter. -providing encouragement re: grooming, self-care, and exercise.
2.0 To improve their psychological functioning. 2.1 To decrease depression, anxiety, guilt, resentment, suspiciousness, psychological inadequacy, and insecurity.	-providing supportive, homelike atmosphere with minimal rules. -referring to outside agencies, groups for counseling. -providing informal counseling and the opportunity for mutual support.
3.0 To improve their social functioning. 3.1 To improve financial situation. 3.2 To improve work situation (if appropriate). 3.3 To improve social support network. 3.4 To improve relationships with family. 3.5 To increase participation in appropriate recreational and leisure activities.	-providing homelike atmosphere with minimal rules. -referring for financial assistance. -devising household work programs. -referring for counseling. -providing opportunity for social interaction. -providing opportunity to participate in appropriate recreational and leisure activities. -planning social functions.
4.0 To decrease illegal behavior.	-providing non-deviant environment.
5.0 To decrease degree of problematic drinking and drug-taking behavior.	-providing "dry" environment. -referring for addictions counseling, group, etc. -developing plan of recovery. -informal counseling.

CHAPTER 4

Evaluation Methodology

Design

In evaluating the program, it would have been unrealistic to obtain a matched control group of transient, homeless men and follow them through time. Therefore, to evaluate the success of the Simon House program, a quasi-experimental pre-test/post-test design was used (pictured in Figure 4.1).

Figure 4.1

Evaluation Design

Study Group	Time 1		Time 2
Residents of Simon House as of time 1.	0	X	0
	--------6 weeks--------		

Key: 0 = Observation of subjects (i.e., measurement of outcome variables).
X = Independent variables or factors controlled by Simon House.

The research instruments were administered to the subjects at the beginning of the study, then again after they had lived in Simon House for six weeks. This six-week lapse between the pre-test and post-test was chosen since the average length of stay in Simon House was eight weeks. The time interval of six weeks produced the optimum results when attempting to achieve both the largest possible sample size and full effect of the independent variable.

The study design also has an element of description, in that data collected was used to describe the sample. A resulting profile of the "Simon House resident" is developed and compared to previously-established profiles of homeless alcoholic men.

Sample

All Simon House residents were asked to participate, and all who agreed did so voluntarily. When the residents were initially approached and asked to participate in the study, 16 of the 20 did so. As new residents were admitted over the following month, they were approached as well. The response rate to the pre-testing was consistently 80%.

Due to admission criteria of Simon House, no subjects were under 18 years of age, female, or showing signs of severe mental illness or mental incompetence. They had to be capable of climbing stairs, thus, no severely physically disabled subjects took part. Most subjects had no other place to live when they requested admission to Simon House. A few were not destitute in this sense, rather they felt they needed a sober environment. The two primary problems identified on the subjects' admission were homelessness and alcoholism.

The high rate of sample attrition posed a problem, as is typical in studies of homeless, transient men (Walker et al., 1982, pp. 5-6). Of the initial 16 subjects interviewed, six remained at Simon House for over six weeks and thus could be post-tested (these 16 subjects are portrayed as Group 1 in Figure 4.2). Of the six pre-tested over the next month, three were post-tested (this group of six subjects is portrayed as Group 2 in

Figure 4.2). Reasons for the attrition are outlined in Figure 4.2. All but one of the subjects who completed the interview were residents of Simon House. One was an ex-resident employed as the night supervisor. He was included in the descriptive analysis of the subject group and was classified as a program "success" in the comparative analysis of program "successes" and "failures". He was not included in any pre-test/post-test analysis as he was no longer in the program. He is shown in Figure 4.2 as the subject in Group 1 who was not post-tested.

The "unplanned discharge" form of attrition was identified as a type of program failure, and conversely, subjects who remained in the program for more than three months were identified as achieving one of the two types of program success. Chapter Five outlines dependent variable differences between these two groups.

Figure 4.2

Rates of and Reasons for Sample Attrition

Pre-tested	Post-tested	Not Post-tested	Reason not post-tested
Group 1 (subjects interviewed in first month)			
N=16	N=6	N=1	-ex-resident
		N=3	-unplanned discharge (destination unknown)
		N=6	-unplanned discharge back to street
Group 2 (subjects interviewed in second month)			
N=6	N=3	N=1	-unplanned discharge (destination unknown)
		N=2	-unplanned discharge back to street
Total N=22	Total N=9	Total N=13	

Definitions of Program Success

Two definitions of program success were operationalized: (1) the subjects remaining in the program for an extended period of time (i.e., their ability to stay sober for an extended period of time); and (2) the movement of subjects toward program objectives.

As outlined in Figure 4.2, a majority of subjects left the program abruptly, failing to receive the full benefit of the program. As these abrupt, unplanned discharges were all characterized by a return to drinking, the first definition of program success relates directly to the subjects' ability to remain sober. This definition of success was operationalized by identifying as program "successes" all subjects who had stayed at Simon House for a minimum of three months and who were still sober. Some of these subjects were still living at Simon House at the time of the post-testing, while others had moved into their own apartments (those who were living on their own had kept in contact with Simon House staff or residents). Nine subjects were characterized by this definition as program successes. The remaining thirteen were identified as program failures.

The three-month stay was chosen as an indicator of program success based on previous research (Katz, 1966; Orford & Hawker, 1974; Rubington, 1970) and the previous experience of Simon House staff. Both found this to be the minimum time in which lasting improvement could take place. Defining success in these terms, and the subsequent assignment of subjects to "success" and "failure" groups was done to enable a comparative analysis of those who stayed in the program and those who were unable to stay sober and "dropped out" of the program.

The second definition of success is the movement of all subjects toward program objectives. The program objectives that were measured are outlined in the following section in Figure 4.3. Due to sample attrition, the movement of a subsample (N=9) related to physical and psychological health was measured.

Measures of Outcome

Figure 4.3 presents the key program objectives that were measured. The right-hand column indicates which specific instrument was used to operationalize these objectives. The instruments are explained in detail in the next section.

Figure 4.3

Measurements of Objectives

Objectives	Measurement*
1.0 Improve biological functioning.	
1.1 Improve physical health.	-Cornell Medical Index Health Questionnaire
1.2 Interest in grooming, self-care.	-unstandardized, structured interview
2.0 Improve psychological functioning.	-Clinical Analysis Questionnaire
3.0 Improve social functioning.	-unstandardized, structured interview
3.1 Financial	
3.2 Work	
3.3 Social support network	
3.4 Family relationships	
3.5 Recreational and leisure activities	
4.0 Illegal behavior	-unstandardized, structured interview
5.0 Drinking and drug-taking behavior	-unstandardized, structured interview

* Cornell Medical Index	(Brodman & Wolff, 1949)
Clinical Analysis Questionnaire	(Krug & Cattel, 1980)
Unstandardized, structured Interview	APPENDIX A

Instruments

All of the data was collected in the form of a structured interview. This was composed of two parts: (1) a self-administered questionnaire; and (2) an interview conducted by the researcher. The instruments used in both of these parts are explained as follows:

Standardized Instruments

Two standardized instruments comprised the part of the research interview that was self-administered. They provided the primary measurements of the variables "biological functioning" and "psychological functioning".

Physical health.

The instrument used to measure physical health was a modified (cut down) version of the Cornell Medical Index Health Questionnaire (1949). This self-administered instrument contains 195 questions which relate to the following four areas: (1) bodily symptoms; (2) past illness; (3) family history illness; and (4) behavior, mood, and feeling. The 51 questions relating to mood and feeling were omitted since these traits were measured by more specific instruments. Although this instrument was developed some time ago, a review of the recent medical literature on this area indicated a relevance of the Cornell instrument for purposes of this study (e.g., Ware et al., 1981; Parkerson et al., 1981).

Psychological functioning.

The instrument used to measure the current psychological functioning of the subjects was the Clinical Analysis Questionnaire (CAQ) (Krug, 1980). This self-administered questionnaire is designed for use in general clinical diagnosis for evaluating therapeutic process.

The primary source traits (Part I of the Questionnaire) are: Sizothymia (reserved, detached, critical, aloof, stiff) vs. Affectothymia (warm-hearted, outgoing); Low Intelligence vs. High Intelligence; Lower Ego Strength (affected by feelings, emotionally less stable, easily upset, changeable) vs. Higher Ego Strength (emotionally stable, mature, calm, faces reality); Submissiveness vs. Dominance; Desurgency (sober, taciturn, serious) vs. Surgency (lively, enthusiastic, happy-go-lucky); Weaker Superego Strength (expedient, disregard rules) vs. Stronger Superègo Strength (conscientious, persistent, moralistic, staid); Threctin (shy, timid, threat-sensitive) vs. Parmia (venturesome, uninhibited, socially bold); Harria (tough-minded, self-reliant, realistic) vs. Premsia (tender-minded, sensitive, clinging, overprotected); Alaxia (trusting, accepting condictions) vs. Protension (suspicious, hard to fool); Praxernia (practical, "down to earth" concerns) vs. Autia (imaginative, bohemian, absent-minded); Artlessness (forthright, unpretentious, genuine) vs. Shrewdness (astute, polished, socially alert); Untroubled Adequacy (self-assured, complacent, secure, placid) vs. Guilt Proneness (apprehensive, insecure, troubled); Conservatism of Temperament vs. Radicalism (experimenting, liberal, free-thinking); Group Adherence (group oriented) vs. Self-Sufficiency (resourceful, prefers own decisions); Low Self-Sentiment Integration (undisciplined self-conflict, lax, follows own urges, careless of social rules) vs. High Strength of Self-Sentiment (controlled, exacting will power, socially correct, compulsive, following self-image); Low Ergic Tension (relaxed, tranquil) vs. High Ergic Tension (tense, frustrated, overwrought).

Factors for the Pathology Supplement (Part II of Questionnaire) are Low Hypochondriases (happy, functions well, does not find ill health frightening) vs. High Hypochondriasis (shows overconcern with bodily functions, health, or disabilities); Zestfulness (is content with life and surrounding, has no death wishes) vs. Suicidal Disgust (is disgusted with life, harbors thoughts or acts of self-destruction); Low Brooding Discontent (avoids dangerous and adventurous undertakings, has little need for excitement) vs. High Brooding Discontent (seeks excitement, restless, takes risks); Low Anxious Depression (is calm in emergency, poised) vs. High Anxious Depression (has disturbing dreams, tense, easily upset); High Energy Euphoria (shows enthusiasm for work, energetic, sleeps soundly) vs. Low Energy Depression (has feelings of weariness, worries, lacks energy to cope); Low Guilt and Resentment vs. High Guilt and Resentment; Low Bored Depression (is relaxed, considerate, cheerful with people) vs. High Bored Depression (avoids contact and involvement with people, shows discomfort with people); Low Paranoia vs. High Paranoia; Low Psychopathic Deviation (avoids engagement in illegal acts of breaking rules, sensitive) vs. High Psychopathic Deviation (has complacent attitude toward own or others' anti-social behavior, is not hurt by criticism, likes crowds); Low Schizophrenia (makes realistic appraisals of himself and others, shows emotional harmony and absence of regressive behavior) vs. High Schizophrenia (hears voices or sounds without apparent source outside of himself, retreats from reality, has uncontrolled and sudden impulses); Low Psychasthenia (is not bothered by unwelcome thoughts or compulsive habits) vs. High Psychasthenia (suffers insistent, repetitive ideas and impulses to perform certain acts); and Low General psychosis (considers himself as good, dependable, and smart as most others) vs. High General Psychosis (has feelings of inferiority and unworthiness, timid).

The second order factors derived from the 28 scales listed above are: Extroversion vs. Introversion; Anxiety; Cortertia vs. Pathemis (alert, poised); Independence vs. Subduedness; Broad Superego vs. Lack of Self-Sentiment (conscientious, social value oriented, shy, conservative); General Frustration Depression; Restless Depression (bored and restless, with guilt, anxiety, and resentment); Suicidal Depression (disgusted, suicidal, and hostile); General Maladjustment Depression (brooding discontent, expressed in psychopathic behavior, but with anxiety).

Figure 4.4 displays the CAQ profile format. Subjects' raw scores on CAQ factors were converted to standard-ten, or "sten" scores using Krug and Cattel's principal norm table for non-clinical males (1973, p. 9). In this reference population, the normative scores have a mean of 5.5, a standard deviation of 2, and a range between 1 and 10.

Figure 4.4

Clinical Analysis Questionnaire (CAQ) Profile Format

NORMAL PERSONALITY TRAITS

Low Score Description				Average		High Score Description					
1	2	3	4	5	6	7	8	9	10	A.	Warmth
1	2	3	4	5	6	7	8	9	10	B.	Intelligence
1	2	3	4	5	6	7	8	9	10	C.	Emotional Stability
1	2	3	4	5	6	7	8	9	10	E.	Dominance
1	2	3	4	5	6	7	8	9	10	F.	Impulsivity
1	2	3	4	5	6	7	8	9	10	G.	Conformity
1	2	3	4	5	6	7	8	9	10	H.	Boldness
1	2	3	4	5	6	7	8	9	10	I.	Sensitivity
1	2	3	4	5	6	7	8	9	10	L.	Suspiciousness
1	2	3	4	5	6	7	8	9	10	M.	Imagination
1	2	3	4	5	6	7	8	9	10	N.	Shrewdness
1	2	3	4	5	6	7	8	9	10	O.	Insecurity
1	2	3	4	5	6	7	8	9	10	Q_1.	Radicalism
1	2	3	4	5	6	7	8	9	10	Q_2.	Self-Sufficiency
1	2	3	4	5	6	7	8	9	10	Q_3.	Self-Discipline
1	2	3	4	5	6	7	8	9	10	Q_4.	Tension

(figure continues)

Figure 4.4 (continued)

THE CLINICAL FACTORS

Low Score Description				Average		High Score Description				
1	2	3	4	5	6	7	8	9	10	D_1. Hypochondriasis
1	2	3	4	5	6	7	8	9	10	D_2. Suicidal Depression
1	2	3	4	5	6	7	8	9	10	D_3. Agitation
1	2	3	4	5	6	7	8	9	10	D_4. Anxious Depression
1	2	3	4	5	6	7	8	9	10	D_5. Low Energy Depression
1	2	3	4	5	6	7	8	9	10	D_6. Guilt & Resentment
1	2	3	4	5	6	7	8	9	10	D_7. Boredom & Withdrawal
1	2	3	4	5	6	7	8	9	10	Pa. Paranoia
1	2	3	4	5	6	7	8	9	10	Pp. Psychopathic Deviation
1	2	3	4	5	6	7	8	9	10	Sc. Schizophrenia
1	2	3	4	5	6	7	8	9	10	As. Psychasthenia
1	2	3	4	5	6	7	8	9	P0	As. Psychological Inadequacy

SECOND ORDER FACTORS

1	2	3	4	5	6	7	8	9	10	Ex. Extraversion
1	2	3	4	5	6	7	8	9	10	Ax. Anxiety
1	2	3	4	5	6	7	8	9	10	Ct. Tough Poise
1	2	3	4	5	6	7	8	9	10	In. Independence
1	2	3	4	5	6	7	8	9	10	Se. Superego Strength
1	2	3	4	5	6	7	8	9	10	So. Socialization
1	2	3	4	5	6	7	8	9	10	D. Depression
1	2	3	4	5	6	7	8	9	10	P. Psychoticism
1	2	3	4	5	6	7	8	9	10	Ne. Neuroticism

Krug & Cattel (1980)

Unstandardized Interview

Social functioning, drug-taking and drinking behavior, etc.

An interview schedule was devised to measure different aspects of the subject's social functioning (Appendix A). It was partitioned into five sections which focused on: (1) background information; (2) circumstances of referral to Simon House; (3) general social functioning over the previous year; (4) drinking/drug-taking behavior and treatment thereof; and (5) present social functioning. For post-testing purposes, sections (1) (2) and (3) were disregarded, as this information did not need to be gathered twice.

The sections designated to measure past and present social functioning ([3] and [5]) focused on areas such as place of residence, financial situation, employment, legal involvement, recreational activities, and familial and social relationships. A small number of questions in these sections pertained to the subjects' physical health, as further information was needed to supplement that obtained from the Cornell Index. Information on subjects' social functioning was to be supplemented with file information supplied by the program director, however, due to the inconsistency of file content, reporting of this data is impossible.

Procedure for Data Collection

As previously mentioned, all residents of Simon House were asked to participate in the two-part research interview. Consistently, 80% of those asked agreed to participate, and subsequently completed the pre-test. The instruments were initially pre-tested by two residents. As insignificant changes resulted, they also were post-tested six weeks later, and this data was included in the analysis. Due to the high rate of sample attrition after the first set of pre-test interviews, another six subjects were enlisted the next month. The research interview was always completed by the subject within three days (the two parts were never done more than two days apart). Figure 4.5 outlines the data collection time frame.

Figure 4.5

Time Line of Data Collection Procedure

Task	(N)	Dates: June	July	August	September
Instruments Pre-tested*	(2)	17th	-	-	-
Baseline Data Collected**	(14)	19th-25th	-	-	-
Baseline Data Collected***	(6)	-	6th-20th	-	-
Re-test Data Collected*	(2)	-	29th	-	-
Re-test Data Collected**	(4)	-	-	5th-9th	-
Re-test Data Collected***	(3)	-	-	27th-30th	-
File Review Done	(22)	-	-	-	2nd-6th

* = Instrument Pre-test Group
** = First Sample Group
*** = Second Sample Group

Information Sheet and Consent Form

The subjects were initially approached by the program director of Simon House who briefly explained the purpose of the study. A further explanation of the research interview and process involved was given by the researcher (see Appendix B). This verbal presentation included the following information: (1) the purpose of the study; (2) what was expected of the subject in terms of time and procedure; (3) measures taken to ensure individual confidentiality; and (4) assurance that failure to participate would in no way affect any service received at Simon House.

If subjects showed interest, they were given a consent form which they signed before engaging in the research interview. The signed consent form (Appendix C) ensured that the subjects understood the study fully, including: (1) what was involved in the research interview; (2) that the subjects would not directly benefit from participating in the interview; (3) that the subjects could withdraw from the study at any time; and (4) that information provided would be held in strictest confidence.

Process for Administration of the CAQ and Cornell Index

The two standardized instruments were administered in groups of four to five with the researcher presiding. The completion time was $1\frac{1}{2}$ hours. Administration took place in either the dining room or living room of Simon House, both of which provided comfortable, adequately-lit environments. Answer sheets were provided, and subjects were identified only by a number on the sheet. Upon completion of the questionnaires, answer sheets were put into a sealed envelope which was also identifiable only by number. At this point, individual appointments were scheduled for administration of the unstandardized interview.

Process for Administration of the Individual Unstandardized Interviews

Before the interview was conducted, subjects were reminded of the types of questions to be asked, and the length of time the interview would take. They were also reassured of confidentiality, and that participation was purely voluntary. Each interview schedule was designated by the individual's identification number, not his name. Upon completion of the interview, it was put in a sealed envelope. The individual interviews took approximately 45 minutes each. On completion of all the research interviews, the master sheet was destroyed, leaving the subjects identified only by number.

Methodological Limitations

A major weakness limiting the methodology of this study is the lack of a control or a comparison group. The transient nature of the homeless alcoholic population prevented a control group from being formed, and the lack of a similar program in the Calgary area prevented a comparison group being formed.

Limited pre-test/post-test analyses were required due to the small sample size (N=9). This size was a result of both the small program size (Simon House has capacity for 20 men) and sample attrition. Following sample attrition data loss, a biased sample of subjects who stayed in the program longer than average remained. The analyses of data reflect this bias and it is accounted for in the discussion of findings and conclusions of the study. Further, having a small sample size made it difficult to achieve statistical significance in data analyses. Thus, the major trends were traced and reported.

Forming aggregate CAQ profiles from individual cases resulted in regression toward the mean; this caused a minimization of variation. This increased the need to carefully observe and report major trends.

The subjects' movement toward program objectives could have been more accurately measured if baseline data had been collected on admission. Some subjects had been living at Simon House prior to the beginning of this study (two for almost one year). For these subjects, movement made over the study's six-week treatment period would have been only a fraction of the movement made since admission. Ideally, baseline data should have been collected on all the subjects upon their admission to Simon House, and measurement should have been repeated at six-week intervals throughout their stay. This was not possible due to time limitations.

Subjects were the only data source in the study. This has a weakening effect on the methodology, as a self-report reliability is never totally accurate (Bahr & Houts, 1971, pp. 374-382; Blumberg et al., 1973, pp. 243-249) and should be supported by another source. An initial attempt was made to collect file data (which was compiled daily by Simon House staff), however, content areas were not consistently recorded from file-to-file, or day-to-day. Thus, useful measurements could not be devised.

In summary, the major methodological limitations were: lack of a comparison group; small sample size; lack of baseline data collected on subjects' admission to the program; and data being collected from a single source. These limitations should be considered while viewing the study results and conclusions.

CHAPTER 5

Results

This chapter will review the results of the study in four sections. In the first, an aggregate profile of the subject group will be described. In the second, differences will be discussed between program successes and program failures. For this section, "successes" and "failures" will be identified using the first definition outlined in the "Definition of Program Success" section of Chapter Four (i.e., the definition based on subjects staying sober and in the program). In the third, subjects' social functioning before entering Simon House will be compared to their social functioning as residents of Simon House. The results discussed in these three sections are based on data collected in the pre-testing only (N=22). In the fourth section, differences found between the pre-test data and the post-test data will be described (N=9). For the third and fourth sections of this chapter, program success is measured in terms of subjects' movement toward program objectives (this is based on the second definition of program success outlined in the "Definition of Program Success" section of Chapter Four).

Defining the success of the Simon House program was difficult, as its residents have always typically improved in some areas and not others. Also, their improvement is often interrupted by a (possibly temporary) return to drinking and homelessness. The two definitions of program success were adopted to enable the execution of a more inclusive and accurate program evaluation which accounts for subject improvement on two levels. The first definition identifies success in terms of subjects' "graduating" from the program as opposed to "dropping out". This definition of program success was used to divide the subjects into the two groups which could then be compared. The results of this comparison indicated why some men graduate from the Simon House program, whereas others drop out.

The second definition of program success identified success in terms of subjects' improvement toward a number of specific program objectives. By identifying success in these terms, it was possible to draw conclusions about program effectiveness, not only in helping subjects maintain their sobriety, but in achieving other, less obvious, objectives as well.

Sample Profile

This section contains a descriptive analysis of the data collected at time one (N=22). In addition to providing a description of the sample, this analysis will enable classification of Simon House residents within the homeless alcoholic male population as identified by previous research.

Demographic Characteristics

The average age of the sample group was 36 years. Subjects ranged in age from 19 to 49, with 82% falling between the ages of 30 and 49. This group was significantly younger than all other groups of homeless men cited (Blumberg, et al., 1973, p. 147; Orford & Hawker, 1974, p. 215; Wattenberg, 1954, p. 589; Young, 1973, p. 60). This indicates either that the proportion of younger men on Calgary streets is larger than other cities, or that Simon House attracts a disproportionate number of younger men.

Table 5.1 displays subjects' marital status, number of children, education, occupation, and religion. The large proportion of divorced and

Table 5.1

Marital Status, Number of Children, Educational Level, Occupation, and Religion of Subjects

Variable	(%)	(N)
Marital Status		
Married	0	(0)
Single	41	(9)
Divorced or Separated	55	(12)
Widowed	4	(1)
Number of Children		
None	46	(10)
1 - 2	41	(9)
3 - 4	0	(0)
5 - 6	13	(3)
Education		
Less than Grade 6	0	(0)
Grade 7 - 9	27	(6)
Grade 10 - 11	50	(11)
Grade 12	14	(3)
Post-secondary	9	(2)
Occupation		
Skilled	59	(13)
Unskilled	41	(9)
Religion		
Roman Catholic	27	(6)
Protestant	41	(9)
Salvation Army	9	(2)
None	23	(5)

separated subjects is consistent with other findings (Blumberg et al., 1973; Young, 1973), although it is unusual that none of the men were married. This may be related to their young age. The educational level of this group was slightly higher than than found in other studies, but the overall educational level (a mean of [grade] 10) was still far below that of the general population. Almost half the group were skilled — again a low proportion when compared to the general population, but a high proportion for the homeless population (Ward, 1979). The data on religion is also consistent with other findings.

Admission and Referral Data

Most subjects (55%) heard about Simon House from a detoxification center. The rest heard about it on the street (27%), an Alcoholics Anonymous (AA) meeting (14%), or from the Calgary Drop-In Center (4%). This is consistent with data showing that many were formally referred to Simon House by a counselor from a detoxification center (45%). The rest (55%) were self-referred.

When asked who most wanted them to come to Simon House, 59% of the subjects responded "self"; however, 41% stated a friend or counselor most wanted them to come. This indicates a significant proportion of subjects may not have been motivated to come, and thus not motivated to change. This is supported by data showing that 36% of the subjects stated the reason for coming was that they "had no other place to go," rather than "that they wanted to change their way of life" (64%). A majority of subjects (59%) stated they would have continued living on the street if they were not admitted to Simon House. Some (27%) said they would have stayed with friends or relatives, whereas 14% would have gone to the Salvation Army or a halfway house. A significant number of the subjects (motivated to change or not) saw Simon House as their only alternative to life on the street.

Physical Functioning

Over half the subjects (55%) stated they had major health problems during the year before admission to Simon House. These were described as symptoms such as stomach pain, seizures, sore back, confusion, vomiting, flashbacks, etc., rather than as diagnoses. This indicates subjects were concerned about their health, but also ignorant about it. A significant number (36%) stated they did not seek medical attention when it was needed, indicating either a lack of self-care due to negligence, or some difficulty accessing the health care delivery system. Scoring more than 25 "yes" answers on the Cornell Medical Index Questionnaire indicates the presence of a serious medical disorder (Brodman, Erdmann, & Wolff, 1949, p. 6). Even though subjects completed only 12 of the 18 sections of the questionnaire, the mean number of "yes" answers for the group was 33 (64% of the subjects had more than 25 "yes" answers). Most problems were indicated in sections C (cardiovascular), F (skin), G (nervous system), and L (habits). This is consistent with data collected on homeless alcoholic men — they are generally a very unhealthy group physically, but do not get proper medical care.

Psychological Functioning

Figure 5.1 compares the subjects' mean scores on the Clinical Analysis Questionnaire (CAQ) with the profile of male alcoholics developed by Krug and Cattel (1980, p. 38) (see Table D1 in Appendix D for mean scores). As a

Figure 5.1

Comparison of Subjects' Clinical Analysis Questionnaire (CAQ) Profile and Krug and Cattel's (1980) Alcoholic Male Profile

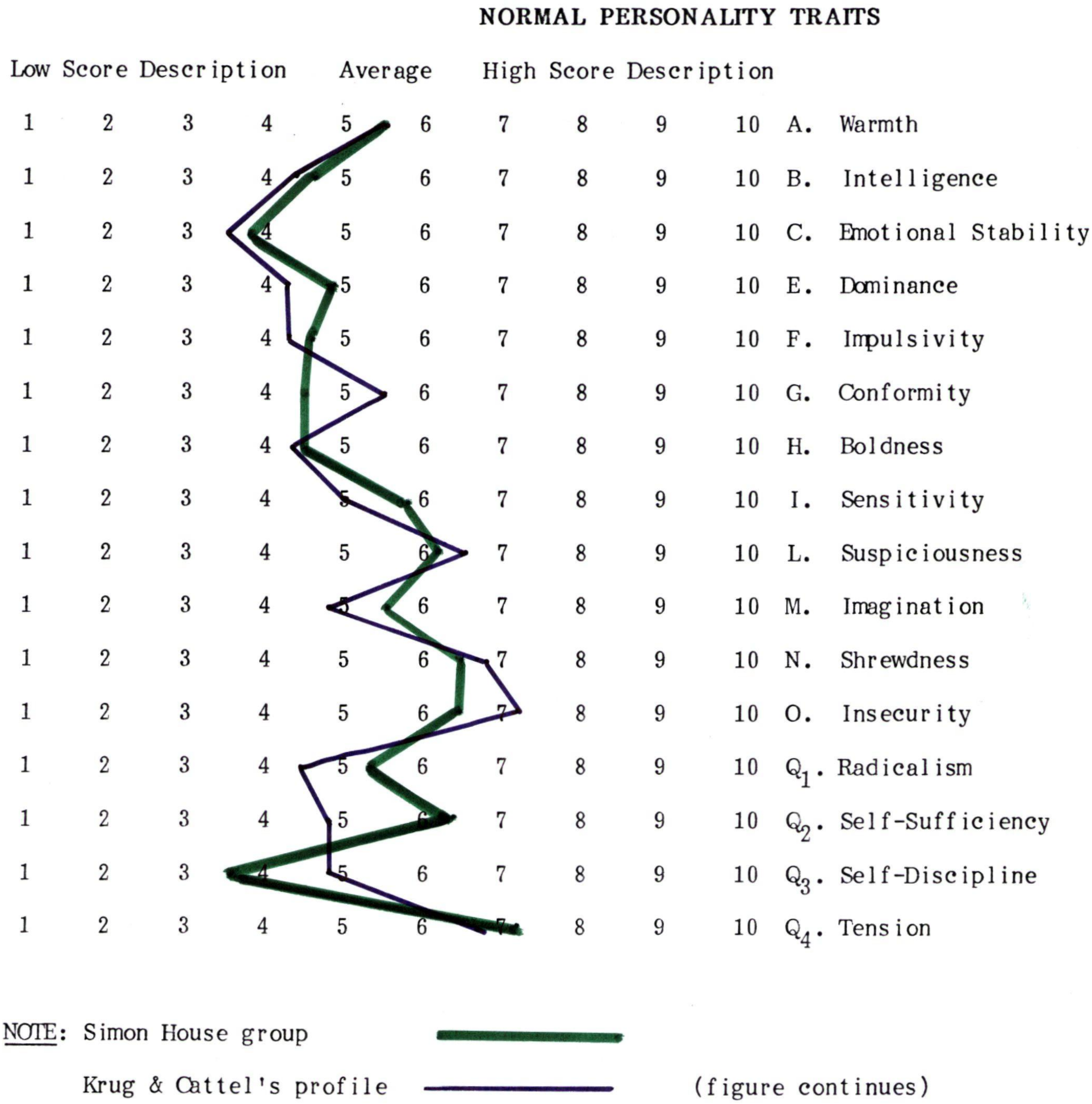
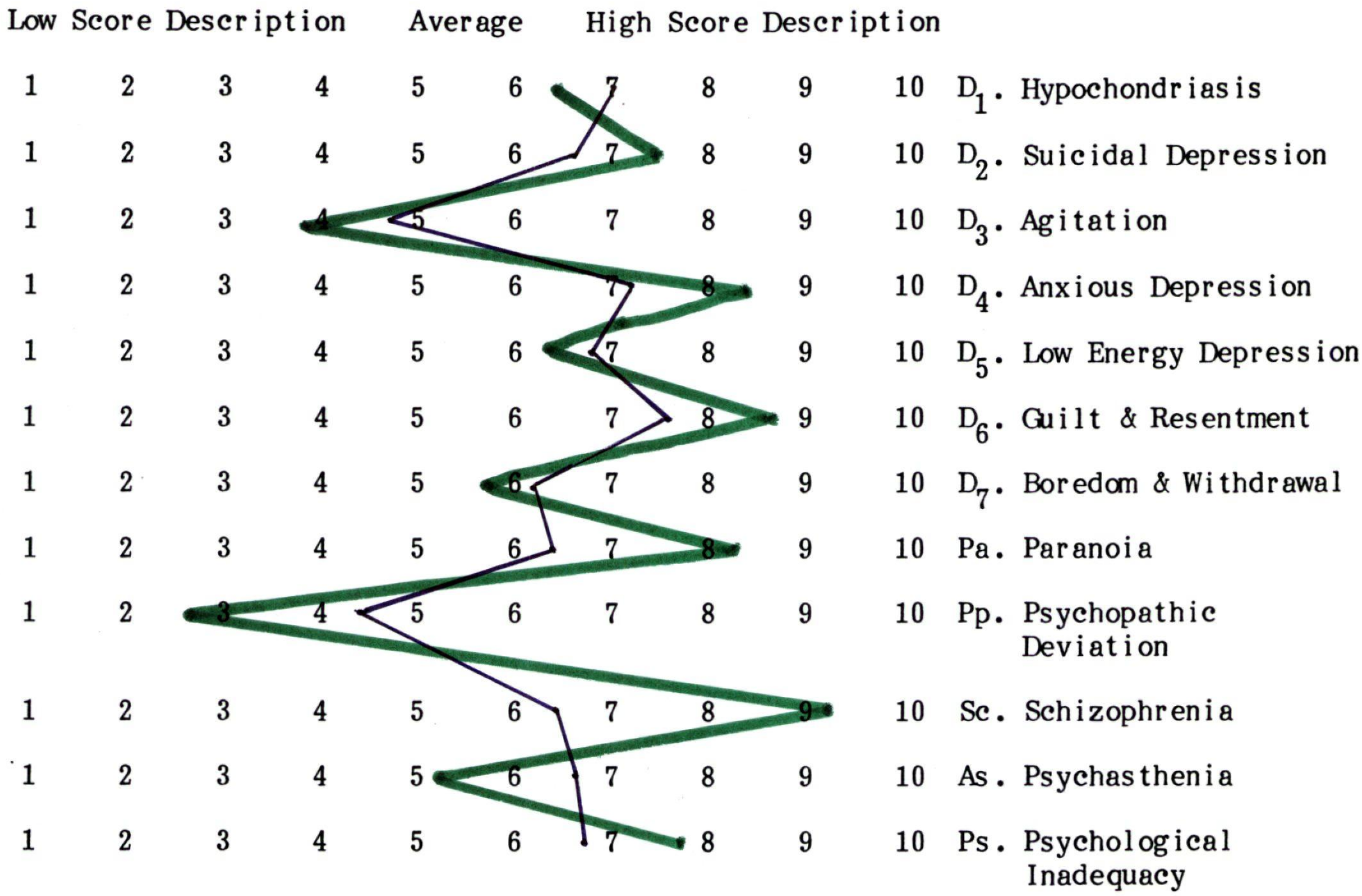
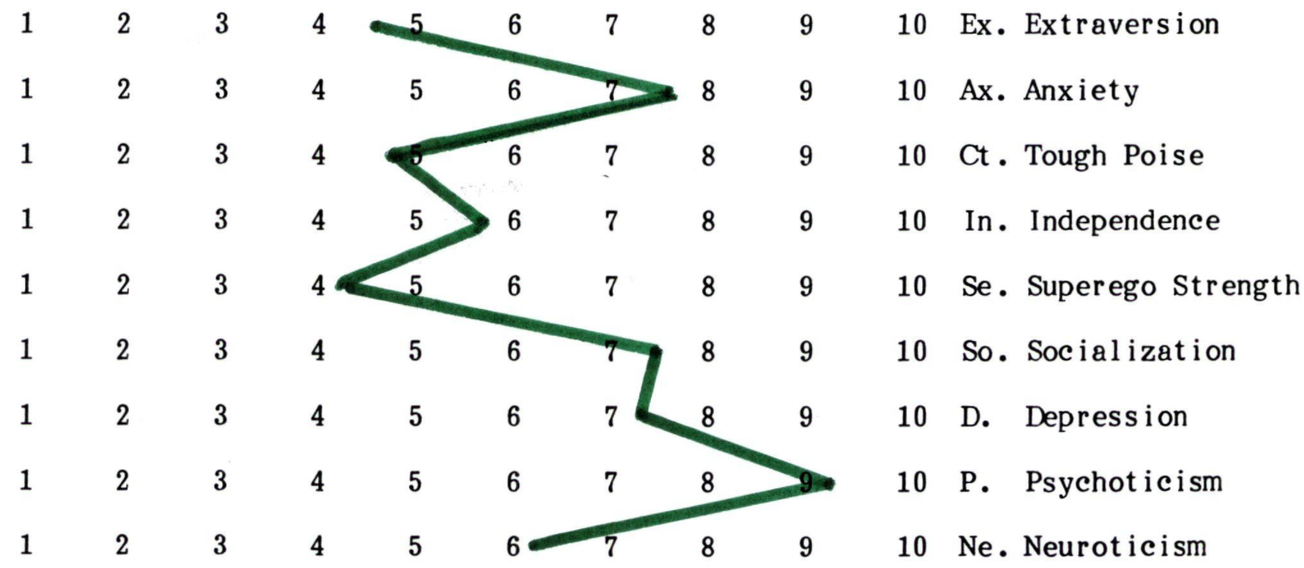


Figure 5.1 (continued)

THE CLINICAL FACTORS



SECOND ORDER FACTORS



Krug & Cattel (1980)
Note: mean scores are in Table D1, Appendix D

group, the subjects scored much lower than average in terms of emotional stability (C), dominance (E), conformity (G), boldness (H), self-discipline (Q3), agitation (D3), and psychopathic deviation (Pp). They scored much higher than average on the shrewdness (N), insecurity (0), tension (Q4), suicidal depression (D2), anxious depression (D4), guilt and resentment (D6), paranoia (Pa), schizophrenia (Sc), and psychological inadequacy (Ps) scales. This appears to be a group of men who are depressed, insecure, timid, and dependent, and who internalize their psychological inadequacies rather than externalizing them (Krug & Cattel, 1980). This trend is similar to that of Krug's alcoholics; however, the subjects in this study are more tense (Q4), and more psychologically inadequate (Pa) (Sc) (Ps), but less disciplined (Q3), less bored (D7), and less psychopathic then Krug's. This indicates the subjects of the Simon House study have more psychological inadequacies than the general male alcoholic group, and are less able to keep their emotions in order.

Blumberg et al. (1973) also found homeless alcoholics to be a depressed group but, in contrast, their group showed abnormally high psychopathic deviation. This is likely due to the fact that the group they surveyed was living on the street, where some kinds of sociopathic behavior are viewed as normal. This behavior would not be appropriate in Simon House.

In the analysis of the CAQ second order factors, the sample means were again compared to the average Sten score of 5.5. The group scored significantly higher than average on the anxiety (7.6), socialization (7.5), depression (7.3), and psychoticism (9.1) scales, and significantly lower than average on the tough poise (4.7) and super ego (4.1) scales. This confirms the subjects are depressed, psychologically inadequate individuals. Krug and

Cattel associate subjects' low scores on the tough poise scale with their being "too wound up in their emotions and. . .unable to muster the resources necessary to deal with problems they are faced with" (1980, p. 25). They also associate low super ego scale scores with sociopathy (1980, p. 25). This is more consistent with the findings of Blumberg et al. (1973).

In summary, this group of subjects are depressed, anxious, and generally psychotic. They have few inner resources to deal with their emotions, and, although they have some sociopathic tendencies, these are not displayed openly.

Social Functioning

Social functioning data was collected via an unstandardized interview with the subjects themselves. During the interview, they were asked to describe their lives over the year prior to entering Simon House. Data was collected concerning their previous living situation, self-care, work, income, finances, socialization, family relationships, intimate relationships, alcohol and drug-taking behavior, and criminal convictions. These variables will be analyzed in depth in later sections of this chapter, therefore, only an overview will be presented here. (All percentages refer to the year prior to the subjects entering Simon House.)

Fifty-nine percent said the street (i.e., flophouses, hostels, or actually living outdoors) was their primary or secondary place of residence. Thirty-six percent lived in their own rented apartment, and 18% lived primarily at the Salvation Army. Some subjects (27%) did not consider themselves to be homeless at all, whereas 41% stated they were homeless for over two months. It appears that although most of the subjects were certainly destitute and often homeless, a minority may have been less so. This data is consistent with Cook's (1975) treatment loop analogy, as the men seem to be continuously living on and off the street. They also fit his analogy in the "treatment" aspect, as 64% had been in an alcohol treatment center at some point during the previous year. The treatment centers frequently used by this group were the hospital program at Ponoka, Salvation Army, and 1835 House (a very structured halfway house in Calgary).

A large proportion of subjects (46%) stated they had poor eating habits, whereas 27% thought they were adequate. Only 50% considered their physical appearance to be consistently neat and clean. Most (68%) got exercise by walking, and a few (13.6%) got none at all. Thirty-six percent went without eyeglasses or dentures the whole year. These findings are consistent with Blumberg et al. (1973) who found homeless men to care poorly for their health.

Most subjects worked casually (64%) or not at all (32%). Only one was steadily employed at the time of admission to Simon House. Forty-one percent collected welfare or unemployment insurance, nine percent received education grants, and forty-two percent stated their primary income was obtained by participating in illegal activities (e.g., petty thievery, selling drugs) or begging. This data indicates the poverty of the group, and is consistent with other studies (Collier & Somfay, 1974; Holloway, 1970; Ward, 1979).

Most subjects (59%) identified drinking as their primary leisure activity. Fifty-five percent socialized only with people from the street, wheras 45% spent time with non-street people as well. A small number had no family contact whatsoever (14%), whereas 23% contacted family once a week.

Although inconsistent with the findings of Collier and Somfay (1974), Blumberg et al. (1973), and Young (1973), this is not uncommon, as alcoholics have been found to either deny emotional closeness to their families or be very enmeshed with them (Bowen, 1978). (Many of the subjects mentioned coming from broken homes. Although this data was not formally collected, it is certainly worthy of note.) Thirty-two percent had nobody they felt they could confide in, and a number commented on how they either could not sustain a lasting relationship with a woman, or that they had "no use for one". The majority of subjects seem to put most of their time and energy into drinking, and have few, if any, social respites from everyday problems.

Only one man did not think he had an addiction problem. Of the rest, 45.5% had both drug and alcohol problems, 45.5% had a stated alcohol problem, and 4.5% (one) had a stated drug problem. Data collected by using the Minnesota Alcoholism Severity Scale (Evenson et al., 1973) indicated that at least 86% of the subjects had serious alcohol problems (see Table D3 in Appendix D).

All subjects except one (95.5%) had had a criminal conviction. Seventy-eight percent had been arrested one or more times in the past year; fifty percent of these arrests were for public drunkenness. These findings are consistent with those of Holloway (1970), Collier and Somfay (1974), and Orford and Hawker (1974), showing these men have a high rate of involvement with the law. A majority of subjects (68%) had seen no counselors outside of those in alcohol treatment programs. Some had seen probation officers (14%), and others had seen a professional therapist (18%). This shows a small degree of professional involvement, considering the extent of this group's psychological and social dysfunction.

In summary, the subjects of this evaluation study can be characterized apart from the general population in several areas. They are young- to early-middle-aged men who are single, and not well-educated. They are largely unskilled and unemployed. They have lived intermittently in programs for chronic alcoholics, in flophouses, hostels, or their own apartments. They are alcoholics with poor eating habits who are physically unwell and do not take care of themselves. Their psychological health is poor; they have difficulty confiding in friends and in accessing professionals. They have sociopathic tendencies and are often in trouble with the law. They are in need of basic necessities, and are unhappy with their lives.

In most respects, the characteristics of subjects in this study have proven to be similar to those of homeless alcoholics studied previously. However, these subjects are younger, better educated, and better skilled than others. They do not show psychopathological traits as clearly, and they do not spend as much time homeless as other homeless alcoholics.

Comparison of Successes and Failures

Research to date has been concerned with either developing profiles of the homeless alcoholic or, to a much lesser degree, attempting to measure the effectiveness of programs for the homeless alcoholic. This study also attempts to describe the population (in section one of this chapter) and evaluate the program based on subjects' movement toward program objectives — the second definition of program success (in sections three and four of this chapter). In addition to these two tasks, this result section provides a comparative analysis of two groups of subjects — program successes and program failures. Subjects were assigned to these two groups based on the first definition of success outlined in the section "Definition of Program Success" of Chapter Four (i.e., their staying in the program rather than dropping out). All variables, changeable and unchangeable, have been studied and differences between the two groups will be presented. This analysis is an attempt to find answers to the question of why some men are able to stay in the Simon House program for a prolonged period of time and "graduate" from it, whereas others are not.

Subjects identified as failures were those who abruptly left the program without a plan for their discharge, or those who were asked to leave by staff (N=13). In all cases, these premature discharges were related to drinking, and most involved the subject's return to a transient, alcoholic lifestyle. (See Figure 4.2 for rate of, and reasons for, sample attrition.) Any subjects who had not been in Simon House for a minimum of three months would have been added to the failure group. However, none of the subjects fell into this category.

The remaining subjects (N=9) were identified as successes. They were those still at Simon House after a minimum stay of three months, or those who had had a pre-planned discharge after at least a three-month stay and were known by staff to be sober. None of the subjects who had been at Simon House less than three months had pre-planned discharges. The three-month stay was chosen as an indicator of success based on previous research (Katz, 1966; Orford & Hawker, 1974; Rubington, 1970) which found this to be the minimum time in which lasting subject improvement could take place.

Demographic Characteristic Differences

There were no differences in the mean ages of the two groups, nor in their ethnic backgrounds. The two major demographic characteristic differences between the successes and the failures were in marital status and religion. More failures had been married (62% of the failure group as compared to 42% of the success group), and had children (62% of the failures had children, whereas 44% of the successes had children). More of the failures were Protestant (54% as compared to 22% of the successes), whereas more of the successes were Roman Catholic (49% compared to 15% of the failures).

Referral Information Differences

Table 5.2 displays the proportion of subjects who wanted to enter the program themselves as opposed to being convinced to enter it by someone else, and the proportion of subjects who were self-referred as opposed to being referred by a counselor. Successes were more likely to be self-referred, whereas failures were more likely to be referred by a counselor. Successes were also more likely to be self-motivated as opposed to being in the program for somebody else. It follows that the program successes are more likely in the program because they want to be.

Failures indicated they would not be staying in the program as long as successes (they planned to stay a mean of 7.7 weeks compared to 15.9 for successes). This overall trend indicates that more program failures are denying a need for help, and thus are less motivated to stay in the program.

To a certain extent, members of these two groups could be identified upon admission by being asked who referred them, and how long they planned to stay.

Table 5.2

Successes' and Failures' Admission Situations

Variable Label and Category	Successes %	Successes (N)	Failures %	Failures (N)	Chi square x^2	Level of Significance NS=not sign.
Who most wanted them to go into program?						
Self	78	(7)	46	(6)	3.12	NS
Other	22	(2)	54	(7)		
Referral source						
Self	56	(5)	38	(5)	0.32	NS
Counselor	44	(4)	62	(8)		

Physical Functioning Differences

The program failures identified more physical problems (on the Cornell Medical Index Health Questionnaire) per person than did the successes. For each section of each subject's health questionnaire, the percentage of "yes" answers was calculated (each "yes" answer denotes a physical symptom). The overall group section means were then calculated. These mean scores were higher for the failure group in nine of the twelve sections of the questionnaire (see Table D2 in Appendix D).

The most noticeable differences were in the Genitourinary System, and Frequency of Illness sections (significant at the 0.05 level). Broadman et al. (1949) state that answering more than 25 "yes" answers on the entire questionnaire indicates the subject has at least one serious medical problem. Although an alarming number of both groups showed this, thirteen percent more of the failure group had over 25 "yes" answers. The failures seem to be less physically healthy than the successes. This indicates they may have a greater physical need to be involved in a program such as this.

Subjects' Social Functioning Differences Before Entering Program

Subjects were asked to reconstruct baseline data regarding their social functioning over the year before they entered Simon House. This section will outline differences between the success group and the failure group in this area. The social functioning variables are: personal health care; finances and work; social patterns; emotional intimacy and family relationships; and alcoholism and drug addiction.

Personal health care differences.

Although both groups took poor care of themselves physically, the failures were slightly more neglectful. More subjects in the failure group had poor eating habits (54%) than did those in the success group (33%). When asked why they did not seek medical attention when it was needed, all of the failures said it was because they simply neglected to, whereas 33% of the successes said it was because they did not like doctors.

Financial and employment differences.

More of the failures had frequent financial problems over the year before coming into the program (69% compared to 44% of the success group). This is probably related to more of the successes collecting public assistance, whereas more of the failures were involved in illegal activities in order to support themselves financially (see Table 5.3).

Social support network.

Although approximately 50% of both groups socialized only with street people, all of the failures spent most of their time drinking, while a larger proportion of successes spent it doing other things ($p<0.07$; see Table 5.3).

In terms of social patterns before entering the program, the failures have proven to be more dysfunctional than the successes. They were more likely to be drinking with others, not taking care of their health, and supporting themselves by illegal means. All of these activities are disallowed by the Simon House program. Thus, the failures would have more difficulty adjusting to the program than the successes.

Differences in emotional intimacy and family relationships.

As displayed in Table 5.4, failures were more likely to confide in a friend or relative, while successes were more likely to confide in their Alcoholics Anonymous sponsor (significant at the 0.03 level). Failures were also more likely to have what they thought was a good relationship with their family of origin. The successes were polarized in the amount of

Table 5.3

Successes' and Failures' Sources of Income and Social Patterns

Before Entering Simon House

Variable Labels and Categories	Successes		Failures		Chi square	Level of Significance
	%	(N)	%	(N)	x^2	NS=not sign.
Source of Income						
Employment	22	(2)	15	(2)	3.15	NS
Welfare/UIC	67	(6)	39	(5)		
Illegal Activities	11	(1)	46	(6)		
Activities Done with Others						
Drinking	56	(5)	100	(13)	7.06	NS (.07)
Getting money illegally	11	(1)	0	(0)		
Visiting (not drinking)	22	(2)	0	(0)		
Alcoholic Anonymous	11	(1)	0	(0)		

contact they had with their families, in that most either contacted family at least once a month, or not at all; the failures more consistently had intermittent contact. This suggests that successes are more dependent on, or in need of, programs for support, whereas failures may get the support from friends or relatives.

Differences in alcoholism and drug addiction.

There were no statistically significant differences between the program successes and failures in alcoholism and drug addiction, however, there were some interesting trends. The successes, as a group, had a longer history of addiction (17 years) than the failures (14 years), but the failures were more likely to have experienced more of the alcoholic symptoms on the Minnesota Alcoholism Severity Scale (see Table D3 in Appendix D). Successes were equally likely to drink on the street (50%) as in bars or at home, whereas failures were less likely to drink on the street (31%) than in bars or at home (69%). The successes were more likely to have attended Alcoholics Anonymous (AA) meetings during the year before entering the program (60%) than the failures (30%). These trends indicate that the successes could more likely be experienced street drinkers than the failures, and may be more desperate in needing and wanting to quit drinking (in AA terms, more may have "hit bottom").

Social Functioning Differences After Entering Program

The previous section outlined the differences between the program successes and failures in their past social functioning. This section will do likewise in terms of their social functioning after having entered the program. Significant differences were noted in the areas of exercise, work and

Table 5.4

Successes' and Failures' Confidants and Family Relationships

Variable Labels and Categories	Successes		Failures		Chi square	Level of Significance
	%	(N)	%	(N)	x^2	NS=not sign.
Confidant						
Friend or relative	25	(2)	53	(7)		
Counselor	0		15	(2)	8.75	.03*
AA Sponsor	50	(4)	0			
None	25	(2)	31	(4)		
Relationship with Family (n=20)						
Good	50	(4)	75	(9)	.45	NS
Bad	50	(4)	25	(3)		
Amount of Family Contact						
More than once/week	33	(3)	17	(2)		
1 - 4 times/month	22	(2)	33	(4)	7.4	NS
1 - 5 times/year	11	(1)	33	(4)		
Less than once/year	0		17	(2)		
None	33	(3)	7			

* significant at the .05 level

income, who their confidant was, and subjects' attitude toward the program and toward life in general.

Work and income.

Table 5.5 displays the difference between the successes and failures in terms of their present source of income and employment situation. The successes were more likely to be employed than the failures, and were less likely to be on welfare. They were also more likely to be casually employed. It follows that the program successes are often the men who find and maintain steady employment.

Emotional intimacy.

Table 5.5 also displays the differences between the groups in terms of their primary confidant. A number of subjects from both groups started confiding in program staff or residents, but a majority of successes still confided in their AA sponsor, and a majority of failures still confided in a friend or relative. The previously-identified pattern (from before entering the program) remains ($p<.03$).

Attitude toward the program and life situation.

Failures, more often than successes, tended to see the program as helpful in fulfilling their basic needs, while successes identified emotional support and help with their addiction problem as the major benefits (see Table 5.5). This is consistent with earlier findings that the successes may be more motivated to change than the failures. The successes were more likely to have no area of their life which they were dissatisfied with, whereas the failures were most often dissatisfied with being unemployed. This supports the hypothesis that there is a correlation between program success and employment and, more specifically, that the subjects who find work and keep it are often the program successes.

Table 5.5

Successes' and Failures' Social Functioning After Entering Program

Variable and Variable Labels	Successes %	Successes (N)	Failures %	Failures (N)	Chi square x^2	Level of Significance NS=not sign.
Work and Income						
Main Source of Income						
Employment	33	(3)	8	(1)		
Education Grant	22	(2)	0		6.59	.08
Unemployment Insurance	11	(1)	15	(2)		
Welfare	33	(3)	78	(10)		
Amount Worked						
Steadily	56	(5)	15	(2)		
Casually	0		39	(15)	6.16	.05*
Not at all	44	(4)	46	(6)		
Emotional Intimacy						
Confidant						
Friend or relative	0		50	(6)		
Sponsor or Counselor	62	(5)	17	(2)	6.9	.03*
Simon House Staff or Residents	38	(3)	33	(4)		
Attitude Toward Simon House and Present Life Situation						
How SH has been most helpful						
Money-shelter wise	22	(2)	75	(9)		
Emotional support	44	(4)	17	(2)	6.37	.09
Help with addiction problem	33	(3)	8	(1)		
Part of Life Situation disliked most						
Personal relationships	0		8	(1)	5.04	NS
Employment situation	33	(3)	54	(7)		
Emotional state	22	(2)	23	(3)		
Living situation	0		8	(1)		
None disliked	44	(4)	8	(1)		

* significant at the.05 level

Psychological Functioning

Figure 5.2 displays the baseline comparisons between the successes and failures on the Clinical Analysis Questionnaire. (Table D4 in Appendix D lists the mean scores and t scores.) No statistically significant differences were found, although the failures differed enough from the successes on five of the personality scales that these differences are worth mentioning. Any differences nearing, or greater than, one Sten score* are mentioned.

The first difference between the successes and failures was in the failures' higher scores on the suspiciousness scale (L). Generally, this means the failures are more suspecting, jealous, and irritable than the successes. A high score on this scale has also been associated with higher frequencies of physical illness (Krug & Cattel, 1980, p. 15).

The next difference was seen in the failures scoring higher on the insecurity scale (0). This indicates they would be more worried, guilty, and depressed than the successes (Krug & Cattel, 1980, p. 16). They would also be more upset, rather than helped, by criticism.

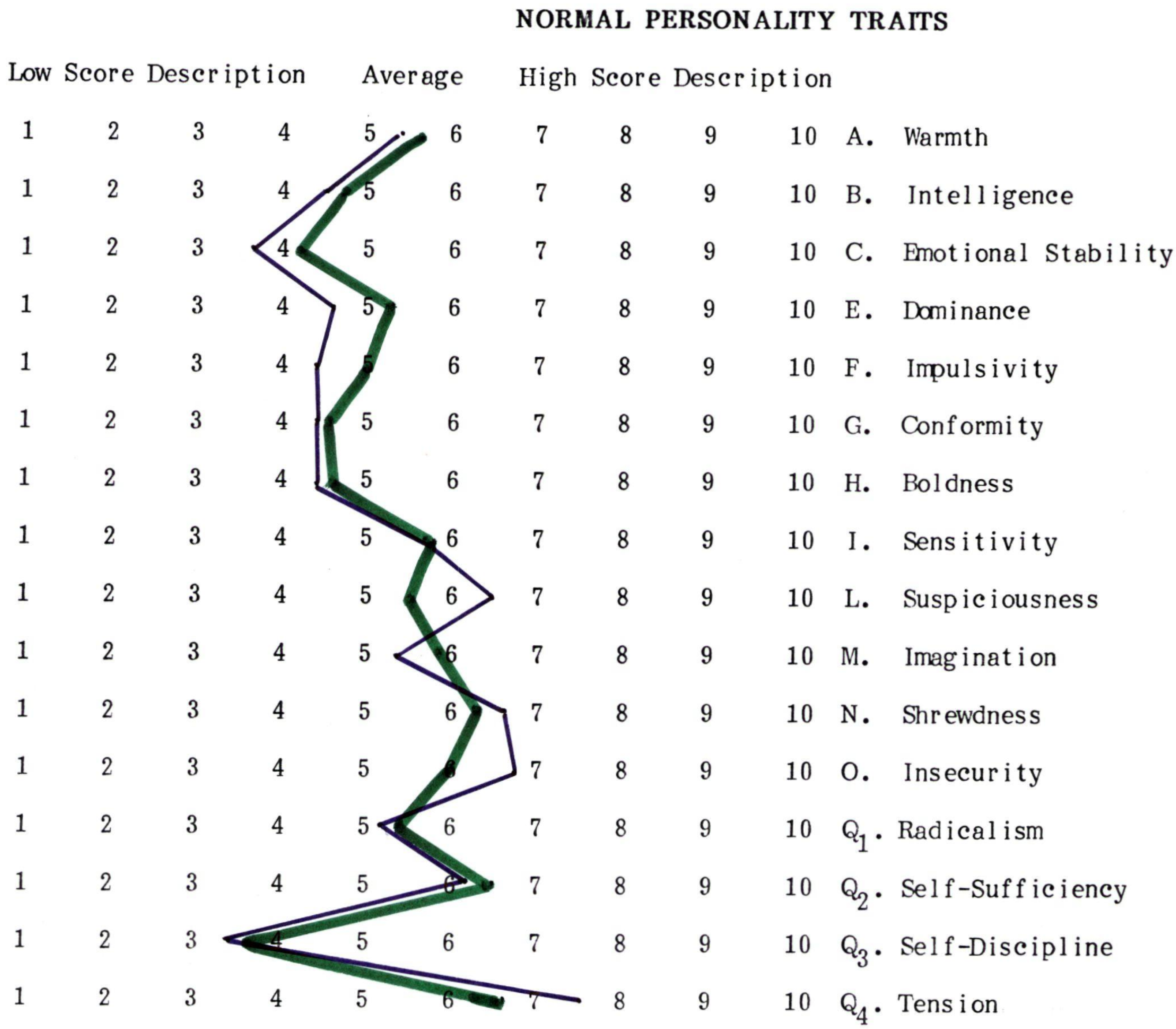
The failures scored higher than the successes on the tension scale (Q4), which indicates they would be more irritated by small things and would take a long time to calm down when they are upset (Krug & Cattel, 1980, p. 17).

Note Subjects' raw scores on CAQ factors wee converted to standard-ten or "Sten" scores using Krug and Cattel's principal norm table for non-clinical males (1973, p. 9). In the reference population, the normative scores have a mean of 5.5, a standard deviation of 2, and a range between 1 to 10.

Figure 5.2

Successes' and Failures' Psychological Profiles:

Clinical Analysis Questionnaire (CAQ) Scores

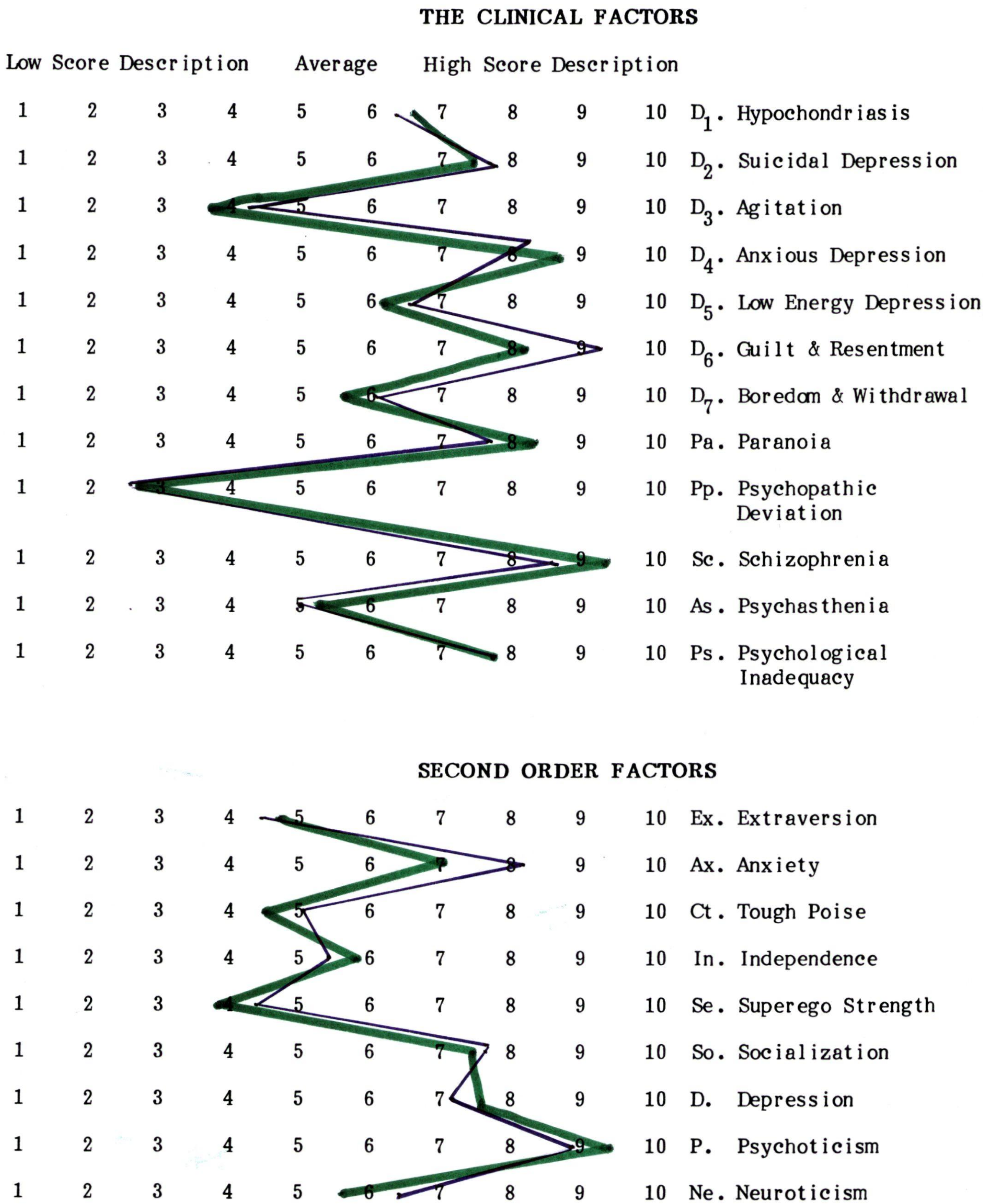


<u>NOTE</u>: Successes

Failures

(figure continues)

Figure 5.2 (continued)



Krug & Cattel (1980)

Note: Mean scores and t scores are in Table D4, Appendix D

The next notable difference between the successes and failures was on the guilt and resentment scale. The failures scored much higher, indicating they are more troubled by feelings of guilt. They would be more inclined to be self-critical and blame themselves when things go wrong. High scores on this factor are also typically found in alcoholics as a group (Krug & Cattel, 1980, p. 19).

The last of the CAQ scales to show a notable difference between the success and failure groups was the second-order factor Anxiety. The failures, again scoring higher than the successes, would have difficulty sleeping, and would get angry with people quickly. This factor has also been associated with frustrated motivation (Krug & Cattel, 1980, p. 17).

The differing scores on the CAQ scales indicate the failures to be more suspicious, insecure, tense, resentful, and anxious than the successes. These differing personality traits could explain why a failure may be more suspecting and less tolerant of a program like Simon House, especially in view of his inability to accept criticism.

In summary, those subjects identified as successes are more likely to be motivated to change their lifestyle, and to enter the program for emotional support rather than for food and shelter. The failure group proved to be more physically and psychologically unhealthy, more financially destitute, more involved in illegal activities, and less dependent on programs and services than did the successes.

Comparison of Subjects' Social Functioning Before and After Entering Program

As some of the subjects had been in the program weeks before the pre-test was given, it was necessary to distinguish between their functioning before and after they entered the program. In the individual interviews, data was collected in regard to the subjects' physical health and self-care, employment situation, income, socialization patterns, leisure activities, family relationships, emotional intimacy, and alcohol/drug-taking behavior over the year before they entered Simon House. The same data were collected a second time in the context of their present situation (i.e., since becoming residents of Simon House). This section will present the differences in social functioning variables found between these two times. It is important to note here that for subjects recently admitted to the program, the impact of the program on the change would be much less than for those who had been there longer.

Physical Health and Self-Care

Subjects experienced more health problems after they were in the program than before entering (68% of the subjects identified a health problem being evident after admission, whereas 45% stated they had one before admission). This is likely due to the subjects' improved ability to identify physical ailments when sober and in an environment conducive to promoting health. Of those who needed medical attention, 16% more sought it after they entered Simon House (an increase from 60% to 76%). Again, this indicates that more subjects will seek medical care when in a program such as Simon House than when living on their own. This finding shows an improvement in the appropriate use of medical facilities, an area which is known to be very problematic in this population (Blumberg et al., 1973).

Table 5.6 displays the difference in how the subjects cared for their health before and after entering Simon House. Statistically significant improvements were made in the subjects' eating habits and grooming. Improvements worthy of note were in the amount they exercised, and in filling their need for eyeglasses and dentures. The subjects were better able to recognize health problems and maintain their health after entering Simon House.

Income, Work, and Finances

Table 5.7 displays the differences in subjects' source of income, work situation, and financial situation before and after entering Simon House. Statistically significant improvements in all these areas were noted. The major shift in the way subjects supported themselves was through public assistance rather than illegal means. This is an indication that the subjects will not be involved in illegal activities if another option is readily available to them. Table 5.7 also indicates that the amount of income from employment does not increase for the group as a whole once they entered Simon House.

More subjects worked casually before entering the program, whereas more worked steadily or not at all after entering the program. This polarization indicates two things: (1) that there was not as much need for the subjects to support themselves by working casually, as most collect public assistance; and (2) that once settled in the program, a minority are able to

Table 5.6

Subjects' Personal Health Care Before and After Entering Program

Variable Label and Categories	Before %	Before (N)	After %	After (N)	Chi square x^2	Level of Significance NS=not sign.
Eating Habits						
Good (3 meals/day)	27	(6)	91	(20)		
Adequate (1-2 meals/day	27	(6)	4	(1)	18.47	.001**
Poor (less than 1 meal/day)	56	(10)	4	(1)		
Amount of Exercise						
3-4 times/week	59	(13)	77	(17)		
Less than 3 times/week	27	(6)	18	(4)	1.93	.38
None	14	(3)	5	(1)		
Appearance/Grooming						
Always neat & clean	50	(11)	77	(3)		
Usually neat & clean	18	(4)	23	(5)	8.39	.04*
Sometimes neat & clean	4	(1)	0			
Never neat & clean	27	(3)	0			
Without Needed Eye-glasses or Dentures						
Yes	41	(9)	27	(6)	.4	NS

* significant at .05 level

** significant at .001 level or greater

Table 5.7

Subjects' Source of Income, Work Situation, and Financial Situation Before and After Entering Program

Variable Labels and Categories	Before		After		Chi square	Level of Significance
	%	(N)	%	(N)	x^2	NS=not sign.
Main Source of Income						
Employment	18	(4)	18	(4)		
Unemployment Insurance	14	(3)	14	(3)	10.91	.05*
Welfare	27	(6)	59	(13)		
Illegal Activities	32	(7)	0			
Education Grant	9	(2)	4	(1)		
Other	0		4	(1)		
Amount Worked						
Steadily	4	(1)	32	(7)		
Off and On	64	(14)	23	(5)	9.29	.01**
Never	32	(7)	45	(10)		
Reason Not Working Steadily						
Unable (illness)	10	(2)	18	(3)		
Unable (addiction)	30	(6)	6	(1)		
Couldn't find work	35	(7)	59	(10)	6.43	.27
Didn't want to work	15	(3)	6	(1)		
Didn't need to work	5	(1)	12	(2)		
School	5	(1)	0			
Finances						
Problematic	77	(17)	27	(6)		
Not problematic	23	(5)	73	(16)	9.11	.003**
Ability to Budget						
Always had ability	23	(5)	73	(16)	16.76	.001***
Sometimes had ability	27	(6)	27	(6)		
Never had ability	50	(11)	0			

* significant at .05 level or greater
** significant at .01 level
*** significant at .001 level

find and sustain steady employment. For those subjects who were not working steadily, the reasons changed after they entered the program in that fewer were unemployed because of an addiction problem, and more were unemployed because they could not find work. This indicates an increase in the subjects' attempts to be employed.

Statistically significant changes took place both in the decrease in number of subjects who experienced financial problems ($p<0.01$) and in subjects' improved ability to budget their money ($p<0.001$). These could be explained in part by the provincial government social workers supplying them with money and controlling how it is spent.

An implicit Simon House policy is that residents should not work for the first one to two months after they enter the program; it follows that the residents working steadily would be those who had been there longer. The financial security that public assistance provides would be an incentive for subjects to stay in the program. It may, however, give them a false sense of being able to budget money, as the budgeting was usually done for them. Those men who do not have a steady job after one to two months could easily suffer from a long-term dependency on the program and resulting boredom.

Social Support Network

Table 5.8 shows the differences in socialization patterns of subjects before and after entering Simon House. Statistically significant differences were seen in the subjects' primary leisure activities, and the people they socialized with. The subjects had less contact with friends from the street, and more contact with friends from Simon House and Alcoholics Anonymous

Table 5.8

Subjects' Social Patterns Before and After Entering Program

Variable Label and Categories	Before %	Before (N)	After %	After (N)	Chi square x^2	Level of Significance NS=not sign.
People Socialized With						
Street	56	(12)	0			
Non-street	36	(8)	95	(21)	18.16	.001*
Both equally	9	(2)	5	(1)		
Primary Leisure Activity						
Drinking/doing drugs	59	(13)	0			
Acquiring money illegally	14	(3)	0			
Hobbies/Activities	14	(3)	45	(0)		
Visiting friends sober	0		9	(2)	28.77	.001*
Alcoholics Anonymous	14	(3)	14	(3)		
Help around Simon House	0		32	(7)		

* significant at the .001 level

(who make up most of the "non-street people" category ($p<0.001$). They also, by definition of the program, spent less time drinking and more time in hobbies and activities that did not involve drinking ($p<0.001$). (The types of hobbies and activities mentioned most often were reading, watching TV, going to the track races, and going to "sober" dances.) The fact that 32% of the subjects "help out around Simon House" as their primary leisure activity demonstrates the dependency they have on the program.

Family Relationships and Emotional Intimacy

There was a slight increase in the number of family contacts made after subjects entered the program. There was a 23% increase in the number of subjects who had contact with their families often, and a 14% decrease in the number who rarely had contact with their families. A 15% increase is also noted in the number of subjects who were on good terms with their families (see Table 5.9). There was a statistically significant change in whom the subjects held as confidants (see Table 5.9). Fewer subjects confided in their friends, while more started confiding in Simon House staff and other residents. Those who were not confiding at all began confiding, and nine percent more confided in relatives. This indicates a movement from previous support systems (or non-existent support systems) to the support systems composed of people from Simon House or the subjects' relatives (level of significance = 0.03). This indicates subjects gained trust in the program, and re-established family ties.

Table 5.9

Subjects' Family Relationships and Emotional Intimacy

Before and After Entering Program

Variable Label and Categories	Before		After		Chi square	Level of Significance
	%	(N)	%	(N)	x^2	NS=not sign.
Contact With Family						
Often (more than 1/mth)	52	(11)	75	(15)		
Occasionally (1/mth - 1/year)	24	(5)	15	(3)	6.13	NS
Seldom (less than 1/yr-never)	24	(5)	10	(2)		
Relationship With Family						
Good	55	(11)	70	(14)	.43	NS
Bad	45	(9)	30	(6)		
Who Confidant Is						
Friend (not from SH)	33	(7)	9	(2)		
Relative	9	(2)	18	(4)		
Counselor or AA sponsor	29	(6)	32	(7)	12.50	.03*
Friend from Simon House	0**		9	(2)		
Simon House staff	0**		23	(5)		
Have none	29	(6)	9	(2)		

* significant at .05 level
** these cells are empty by definition of the independent variable

<u>**Alcoholism and Drug Addiction**</u>

As subjects must be sober and not taking mood-altering drugs to remain at Simon House, comparison of this variable would be tautological. Those who returned to street life, drinking, and/or drug use were studied in depth in section two of this chapter.

Table D5 in Appendix D displays the increase in subjects' involvement in AA from 64% (before entering the program) to 82% (after entering the program). Those subjects who attended AA meetings attended them more frequently after they entered the program (see Table D5). Only nine percent of the subjects sought counseling at AADAC (the Alberta Alcohol and Drug Abuse Commission) outpatient counseling department. As the philosophies of Simon House are parallel to those of AA, and as all four Simon House staff members advocate AA principles, the AA influence is a predominant one.

In summary, a number of notable differences were found (some statistically significant) between subjects' social functioning before and after entering the Simon House program. Once in Simon House, subjects were more able to identify health problems, and have them cared for. They were more apt to eat well, groom themselves, and exercise. They were much less likely to support themselves through illegal activities and much more likely to collect public assistance or work steadily. For those who were not working, the reason changed from "because of alcoholism" to "cannot find work". They socialized with fellow residents rather than friends from the street. They took part in a number of activities to pass their time, but did not drink alcohol or take drugs. The subjects had more contact with their families of origin and identified relationships with them as being better than they were before entering the program. Finally, most subjects commenced or increased involvement with Alcoholics Anonymous after entering the Simon House program.

Comparison of Pre-test and Post-test Data

Due to sample attrition, the sample size in the post-test and subsequent data analysis is drastically reduced (N=9). Few results in this section are statistically significant, even though trends are observable. These trends will be identified and commented upon. Although a six-week treatment period between the pre-test and post-test was implemented, some subjects were in the program for a longer period. This six-week study would illuminate only a portion of the total movement they made toward program objectives.

Physical Health

Table D6 in Appendix D displays the difference between pre-test and post-test scores on the Cornell Medical Index Health Questionnaire (Brodman et al., 1949). There were slight increases in the number of problems which subjects identified in the sections related to eyes and ears, the cardiovascular system, the genitourinary system, miscellaneous diseases, and habits. In fact, the overall number of "yes" answers between time one and time two increased. There was also a 22% increase in the number of health problems identified by subjects in the time one and time two individual, unstandardized interviews. These increases could be due to an increase in the number of physical problems the subjects were able to identify — not necessarily their existence. It is conceivable that as the men become less dependent on alcohol they would be more sensitive to, and more concerned about, physical symptoms. There are slight decreases in the number of problems identified in the subjects' respiratory systems, skin, nervous systems, and fatiguability. Skin ailments could easily have improved with the improvement in subjects' grooming (see section three, chapter five). Nervous system problems and fatiguability changes could be due respectively to the subsiding of alcohol withdrawal symptoms and having a safe, warm place to sleep.

Social Functioning

The changes measured here are those that occurred over a six-week period after the pre-testing and before the post-testing.

Employment and financial situation.

Table 5.10 shows the differences in subjects' employment and financial situations between the pre-test and post-test. Although none of the changes are statistically significant, a trend toward steady, full-time employment can be seen. This trend supports the finding in the previous section of this chapter that the subjects collect public assistance or unemployment insurance upon first entering the program, then start to work. Subjects also continue to move toward being better able to budget.

Emotional intimacy and family relationships.

There were notable differences between pre-test and post-test data on subjects' emotional intimacy and family relationships (see Table D7 in Appendix D). There was an increase of 34% in those who confided "very

Table 5.10

Pre-test and Post-test Comparisons of Subjects' Employment and Financial Situations

Variable Label and Number	Pre-test %	Pre-test (N)	Post-test %	Post-test (N)	Chi square x^2	Level of Significance NS=not sign.
Amount Worked (in past week)						
Steadily	55.6	(5)	66.7	(6)		
Casually	11.1	(1)	11.1	(1)	.29	NS
Not at all	33.3	(3)	22.2	(2)		
Hours of Work (in past week)						
Full time	66.7	(4)	71.4	(5)		
Part time	33.3	(2)	14.3	(1)	1.38	NS
Casual	0		14.3	(1)		
Main Source of Income						
Employment	33.3	(3)	66.7	(6)		
Unemployment Insurance or Welfare	44.4	(4)	22.2	(2)	2.67	NS
Education Grant	11.1	(1)	0		12.50	.03*
Compensation	11.1	(1)	11.1	(1)		
Mobility to Budget						
Good	55.6	(5)	88.9	(8)		
Poor	44.4	(4)	11.1	(1)	1.11	NS

* significant at the .05 level

often" in someone. At the opposite end of the continuum, there was a decrease of 22% in those who "never confided at all". Subjects also confided more in Simon House staff (a 32% increase) and Simon House residents (an 11% increase), and less in friends and relatives (a 22% decrease). This general trend indicates subjects are generally disclosing more as their stay in Simon House lengthens. This could be related to their becoming more trusting of, and perhaps more dependent on, staff and fellow residents.

Subjects' quantity of contact with their families decreased 34% over the study's six-week treatment period. At the same time, the proportion of those having no family contact increased 22%. There are likely two factors contributing to these changes. Firstly, the post-testing took place in the middle of the summer, thus some subjects' family members were on holidays which prevented contact. Secondly, those subjects who contact family members frequently do so soon after entering Simon House (see data on family relationships in previous section). As their stay lengthens, the number of contacts with family decrease (44% had an average amount of contact at post-test).

AA Involvement, Attitudes Toward Simon House and Life Situation

There was a slight increase in subjects' AA involvement over the six-week treatment period of the study (11%). At post-testing, all nine subjects were involved in AA. The mean number of AA meetings attended per week was 4.67. This is not surprising, as program success is very closely linked to AA involvement in the eyes of Simon House staff and long-time residents, so it is strongly advocated.

Over the six-week period, 22% of the subjects had some difficulty with the rules of Simon House, and 44% moved from the category "sometimes enjoy Simon House meetings and activities" to "never enjoy Simon House meetings and activities" (see Table 5.11; $p<0.05$). These findings indicate that as some subjects stay longer in the program they become less tolerant of the rules and structure. This could be an indication that these subjects are becoming less dependent on the program and starting to individuate from it.

Forty-five percent of the subjects who, in the pre-test, stated they make some decisions about their life on their own, stated in the post-test they made all decisions about their life on their own. This again indicates subjects are becoming more independent, less confused, and less ambivalent (see Table 5.11).

There was one notable difference in the subjects' feelings about their life situations (see Table 5.11). Thirty-three percent stated peer and family relationships were their primary problem in the post-test. None identified this as a problem in the pre-test. One could postulate that subjects become more aware of existing problems with interpersonal relationships after they have been in Simon House for six weeks or more. One contributing factor may be the Alcoholics Anonymous influence, as AA encourages its members to become more aware of themselves in the context of other relationships. Another could be that subjects are in a communal living situation which forces them to notice interpersonal relationship problems.

Table 5.11

Pre-test and Post-test Comparisons of Subjects' AA Involvement, Attitudes Toward Program and Attitudes Toward Their Life Situation

Variable Label and Categories	Pre-test %	Pre-test (N)	Post-test %	Post-test (N)	Chi square x^2	Level of Significance NS=not sign.
AA Involvement						
Yes	89	(8)	100	(9)	.0	NS
No	11	(1)	0	(0)		
Attitudes Toward Simon House Rules						
Pose no problems	100	(9)	78	(7)		
Pose some problems	0	(0)	22	(2)	.56	NS
Pose many problems	0	(0)	0	(0)		
Enjoyment of Household Activities and Meetings						
Always	0	(0)	11	(1)		
Sometimes	100	(9)	44	(4)	6.92	.03*
Never	0	(0)	44	(4)		
Attitudes Toward Life Situation						
Part of Life Situation Disliked Most						
Personal and family relationships	0	(0)	33	(3)		
Employment situation	33	(3)	22	(2)		
Financial situation	11	(1)	11	(1)		
Emotional state	11	(1)	11	(1)	5.2	NS
Living situation	11	(1)	0	(0)		
None disliked	33	(3)	22	(2)		
Decisions Made On Own						
All of them	33	(3)	78	(7)		
Some of them	56	(5)	11	(1)	4.27	NS
None of them	11	(1)	11	(1)		

* significant at .05 level

<u>**Individual Clinical Analysis Questionnaire (CAQ) Profile**</u>

Figure 5.3 displays the pre-test and post-test CAQ scores of a single subject (mean scores are in Table D8 in the Appendix). The other CAQ profiles reported in this study display only aggregate scores. With grouped scores, the degree of individual change is not apparent due to regression toward the mean. This individual profile has been included to show how much change individual subjects make over time in terms of their CAQ scores.

This subject's pre-test scores, although much more extreme, follow the general pattern of the group scores in Figure 5.1). His pre-test profile shows him to be unstable emotionally (C^-), submissive (E^-), serious (F^-), and careless of rules (G^-, $Q1^-$). The clinical factor scores indicate he has been depressed, as he scored in the extreme range on six of the seven depression primaries. (With all the clinical factors except D3, only movement to the right is considered extreme. In the case of D3, low and high scores both represent departures from the norm as low scores on the D3 scale appear in neurotics, alcoholics, and schizophrenics [Krug & Cattel, 1980, p. 18].) This subject's extremely high scores on the paranoia, schizophrenia, and psychological inadequacy scales indicate significant mental health abnormalities characterized by a pathological suspicion of others, withdrawal from reality, and feelings of being doomed or condemned (Krug & Cattel, pp. 19-20).

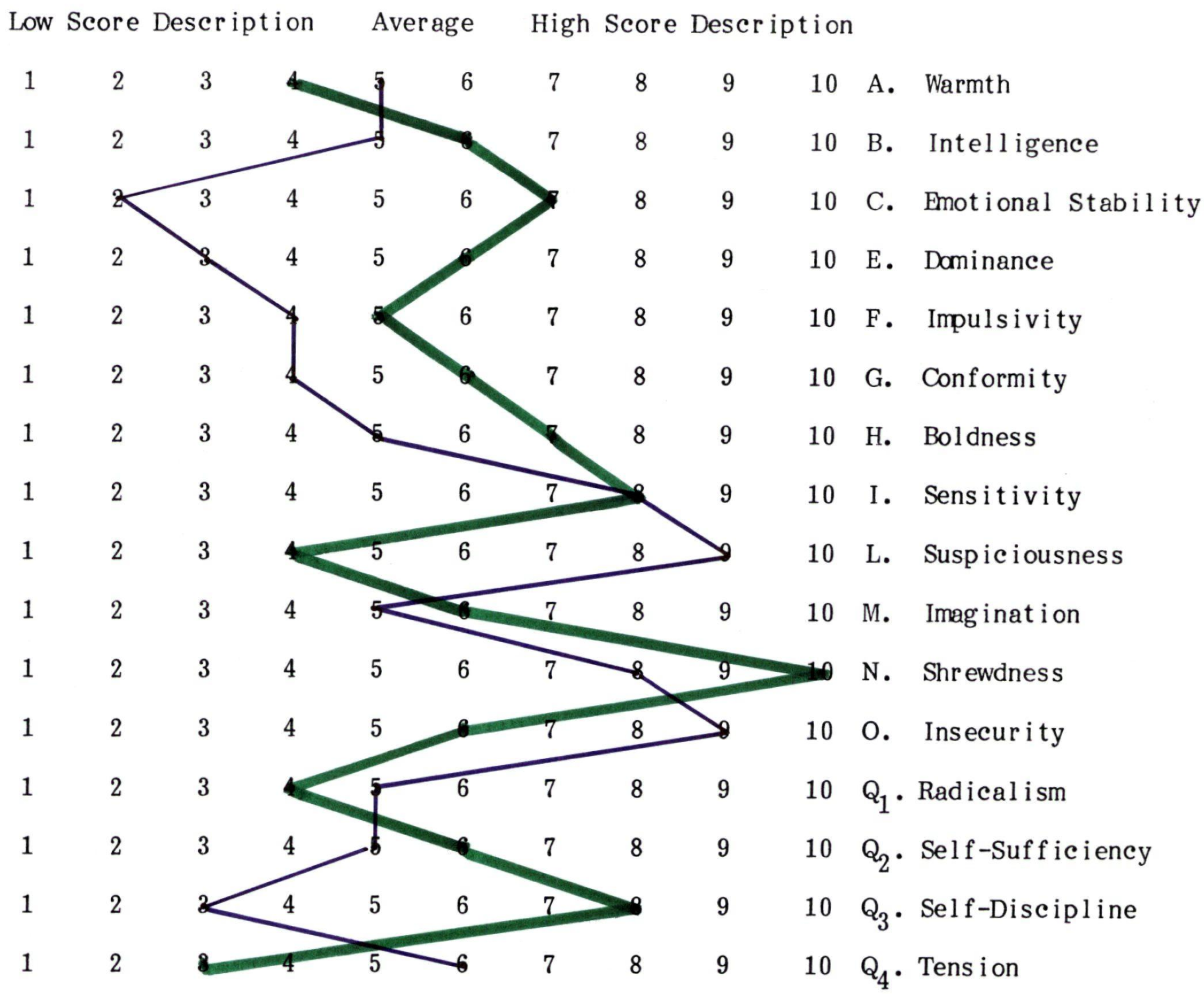
Seven of the second-order factor scores fall within the extreme range: Anxiety (Ax), Socialization (So), Depression (D), and Psychoticism (P) are high; while Tough Poise (C+), Independence (In), and Superego strength (Se) are low. These scores portray this subject as anxious (Ax+) and depressed (D+), but unrestrained (Se-) and unable to get a handle on these emotions (C+-); he is also controlled by others (In-).

Figure 5.3

A Single Subject's Pre-test and Post-test Psychological Profiles:

Clinical Analysis Questionnaire (CAQ) Scores

NORMAL PERSONALITY TRAITS

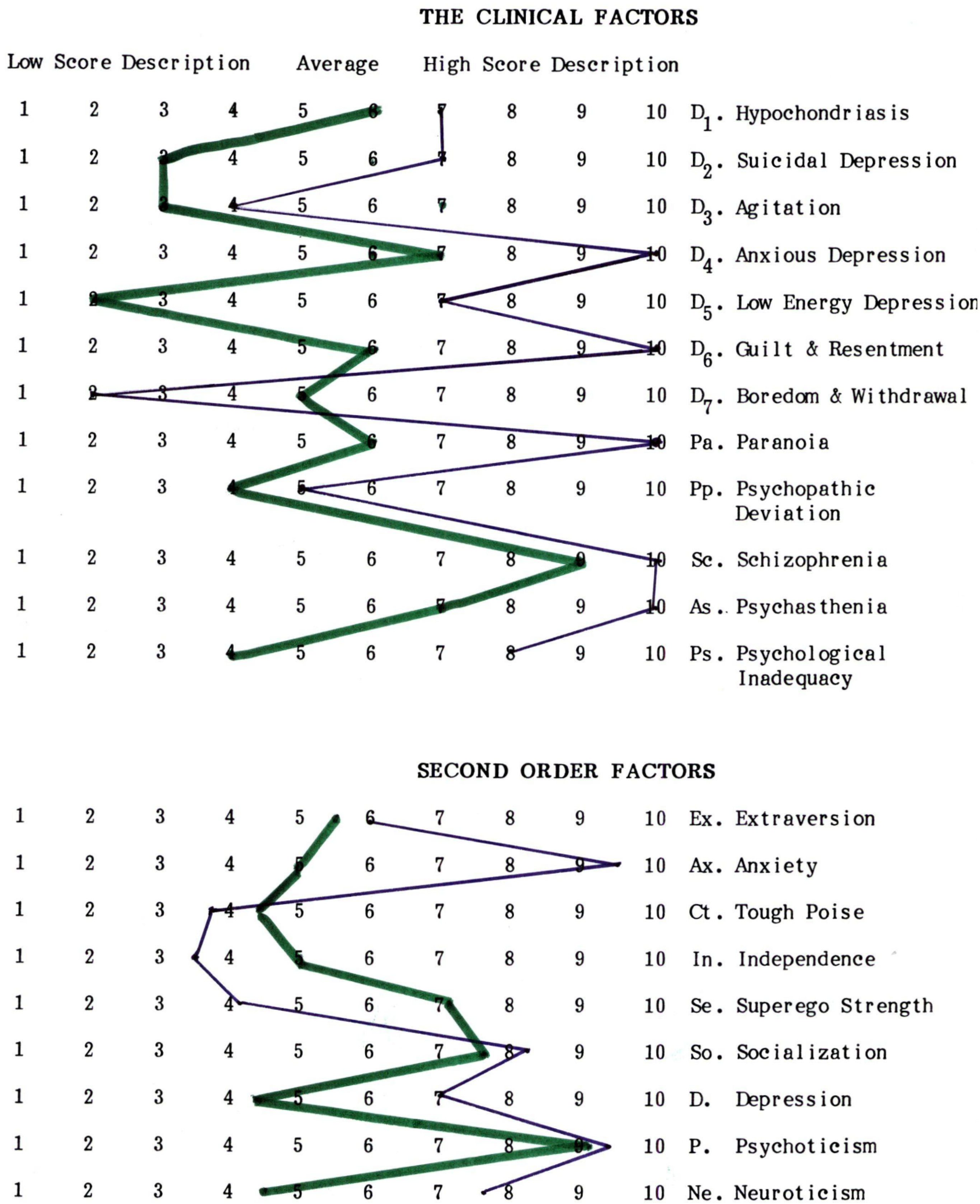


NOTE: Pre-test

Post-test

(figure continues)

Figure 5.3 (continued)



Krug & Cattel (1980)
Note: Mean scores are in Table D8, Appendix D

The post-test scores show a number of significant changes in this subject's personality. In the normal personality traits, the most significant changes are in the Emotional Stability (C), Dominance (E), Suspiciousness (L), Insecurity (O), and Self-discipline (Q3) scales. All show movement toward the norm. This subject, upon post-testing, had more emotional resources (C+) and was more able to control his emotional life and behavior in general (Q3+). He was more able to externalize his feelings (E+), (F+), and was less suspicious, moody, and depressed (L-, O-) (Krug & Cattel, pp. 12-17). Less drastic changes were in his being more conforming and conscientious (G+), and more constrained by rules and standards (N+) (Krug & Cattel, pp. 14-16).

A substantial improvement was shown in the movement of clinical factor scores toward the norm on all but two of the scales (those being D3 and D7). In general, this indicates he is much less depressed, anxious, and resentful, and that he has more energy (D5-) and more sense of worth (Ps-). The increase in the Boredom and Withdrawal score (D7) indicates he has more of a tendency to avoid people although this is not in the extreme range.

On the second-order factors, obvious improvement was shown in six of the nine factors. After the treatment period, the subject was less frustrated and panicky (Ax-), more able to control his emotions (Ct+), less controlled by others (In+), more responsible (Se+), happy (D-), and well-adjusted (Ne-) (Krug & Cattell, pp. 21-26).

In summary, this subject changed from being an emotionally and psychologically unstable man who was unable to express and control his emotions, to being a man who was very sensitive and somewhat withdrawn (N+, Se+), but significantly less depressed and anxious, more conforming, and much more able to cope with life's stresses. It must be reaffirmed that this is an individual subject's profile, and is not characteristic of the entire group.

Differences Between Mean Group CAQ Scores - Pre- and Post-Test

The subjects' mean post-test scores differed notably from their mean pre-test scores on 11 of the 37 scales. Five of these differences were statistically significant at a 0.05 level or less. Figure 5.4 displays the subjects' mean pre-test and post-test scores. The mean values and standard deviation values are listed in Table D9 in Appendix D.

The first normal personality trait showing a statistically significant difference from time one to time two was Sensitivity (I). Subjects scored higher on this factor at time two, producing a shift from the mid-normal variable range to the high-normal range. This indicates they were more dependent, overprotected, and sensitive than they were at time one (Krug & Cattel, p. 14).

The second scale showing a statistically significant difference was Imagination (M). The group mean again moved from mid-normal range to high-normal range. This indicates that subjects became more absent-minded and more careless of practical matters than they were previously (Krug & Cattel, 1980, p. 15) (significant at the 0.05 level).

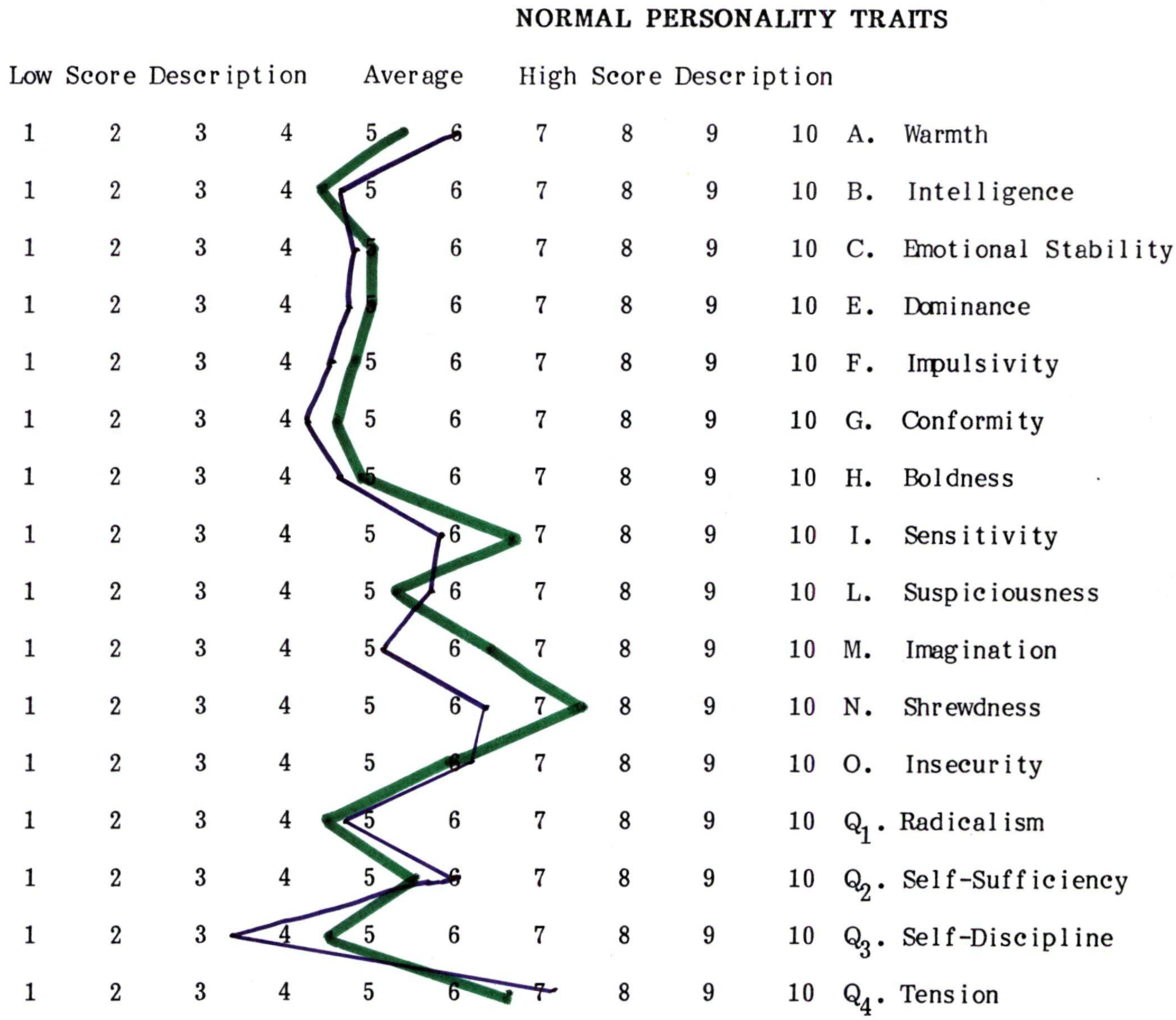
The group mean was significantly higher on the Shrewdness (N) scale at post-testing (at a 0.05 level). This indicates subjects were more constrained by rules and standards and that they preferred to keep problems to themselves (Krug & Cattel, p. 16).

The last normal personality trait to show a statistically significant difference was Self-discipline (Q3). The group mean shifted from below-

Figure 5.4

Subjects' Pre-test and Post-test Psychological Profiles:

Clinical Analysis Questionnaire (CAQ) Scores



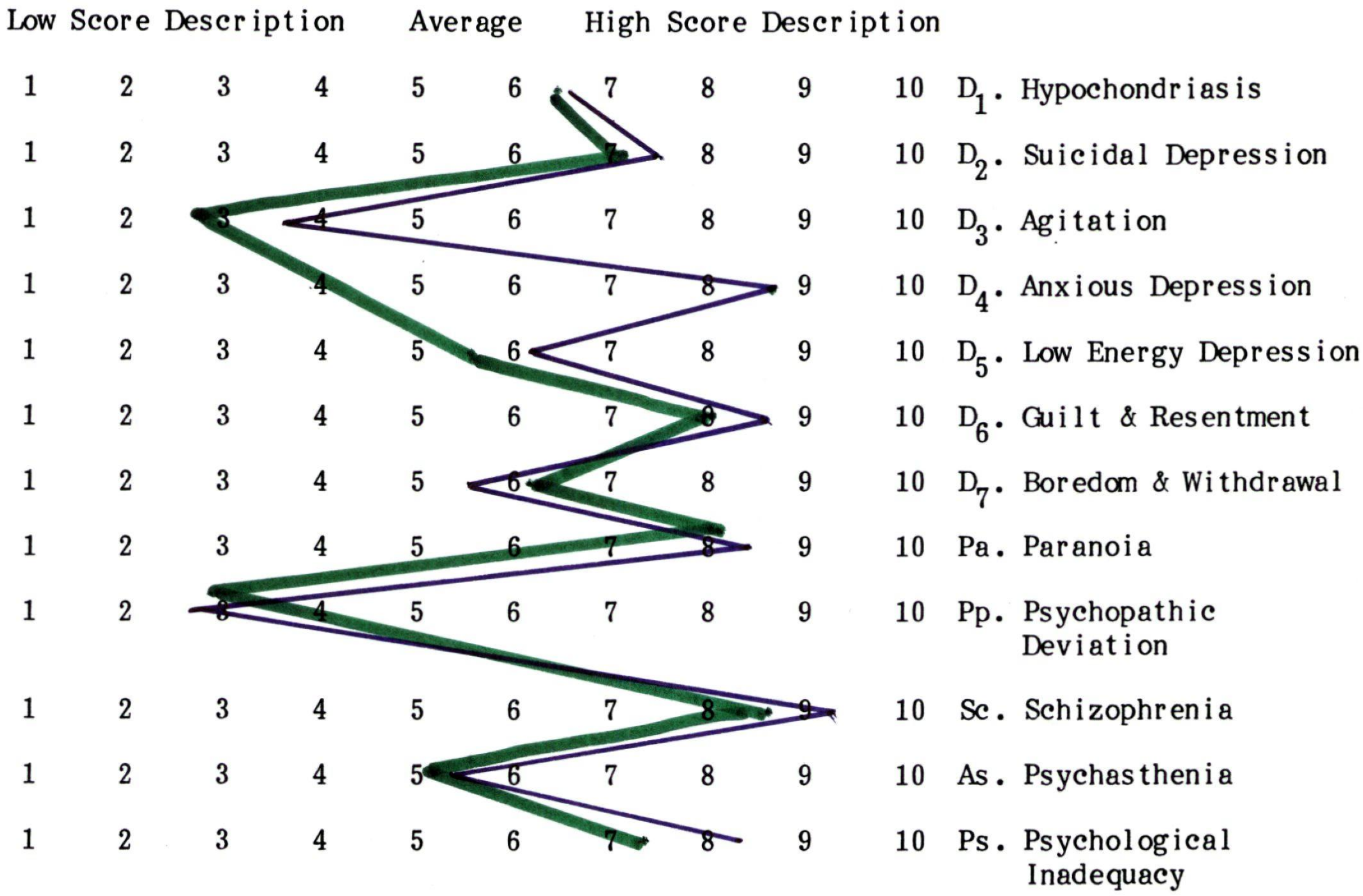
NOTE: Pre-test

Post-test

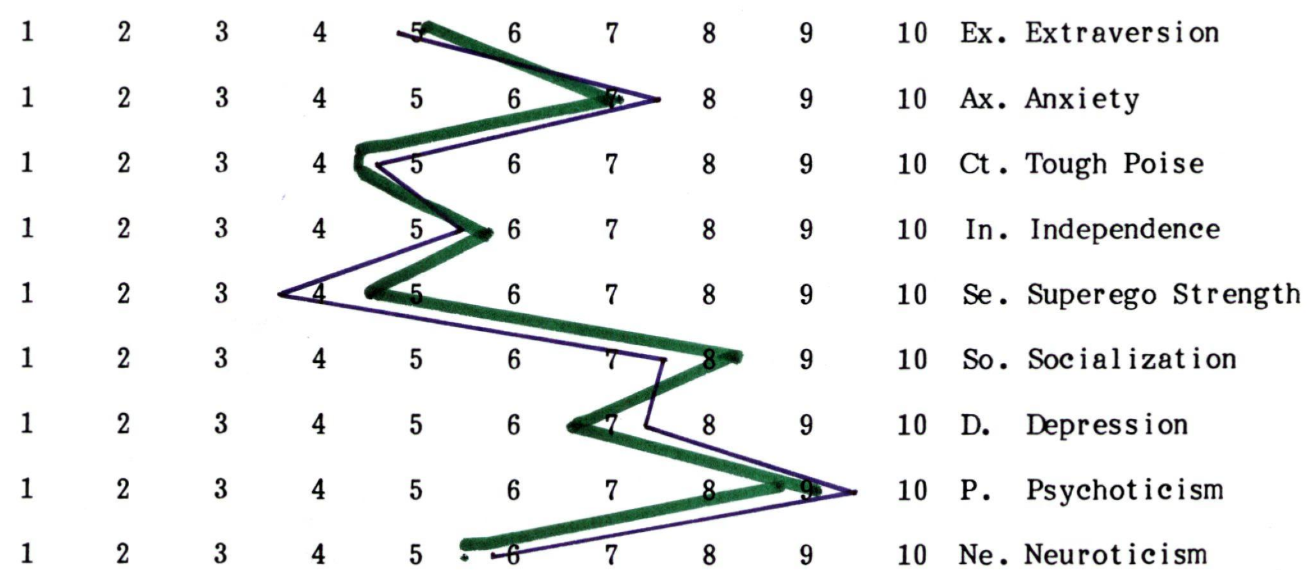
(figure continues)

Figure 5.4 (continued)

THE CLINICAL FACTORS



SECOND ORDER FACTORS



Krug & Cattel (1980)
Note: mean scores and t scores are in Table D9, Appendix D

average to low-average. This shows subjects were better able to keep their emotions in order, and were more mindful of social rules (Krug & Cattel, p. 17).

Of the clinical factors, the first to show a difference was Agitation (D3). The group mean dropped significantly ($p<0.05$), indicating the subjects became less agitated and adventurous. (This decrease, unlike the other clinical factors, was a move toward the abnormal.)

Subjects showed an increased tendency to avoid people, as was indicated by the increased score on the Boredom and Withdrawal (D7) scale. This also indicates they were generally more bored (Krug & Cattel, 1980, p. 19). This score remained within the average range.

A significant decrease (at a 0.05 level of significance) in the Schizophrenia (Sc) factor indicates subjects were becoming more realistic, and less likely to have sudden impulses (Krug & Cattel, 1980, p. 20).

The last notable clinical factor difference was in the Psychological Inadequacy (Ps) scale. The mean score decreased over the study's six-week period. This indicates subjects (although still scoring fairly high) were less apt to have negative self-worth feelings (Krug & Cattel, 1980, p. 20).

Of the second-order factors, the greatest difference occurred in Superego Strength (Se) (significant at a 0.05 level). Subjects were more restrained and responsible and less sociopathic (Krug & Cattel, p. 25).

Subjects scored higher on the Socialization scale (So) and lower on the Depression (D) scale which indicates they were generally less depressed at the time of post-testing (Krug & Cattel, p. 25).

At time two, subjects were somewhat more dependent (I+, M+), bored (D7+), and more constrained by rules and standards (N+) than they were previously. They were also better able to keep their emotions in order (Q3+), more realistic (Sc-), less sociopathic (Se+), and less depressed (D-).

These changes indicate the Simon House program is successful in decreasing subjects' levels of deviance, and in increasing their levels of self-worth. In doing so, it tends to constrain their independence (which is not unusual in any semi-institutional program). This may be the only way to positively affect the sociopathy, but, once dependent on the program, subjects get bored and restless.

Regardless of changes made during the six-week period of the evaluation study, subjects' overall psychological profiles remain abnormal, showing high levels of suicidal disgust, anxious depression, guilt and resentment, paranoia, schizophrenia, and general psychosis. This is a group of men who are in need of mental health assessment and treatment.

In summary, the assessment of pre-test post-test differences indicates that subjects continue to identify more physical problems, that they continue to disclose more — especially to Simon House staff and residents, and that their work situation improves as their length of stay in Simon House increases. Subjects' overall psychological health showed improvement despite increasing boredom and dependence.

CHAPTER 6

Conclusions and Recommendations

The purpose of this evaluation study was to test the effectiveness of a program designed to help homeless alcoholic men. The program consisted of a homelike residence supervised by four staff members who provided day and night surveillance and informal counseling.

The research design employed to test the effectiveness of the program was a quasi-experimental pre-test/post-test design with reconstructed base-line data collected from subjects in regard to their previous social functioning.

The strategy for analysis of data involved the following:

(1) The sample of homeless men was described (N=22).

(2) Characteristics which differed between program successes and program failures (i.e., between those who stayed in the program and those who dropped out) were identified (N=22).

(3) Subjects' social functioning over the year before they entered the program was compared with their social functioning while they were in the program (N=22).

(4) Pre-test data was compared with post-test data to determine what movement toward program objectives occurred over a prolonged period of time (N=9).

Subject Profile

The subjects of this study were characterized as follows: They are young to early middle-aged men who are single, and not well-educated. They are unskilled and unemployed. They are alcoholics with poor eating habits who do not take care of themselves physically. Both their physical and psychological health are poor, and they have difficulty confiding in friends and in accessing professionals. They have sociopathic tendencies, and have lived intermittently in programs for chronic alcoholics, flophouses, hotels, and their own apartments.

This profile coincides with those done by other researchers; however, there are differences. The Simon House residents are younger, better educated, more skilled, and not as psychopathological as those identified in other studies. The Simon House residents have also spent less time homeless than have other homeless alcoholics.

When put into the larger context of Canada's present economic situation, these discrepancies make sense. There have been an increasing number of Canadians living below the poverty line in the past two years (Statistics Canada, 1984). Less deviant men with better educations and more skills are now needing the services of a program for homeless men, whereas, when the previous studies cited were undertaken, this was not so. This suggests that the program planning and development mechanisms of Simon House must be flexible, to allow for program changes as the needs of the client population change.

Successes and Failures

The findings related to the comparison of the program successes and program failures (as grouped in reference to those who stayed in the program and those who dropped out) indicate that Simon House is presently providing services for two client groups. One group of clients (those who fail to graduate from the program) are more unhealthy physically, more destitute financially, more involved in illegal activities, and less likely to sever ties with companions of disreputable character. In terms of personality, the same group is more suspicious, insecure, guilty, and anxious than the other group. Findings indicate that those in the failure group are less able to accept criticism, less motivated to change, and less dependent on organizations and programs in general than are those in the success group.

One could postulate that the success group is composed of clients who are more likely to graduate from the Simon House program because they are more suited to it. The successes are in the program because they want to change their life. They have been more involved in Alcoholics Anonymous than the failures and, upon entering the program, they are more likely to be collecting public assistance, whereas the failures are more likely to be breaking the law to support themselves financially. Subjects' motivation to change was repeatedly indicated by their prior involvement in other treatment programs. Successes also see Simon House as helping to fulfill their emotional needs, whereas the failures see it as fulfilling their basic needs of food and shelter. Simon House meets more of its program objectives with those clients identified as "successes" than it does with those identified as "failures".

Social Functioning Before and After Entering Program

Research has shown some homeless alcoholic men become entrenched in a cycle which keeps them oscillating from living on the street to living in treatment residences (Cook, 1975). This was certainly the pattern of some subjects in this study; when their social functioning before they entered the program was compared to that while in the program, it became apparent they experience significant social changes in the transition.

Subjects were more able to identify physical problems and have them cared for medically after entering the program. They took part in less illegal activity and, instead, started receiving public assistance. They were less likely to work casually than before, probably because they did not need to. They had less contact with people from the street, and more with friends from Simon House and Alcoholics Anonymous. They spent leisure time on hobbies and taking part in "sober" activities, whereas most leisure time was previously spent drinking. They had more family contact and generally disclosed more about themselves. Simon House staff and residents became their confidants, which indicates subjects gained trust in the program fairly quickly. Finally, more subjects became involved in Alcoholics Anonymous after entering the program. These changes in social functioning were more noticeable in subjects who had been in the program longer at the time pre-tests were done. However, results indicate all subjects moved toward improved social functioning to some degree.

At the same time, results of this analysis indicate subjects started to become dependent on the program to fulfill their physical, emotional, and social needs. This shift of dependence from street life and alcohol to the program is necessary; however, it is doubtful that most subjects would be able to individuate from the program easily upon discharge, as few other linkages with outside social supports are made (over 92% of the referrals made by Simon House are to Alberta Social Services for public assistance, a medical doctor, or to Alcoholics Anonymous — few other referrals are made).

In summary, this comparison of subjects' social functioning before and after they entered the Simon House program demonstrates the program is successful in producing rapid improvement in its residents' social functioning.

Pre-test/Post-test Results

The subjects who stayed in the program long enough to be post-tested (N=9) formed 89% of the group subsequently identified as program "successes" (in relation to the first definition of program success outlined in Chapter Four). Therefore, the pre-test/post-test analysis was a continuing study of this group's movement in terms of social functioning with the added comparison of their pre-test and post-test scores in both the Cornell Medical Index Questionnaire, and the Clinical Analysis Questionnaire.

The post-test data showed that subjects continued to identify more of their medical abnormalities as their stay progressed (as the ratios of "yes" answers on the Cornell Medical Index increased). Some subjects who were previously unemployed or performing casual labor began working steadily at full-time jobs. More of the subjects often disclosed about themselves and more also confided in Simon House staff and residents than did six weeks before.

The subjects' number of family contacts decreased over the six-week study period and more subjects were frequently attending Alcoholics Anonymous meetings. More subjects identified interpersonal relationships as the major problem in their lives, and more showed intolerance of program rules and activities. Subjects made more decisions about their lives unilaterally.

In terms of their psychological health, subjects' scores indicating sociopathy decreased as did the depression factors and some independence factors. In general, findings showed an increase in subjects' feelings of self-worth and in boredom and restlessness.

The findings demonstrate a few overall trends in subjects' movement over the six-week study period: (1) Subjects collect public assistance or UIC for one or two months, then move on to full-time employment; this strategy appears to be beneficial to most, as time is needed for lifestyle adjustment; (2) Subjects become increasingly more trusting of program staff and residents and show this by disclosing to them and confiding in them. This is a positive trend as the pre-test profile of subjects indicated they tended to internalize their frustrations; (3) A correlation seems to exist between a change in subjects' personalities (i.e., a decrease in their sociopathy, an increase in their self-worth, and an increase in general psychological functioning) and an increase in their level of dependence on the program (as was indicated by some CAQ scores as well as social functioning variables). This dependence appears to be necessary. However, as the subjects' dependence is prolonged, their boredom increases and their tolerance for program structure decreases. Thus, they could be more apt to fail (i.e., leave the program abruptly and return to life on the street); (4) The fact that subjects become less tolerant of the program structure yet make more decisions on their own indicates they are gaining independence. (The second- order Independence factor on the CAQ also showed a slight increase.) These are positive signs if preceded by a period of dependence on the program and simultaneous movement toward program objectives. It appears the subjects are struggling to find an appropriate balance between dependence on the program and individual autonomy.

Summary of Conclusions

The findings of this study lead one to conclude that measuring success is not a straightforward task. Two measures of success were utilized: success in terms of subjects' graduating from the program; and success in terms of subjects' movement toward program objectives. The two have proven to be inextricably interrelated.

The subjects who left the program prematurely (N=13) were provided with food, shelter, clothing, and medical care while in Simon House. They also showed some improvement in their social functioning upon entering program; however, could not be post-tested to determine if this improvement continued. Thus, the program objectives that were achieved with these men may have been achieved only temporarily.

The subjects who remained in the program longer than three months and graduated from the program (N=9) showed a prolonged improvement in major aspects of their biological, psychological, and social functioning. Results indicated that as change occurred, subjects showed some dependence on the Simon House program in all three of these aspects of functioning.

An overall assessment of the findings leads to the conclusion that Simon House is meeting its program objectives and is thus successful with one particular client group. This group is characterized by motivation to change and by dependence on programs and institutions for physical, psychological, and social support. The other client group, the dropouts, however, showed only a temporary improvement in their social functioning. This group is characterized by less motivation to change, premature discharge from Simon House, and a return to chronic alcoholism and homelessness.

Recommendations

The findings of this study and experiences encountered in its implementation have led to a number of recommendations. These have relevance both for those interested in program development in this area, as well as research.

The recommendations for those interested in programs for homeless alcoholic men are as follows:

(1) Planned work activities should be made available often for residents to reverse the progression of boredom and withdrawal.

(2) Future development should include a final program phase which offers a more autonomous living situation for program graduates who are still dependent on the program.

(3) Program residents should be referred regularly for mental health counseling.

(4) A large variety of community services should be accessed to decrease long-term dependency on the single program.

(5) Establishment of a formal program structure which delineates the two client types as (1) those who are more internally motivated to enter Simon House and thus more motivated to change, and (2) those who are

more externally motivated to enter Simon House and thus less motivated to change. Services offered each of these two groups should also be clearly outlined. Those clients identified in the initial assessment as belonging to the second group (i.e., those unmotivated to change) should either be referred elsewhere or should be provided with a program which is more apt to retain them for extended periods of time. This would involve establishing more structured activities for the men in terms of social and leisure activities, formal counseling, as well as work activities.

(6) The assessment procedure should be more rigorous and its purpose more clearly defined. This would enable proper identification and possible referral elsewhere of those men who are unmotivated to change. It would also provide an opportunity for recognition of the need for involvement of other community agencies in residents' treatment. For example, based on this initial assessment, more residents could be referred to Alberta Mental Health, AADAC, Canada Manpower, Calgary Self Help Association, etc. for specific types of counseling. Simon House could consider the use of professional social work resources to upgrade the process of assessment.

(7) Ongoing program evaluation would be promoted and simplified by having a management information system with established recording guidelines (i.e., designated content areas and operational definitions). An example of such a recording system is in Appendix E.

The recommendations for those interested in future research in this area are as follows:

(1) Further evaluation research on programs for homeless alcoholic men should be encouraged, especially if a variety of data sources and control groups are used.

(2) Further use of the Clinical Analysis Profile to measure the psychological functioning of homeless alcoholic men should be encouraged.

(3) Follow-up studies of programs should be encouraged to further explore their long-term treatment effects on homeless alcoholic men.

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APPENDIX A

Unstandardized, Structured Interview Schedule

INTERVIEW SCHEDULE

I. General Background Information

1. How old were you on your last birthday?

2. What is your marital status?

   1=married
   2=single
   3=divorced
   4=separated
   5=common law
   6=widowed

3. Do you have children?

   1=Yes (go to 3.1)
   2=No (go to 4)

3.1 How many?

4. What is your level of education?

   1-6=Grade School
   7-9=Junior High
   9-13=Senior High School
   14+=Some post-secondary education

5. Do you have a trade or occupation?

   1=Yes (go to 5.1)
   2=No (go to 6)

5.1 What is it?

6. How long have you been living at Simon House?

7. What is your ethnic background?

8. What is your religious affiliation, if you have any?

II. Circumstances of Referral to Simon House

9. Is this your first time living at Simon House?

1=Yes (go to 10)
2=No (go to 9.1)

9.1 When was/were the previous time(s)?

9.2 What was/were the average length(s) of stay?

10. How did you find out about Simon House?

1=on the street
2=while in hospital
3=while in detox
4=friend
5=A.A.
6=relative
7=other (write in)
8=drop-in centre

11. Who most wanted you to come?

1=friend
2=self
3=counsellor
4=doctor
5=relative
6=other (write in)

11.1 Who second most wanted you to come?
(use above categories) (write in)

12. On a scale from 1 to 5, how anxious/frightened were you about coming? (1 being not at all, 5 being very)

13. How anxious are you about being here now? (1 being not at all, 5 being very)

III. Before Simon House

16. Have you had any health problems in the past year?

1=Yes (go to 16.1)
2=No

16.1 What was the health problem that troubled you the most? (write in)

17. Before you came here, would you say you sought medical attention when it was needed?

17.1 How many times in the past year did you not go to the doctor when you should have?

17.2 Why?

1=do not like doctors
2=did not know how to go about arranging it
3=have been too sick to go
4=other (write in)
5=neglected to

18. Where were you living most often in the 12 months before you arrived here?

1=Sally Ann
2=hostel
3=street
4=rooming house
5=flop house
6=own apartment
7=hospital
8=other institution
9=other (write in)

18.1 How long did you live there? (write in)

18.1.1 Did you like where you were living?

1=Yes
2=No

18.1.2 Why?

18.1.3 Why not?

1=was living with drinkers/druggies
2=place was a hole
3=other

18.2 Where were you living second most often?

1=Sally Ann
2=hostel
3=street
4=rooming house
5=flop house
6=own apartment
7=hospital
8=other institution
9=other (write in)

18.2.1 How long did you live there?

18.2.2 Did you like it? Why? Why not?

18.3 Were you living alone most of the time?

1=Yes
2=No

18.4 Have you ever been without a home?

1=Yes (go to 18.4.1)
2=No

18.4.1 For how long?

19. Would you say you got enough exercise then?

1=Yes
2=No

19.1 What did you do for exercise?

19.2 On the average, how often per week did you get exercise during the past year?

1=once
2=twice
3=three or more times
4=none

20. Was your financial situation ever a problem?

1=Yes (go to 20.1)
2=No (go to 20.3)

20.1 How often?

1=all the time
2=almost always
3=sometimes
4=very rarely

20.2 When it was a problem, how did you usually get by?

1=welfare
2=begging
3=stealing
4=selling belongings
5=borrowing
6=Sally Ann
7=other (write in)

20.3 Where did your income come from?

1=employment
2=savings
3=UIC
4=welfare
5=pension
6=other (write in)

20.4 How often could you budget your money to make it last?

1=always
2=sometimes
3=never

21. How much were you working in the year before you arrived here?

1=steadily (go to 21.2)
2=off and on (go to 21.1)
3=never (go to 21.1)

21.1 What were the circumstances?

1=unable to work due to illness (go to 21.4)
2=unable to work due to constant inebriation or being stoned (go to 21.4)
3=could not find work (go to 21.4)
4=did not want to work (go to 21.4)
5=did not need to work (go to 21.1.1)
6=other

21.1.1 Why? (write in) (go to 22)

21.2 What kind of work were you doing? (write in)

21.3 What were the hours like?

1=full time
2=part time
3=casual
4=other (write in)

21.4 Did you lose any jobs in the past year before S.H.?

1=Yes (go to 21.4.1)
2=No (go to 22)

21.4.1 Why?

1=absenteeism
2=punctuality
3=work relationships
4=drinking or drugs
5=other (write in)

22. Have you ever been convicted of a criminal offense?

1=Yes (go to 22.1)
2=No (go to 23)

22.1 How many times in the past year? (write in)

22.2 What were the offenses? (write in)

22.3 When did they occur?

23. Have you been picked up by the police in the past year or so?

1=Yes (go to 23.1)
2=No (go to 24)

23.1 How many times in the past year? (write in)

23.2 What was the reason?

1=public drunkenness
2=other (write in)

24. How would you describe your eating habits the year before you came to Simon House?

1=good
2=adequate
3=poor
4=otherwise (explain)

24.1 Which of the following would best describe your appearance before you came here?

1=neat and clean always
2=usually neat and clean
3=sometimes
4=never neat and clean

24.1.1 What kind of clothing did you wear?

1=adequate
2=not adequate

24.2 Did you ever go without needed eye glasses or dentures?

1=Yes (go to 24.2.1)
2=No (go to 25)

24.2.1 For how long? (write in number of days or months)

25. What did you usually do in your spare time before you came here?

1=TV
2=visited
3=partied
4=drank alone
5=tried to find means of sustenance
6=hobbies
7=sports
8=other (write in)
9=AA

26. What type of people did you most often socialize with before you came here?

1=street
2=non-street
3=work
4=relatives
5=other (write in)

26.1 What did you most often do with them?

1=talk
2=party
3=TV
4=games
5=sports
6=other (write in)
7=drink

27. How much contact with your family have you had over the past year?

1=more than one contact per week
2=more than one contact per month
3=3 to 4 contacts per year
4=1 contact per year
5=less than one contact per year
6=other (write in)

28. Did you have someone you felt you could confide in over the past year?

1=Yes (go to 28.1)
2=No (go to 28.3)

28.1 Who?

1=friend
2=relative
3=counsellor
4=doctor
5=other (write in)

28.2 How often did you confide in them over the past year? (go to 29)

1=very often
2=often
3=sometimes
4=rarely
5=never

28.3 Why?

1=did not want to share problems
2=did not think anyone would want to hear problems
3=people should solve own problems
4=other (write in)

29. During the past year, did you see any counsellors, social workers, psychiatrists, etc. for counselling?

1=Yes (go to 29.1)
2=No (go to 30)

29.1 Who did you see?

1=social worker
2=psychiatrist
3=psychologist
4=other (write in)

29.2 For what?

1=alcohol/drug problem
2=emotional problem
3=other (write in)

30. Did you go to any sort of group?

1=Yes (go to 30.1)
2=No (go to 31)

30.1 What kind?

1=AA
2=Emotions Anonymous
3=other (write in)

30.2 How often? (write in number of times per week)

31. Before you came to Simon House, what services were you in need of? (list in order of priority)

1=financial assistance
2=employment counselling
3=medical
4=emotional support
5=basic needs
6=counselling (general)

31.1 Why did you not receive them before you came here?

1=was refused
2=did not know about them
3=did not want to ask for them
4=didn't care/neglect
5=other (write in)

31.2 Before you moved to Simon House, what was the part of your life situation you disliked most?

1=personal relationships
2=family relationships
3=employment situation
4=financial situation
5=personal habits
6=emotional state
7=living situation

31.2.1 Next most?

31.2.2 Next most?

IV. Drinking/Drug-Taking Behavior and Treatment

32. Has anyone every told you that they think you have a drinking or drug use problem?

    1=Yes (go to 32.1)
    2=No (go to 33)

32.1 Which?

    1=drinking
    2=drug use
    3=both

33. Would you say you have ever had a drinking or drug use problem?

    1=Yes (go to 33.1)
    2=No (go to 34)

33.1 Which?

    1=drinking
    2=drug use (go to 33.3)
    3=both (go to 33.2)

33.2 Which is more of a problem for you?

    1=drinking
    2=drugs

33.3 How long have you had this problem? (write in number of years)

34. How old were you when you started using drugs/alcohol? (write in number of years)

35. What was your drinking/drug use pattern over the past year?

    1=binge
    2=daily
    3=occasional
    4=other (write in)

36. In the year before you lived here, have you experienced any of the following due to drinking?

1=blackouts?
2=delireum tremens?
3=loss of control
4=tolerance decreasing?
5=auto accidents?
6=missed work?
7=quarrels when drinking?
8=alcoholic seizures?
9=liver disease?

37. In the year before you lived here, have you experienced any of the following due to drinking?

1=gone on benders?
2=drank in the morning?
3=been frightened (as a withdrawal symptom)?
4=nightmares (as a withdrawal symptom)?
5=being arrested?
6=not being able to stop drinking?
7=used non-beverage alcohol?
8=a detox centre admission?
9=a hospital emergency admission?

38. Where did/do you usually partake in alcohol/drug use over that year?

1=bars
2=home
3=street
4=at friends' houses
5=other (write in)

39. Who were you most often with?

1=people living on the street
2=people not living on the street
3=both, equal amounts of time

40. What was your longest period of abstinence ever? (write in number of years, or number of months)

40.1 When was that? (write in)

41. How long have you been off drugs/sober this time? (write in)

V. Present Health Status

42. Have you had any health problems since you have been here?

    1=Yes (go to 42.1)
    2=No (go to 43)

42.1 What troubled you the most? (write in)

43. Have you received medical attention since you have been here?

    1=Yes (go to 43.1)
    2=No (go to 44)

43.1 When? (write in) (go to 45)

44. Would you say you have needed any?

    1=Yes (go to 44.1)
    2=No (go to 45)

44.1 Why have you not gotten any?

    1=do not like doctors
    2=did not know how to go about arranging it
    3=have been too sick to go
    4=don't care
    5=other (write in)

45. Are you on any medications or treatments?

    1=Yes (go to 45.1)
    2=No (go to 46)

45.1 What? (write in)

46. Do you need new glasses or dentures?

    1=Yes (go to 46.1)
    2=No (go to 47)

46.1 Have plans been made to get them?

1=Yes (go to 47)
2=No (go to 46.2)

46.2 Why?

1=no coverage
2=no effort
3=did not know where to go
4=other (write in)

47. Would you say you have been getting enough exercise since you have been here?

1=Yes
2=No

48. How often have you exercised in the time you've been here? (write in the number of times)

49. What do you usually do for exercise? (write in)

VI. Present Social Functioning

50. How long do you plan to stay at Simon House?

1=do not know
2=1 month
3=2 to 3 months
4=3 to 6 months
5=other (write in)

51. Do you have plans re: where you will go when you leave here?

1=Yes (go to 51.1)
2=No (go to 52)

51.1 Where do you plan to go?

1=treatment centre
2=halfway house
3=own apartment
4=stay with friend
5=stay with relative
6=rooming house
7=street
8=do not know
9=other (write in)

52. How would you describe your eating habits since you have been in Simon House?

1=good
2=adequate
3=poor
4=otherwise (explain)

53. What kind of clothing do you wear?

1=adequate
2=not adequate

54. What would you say best describes your appearance since you have been here?

1=neat and clean always
2=usually neat and clean
3=presentable
4=pretty rough most of the time
5=never neat and clean

55. What is your main source of income now?

1=employment
2=UIC
3=welfare
4=pension
5=have none
6=other (write in)

56. Would you say your financial situation is a problem now?

1=Yes (go to 56.1)
2=No (go to 57)

56.1 Why? (write in)

57. Do you feel you are, at present, able to budget your money adequately?

1=Yes
2=No

58. Are you working now?

1=Yes (go to 58.1)
2=No (go to 58.4)

58.1 What type of work are you doing? (write in)

58.2 What are the hours like?

1=full time
2=part time
3=casual
4=other (write in)

58.3 How have things been between you and your boss/fellow workers?

1=fine (go to 59)
2=some problems (go to 58.3.1)
3=many problems (go to 58.3.1)

58.3.1 Why? (write in) (go to 59)

58.4 Why?

1=unable, due to illness (go to 59)
2=unable, due to constant inebriation (go to 59)
3=cannot find any (looking) (go to 59)
4=do not want to (go to 59)
5=do not need to go (go to 58.4.1)
6=other (write in) (go to 59)

58.4.1 Why? (write in)

59. Have you lost any jobs since you have been here?

1=Yes (go to 59.1)
2=No (go to 60)

59.1 Why?

1=absenteeism
2=punctuality
3=work relationships
4=other (write in)

60. Since you have lived at Simon House, have your drinking and/or drug use habits changed?

1=Yes (go to 60.1)
2=No (go to 61)

60.1 How?

1=using more
2=using less
3=using no drugs or alcohol
4=other (write in)

61. Since you moved here, have you experienced any of the following due to drinking?

1=blackouts?
2=delireum tremens?
3=loss of control?
4=decreased tolerance?
5=auto accidents?
6=missed work?
7=quarrels when drinking?
8=alcoholic seizures?
9=liver disease?

62. Since you moved here, have you experienced any of the following due to drinking?

1=going on a bender?
2=drinking in the morning?
3=being frightened (as a withdrawal symptom)?
4=nightmares (as a withdrawal symptom)?
5=being arrested?
6=not being able to stop drinking?
7=using non-beverage alcohol?
8=a detox centre admission?
9=a hospital emergency admission?

63. Have you been in trouble with the law since you moved here?

1=Yes (go to 63.1)
2=No (go to 64)

63.1 What for? (write in)

64. Are you presently involved in AA?

1=Yes (go to 64.1)
2=No (go to 65)

64.1 How many meetings have you been to in the past week? (write in)

65. Have you been involved with any other agency for treatment or counselling?

1=Yes (go to 65.1)
2=No (go to 66)

65.1 Which one?

1=AADAC in patient
2=AADAC out patient
3=other (write in)

(for those who have a stated problem)
66. Do you have a plan for recovery?

1=Yes (get brief description)
2=No

67. What do you usually do in your spare time now?

1=TV
2=visit with friends
3=sports
4=hobbies
5=help out around Simon House
6=games
7=read
8=AA meetings
9=other (write in)

68. Who do you socialize with most often now?

1=friends from street
2=friends from work
3=relatives
4=friends from Simon House
5=AA friends
6=non-street friends
7=nobody (go to 70)
8=other (write in)

69. What do you usually do with them?

1=talk
2=drink
3=TV
4=games
5=sports
6=working around house
7=other (write in)

70. Do you feel you have anyone you can confide in?

1=Yes (go to 70.1)
2=No (go to 70.2)

How often?

70.1 Who? (go to 71)

1=friend from Simon House
2=counsellor
3=Simon House staff
4=relative
5=doctor
6=sponsor
7=other (write in)
8=friend from AA

70.2 Why?

1=do not want to share my problems
2=do not think anyone would care
3=have no one to talk to
4=people should solve own problems
5=other (write in)

71. Would you like to have a greater number of meaningful relationships?

1=Yes
2=No

72. How much contact with your family do you have now?

1=more than one contact per week
2=more than one contact per month
3=3 to 4 contacts per year
4=1 contact per year
5=less than one contact per year
6=other (write in)

72.1 When was the last time you spoke with or corresponded with a family member? (write in)

72.1.1 Would you like to have more/less or the same amount of contact with them?

72.2 Has your relationship with your family changed since you have been at Simon House?

72.3 How?

1=closer
2=more distant

72.3.1

1=better
2=worse
3=other

73. How do you find carrying out responsibilities and following rules at Simon House?

1=no problem (go to 74)
2=they pose minor difficulties (go to 73.1)
3=have some problems (go to 73.1)
4=having much trouble (go to 73.1)

73.1 What is posing most difficulties? (write in)

74. How have you, for the most part, handled conflictual situations at Simon House?

1=by withdrawing
2=persisting until winning
3=letting someone else handle it
4=helping to find some common ground (compromising)
5=other (write in)

75. How often do you take part in house meetings, parties, etc.?

1=always
2=sometimes
3=never

76. How much do you enjoy these activities?

1=not at all
2=they are okay
3=very much
4=other (write in)

77. Have you ever been given an ultimatum by Simon House staff (i.e., if you do something one more time, you will have to leave)?

1=Yes (go to 77.1)
2=No (go to 78)

77.1 How many times? (write in)

77.2 What was the issue? (write in)

78. What services/group have you been referred to since you arrived?

1=ASS&CH
2=employment counselling or job
3=medical
4=therapy
5=AA
6=other (write in)

79. Now, what is the part of your life situation you dislike the most?

1=personal relationships
2=family relationships
3=employment situation
4=financial situation
5=personal habits
6=emotional state
7=living situation

79.1 Next?

79.2 Next?

Do you have any further comments or questions?

APPENDIX B

Information Sheet

Information Sheet

(to be read to the subjects before administration of the research interview)

Doreen (the director of Simon House) has already mentioned this study briefly. More specifically, we are doing a study which looks at the services offered by Simon House, and how useful they are to you. We would be trying to find out how things have been for you in the past, how they are now, and then again how they are after you have lived here for six weeks.

This means you would take part in a research interview. The interview is composed of two major parts. For the first part, we would ask you to fill out a questionnaire. This involves checking off answers. The questions in this part begin by looking at your state of health, then focus on your interests and how you feel about life. For this part, there are no right or wrong answers—so you would answer what <u>you think</u> is appropriate for you. This part takes about one hour.

The second part of the interview would involve each of you meeting with me separately. I would ask you a number of questions about things like your employment situation, your social life, and whether or not you use drugs or alcohol. For example, a couple of questions you would be asked are: "Were you working when you arrived here?", "If not, what were the circumstances?", "If so, what kind of work were you doing?"

There are a few important things to note here. First, everything you say would be held in strict confidence (your name would not appear on the answer sheets, rather, identification numbers would be used). Second, no information about you as individuals would be shown to any staff from Simon House, or anyone else. All data would be displayed in group form. Third, some of the things you would be asked could be difficult to talk about or be seen as personal issues, thus, what you share would be respected as such. Fourth, you are under no obligation to participate in this study if you do not want to. If you choose not to participate, this will in no way affect the services you receive from Simon House.

Remember that I would be asking you to do the questionnaire and interview again in about six weeks.

Thank you for coming today, and please feel free to ask any questions about any part of this process.

APPENDIX C

Consent Form

Consent Form

An Evaluation Study of Simon House

Dear Simon House resident:

We are currently conducting a research evaluation study of the services offered by Simon House and would like to ask you to participate in this study. If you agree, Donna Phillips will be interviewing you to obtain information from you about yourself and your personal experiences. The interview will take up to two hours (about one hour now, and another hour later on in the week). We would also like to read your Simon House file and use some of the information found there.

All information collected will be considered absolutely confidential and your name will not appear on any of it. Please understand there may not be any direct benefit to you as a result of your participating in the study. You may withdraw from the study at any time, even after signing this form, and this will, in no way, affect the services you receive from Simon House. You are under no obligation to participate in any part of this study if you do not want to.

If you have any questions about the study and your possible involvement in it, please ask them before signing the statement below.

Sincerely,

D.M. Phillips, B.S.W.

J.P. Hornick, Ph.D.

I understand the above explanation of the study. The study and my part in it have been defined and fully explained to me by Donna Phillips and all questions have been answered to my satisfaction.

NAME (print)	SIGNATURE	DATE

APPENDIX D

Table D1

Mean Scores of Figure 5.1

Comparison of Subjects' Clinical Analysis Questionnaire (CAQ) Profile and Krug and Cattel's (1980) Alcoholic Male Profile

Variable Labels		Subject of this study		Krug's Alcoholic Men	
		$\bar{X}$	SD	$\bar{X}$	SD
Warmth	(A)	5.5	1.5	5.5	1.7
Intelligence	(B)	4.7	1.1	4.4	1.5
Emotional Stability	(C)	3.9	1.7	3.6	1.8
Dominance	(E)	4.9	1.4	4.2	1.9
Impulsivity	(F)	4.6	1.3	4.2	1.8
Conformity	(G)	4.5	1.5	5.5	1.6
Boldness	(H)	4.5	1.5	4.4	2.1
Sensitivity	(I)	5.9	1.2	5.0	1.6
Suspiciousness	(L)	6.1	1.7	6.5	2.0
Imagination	(M)	5.6	1.6	4.9	1.8
Shrewdness	(N)	6.5	1.3	6.9	2.0
Insecurity	(O)	6.5	1.8	7.1	2.0
Radicalism	(Q1)	5.2	1.9	4.5	1.6
Self-Sufficiency	(Q2)	6.3	1.1	4.9	1.7
Self-Discipline	(Q3)	3.6	1.3	4.9	2.2
Tension	(Q4)	7.1	1.8	6.7	2.0
Hypochondriasis	(D1)	6.5	1.1	7.0	2.0
Suicidal Depression	(D2)	7.5	1.5	6.7	2.1
Agitation	(D3)	3.9	1.5	4.7	2.3
Anxious Depression	(D4)	8.3	1.3	7.1	2.0
Low Energy Depression	(D5)	6.2	0.9	6.8	1.8
Guilt & Resentment	(D6)	8.7	1.6	7.7	2.0
Boredom & Withdrawal	(D7)	5.8	1.4	6.1	2.0
Paranoia	(Pa)	8.2	1.7	6.3	2.1
Psychopathic Deviation	(Pp)	2.7	0.9	4.4	2.0
Schizophrenia	(Sc)	9.1	1.1	6.4	1.9
Psychasthania	(As)	5.1	1.4	6.7	1.8
Psychological Inadequacy	(Ps)	7.8	1.9	6.8	2.0
Extraversion	(Ex)	4.6	1.2		
Anxiety	(Ax)	7.6	1.7		
Tough Poise	(Ct)	4.8	1.3		
Independence	(In)	5.7	1.6		
Superego Strength	(Se)	4.1	1.2		
Socialization	(So)	7.5	0.9		
Depression	(D)	7.2	1.5		
Psychoticism	(P)	9.1	1.6		
Neuroticism	(Ne)	6.1	1.3		

Table D2

Comparison of Successes' and Failures' Mean Ratios of "Yes" Answers on the Cornell Medical Index Health Questionnaire

Section	Successes		Failures		Difference*	t Value	P Value
	$\bar{X}$	SD	$\bar{X}$	SD			
A Eyes and Ears	.22	.17	.19	.14	.025	0.36	NS
B Respiratory System	.22	.21	.24	.16	-.026	0.31	NS
C Cardiovascular System	.20	.14	.29	.21	-.092	1.07	NS
D Digestive Tract	.20	.17	.20	.15	-.006	0.09	NS
E Musculoskeletal System	.14	.09	.23	.30	-.089	0.82	NS
F Skin	.33	.22	.21	.20	.123	1.30	NS
G Nervous System	.26	.20	.33	.21	-.074	0.80	NS
H Genitournary System	.09	.06	.19	.16	-.105	1.75	.05**
I Fatiguability	.13	.21	.24	.26	-.113	1.04	NS
J Frequency of Illness	.04	.07	.13	.03	-.091	1.34	NS (.096)
K Miscellaneous Diseases	.16	.08	.23	.12	-.063	1.29	NS
L Habits	.44	.23	.51	.23	-.071	0.67	NS
Total Ratio of "Yes" Answers	.29	.16	.36	.20	-.716	0.85	NS

* Differences are calculated by the successes' mean minus the failures' mean.

** Significant at the .05 level; one tailed test.

Note: Answers are "yes" or "no"; each yes answer identifies a physical symptom.

Table D3

Successes' and Failures' Total Number of Alcoholic Symptoms*

Variable	Successes %	Successes (N)	Failures %	Failures (N)	Chi square (x^2)	Level of Sig. NS=not sig.
Number of symptoms experienced (in year prior to program entry)						
None	22	(2)	0	(0)		
1 - 5	0	(0)	8	(1)		
6 - 10	44	(4)	38	(5)	4.5	NS
11 - 15	22	(2)	46	(6)		
16 - 18	11	(1)	8	(1)		

* The Alcoholic Symptoms measured on the Minnesota Alcoholism Severity Scale (Evenson et al., 1973) are:

Blackouts
Delireum tremens
Loss of control
Decreasing tolerance
Auto accidents
Missed work
Quarrels
Alcoholic Seizures
Liver disease
Benders
Drinking in the morning
Fright
Nightmares
Being arrested
Not able to stop drinking
Non-beverage alcohol use
Detox center admission
Hospital emergency admission

Table D4
Mean Scores of Figure 5.2

Successes' and Failures' Psychological Profiles:
Clinical Analysis Questionnaire (CAQ) Scores

Variable Labels		Successes		Failures		Differ-ence*	t Value	P** Value
		$\bar{X}$	SD	$\bar{X}$	SD			
A. Normal Personality Factors								
Warmth	(A)	5.7	1.9	5.4	1.1	.28	0.41	NS
Intelligence	(B)	4.8	0.9	4.6	1.2	.16	0.32	NS
Emotional Stability	(C)	4.1	1.7	3.7	1.7	.41	0.54	NS
Dominance	(E)	5.2	1.4	4.7	1.5	.53	0.84	NS
Impulsivity	(F)	5.0	0.8	4.4	1.6	.61	1.01	NS
Conformity	(G)	4.6	1.8	4.5	1.2	.09	0.14	NS
Boldness	(H)	4.7	0.9	4.5	1.8	.20	0.30	NS
Sensitivity	(I)	5.9	1.4	5.9	1.1	-.03	0.06	NS
Suspiciousness	(L)	5.6	2.1	6.5	1.3	-.90	1.19	NS (.12)
Imagination	(M)	5.9	1.8	5.4	1.4	.50	0.71	NS
Shrewdness	(N)	6.2	1.4	6.6	1.3	-.39	0.65	NS
Insecurity	(O)	6.0	1.9	6.8	1.7	-.84	1.04	NS (.15)
Radicalism	(Q1)	5.3	1.8	5.1	2.0	.26	0.30	NS
Self-Sufficiency	(Q2)	6.4	1.0	6.2	1.2	.29	0.59	NS
Self-Discipline	(Q3)	3.7	1.1	3.6	1.4	.05	0.09	NS
Tension	(Q4)	6.7	1.4	7.5	1.9	-.79	1.01	NS (.16)
B. Clinical Factors								
Hypochondriasis	(D1)	6.6	0.7	6.4	1.4	.14	0.26	NS
Suicidal Depression	(D2)	7.4	0.7	7.6	1.9	-.14	0.20	NS
Agitation	(D3)	3.8	1.5	4.0	1.6	-.22	0.31	NS
Anxious Depression	(D4)	8.8	1.3	8.2	1.2	.61	1.05	NS
Low Energy Depression	(D5)	6.1	0.9	6.3	0.9	-.14	0.33	NS
Guilt & Resentment	(D6)	8.1	1.6	9.2	1.5	-1.06	1.50	NS (.07)
Boredom & Withdrawal	(D7)	5.7	1.4	5.9	1.3	-.25	0.40	NS
Paranoia	(Pa)	8.3	1.6	8.2	1.9	.17	0.21	NS
Psychopathic Deviation	(Pp)	2.8	1.1	2.7	0.7	.11	0.26	NS
Schizophrenia	(Sc)	9.4	0.8	8.8	1.2	.61	1.24	NS
Psychasthania	(As)	5.2	1.6	5.0	1.2	.22	0.34	NS
Psychological Inadequacy	(Ps)	7.8	1.4	7.8	2.3	-.06	.06	NS
C. Second-Order Factors								
Extraversion	(Ex)	4.8	0.9	4.5	1.4	.31	.53	NS
Anxiety	(Ax)	7.0	1.7	8.1	1.5	-1.03	1.34	NS (.09)
Tough Poise	(Ct)	4.5	1.3	5.0	1.3	-.56	.94	NS
Independence	(In)	5.9	1.5	5.6	1.6	.34	.47	NS
Superego Strength	(Se)	3.9	1.1	4.2	1.3	-.26	.46	NS
Socialization	(So)	7.4	0.6	7.6	1.1	-.17	.38	NS
Depression	(D)	7.5	1.2	7.1	1.8	.43	.60	NS
Psychoticism	(P)	9.3	1.0	9.0	2.0	.28	.37	NS
Neuroticism	(Ne)	5.7	1.5	6.4	1.1	-.644	1.07	NS

* Difference is the mean of the succes group minus the mean of the failure group.
** one-tailed test

Table D5

Subjects' Alcoholics Anonymous (AA) Involvement

Before and After Entering Program

Variable Level	Before %	Before (N)	After %	After (N)	chi square x^2	Level of Significance NS=not sign.
AA Involvement						
Yes	64	(14)	82	(18)	1.03	NS
No	36	(8)	18	(4)		
Frequency of Attendance						
Less than once/month	33	(5)	06	(1)		
More than once/month; Less than once/week	20	(3)	18	(3)	4.39	NS
1-3 times/week	20	(3)	29	(5)		
More than 3 times/week	27	(4)	47	(8)		

Table D6

Subjects' Pre-test and Post-test Scores on the

Cornell Medical Index Health Questionnaire

Health Index Categories	Pre-test $\bar{X}$*	Pre-test SD	Post-test $\bar{X}$*	Post-test SD	t Value	P Value NS=not sign.
A Eyes and Ears	.26	.16	.29	.16	.59	**NS
B Respiratory System	.30	.20	.23	.21	.88	***NS
C Cardiovascular System	.29	.19	.36	.24	.29	**NS
D Digestive Tract	.20	.17	.20	.17	.16	NS
E Musculoskeletal System	.24	.28	.26	.34	.21	NS
F Skin	.36	.23	.29	.30	.88	***NS
G Nervous System	.35	.23	.30	.23	.75	***NS
H Genitourinary System	.15	.18	.28	.27	1.91	**+(.05)
I Fatiguability	.24	.24	.19	.25	.56	***NS
J Frequency of Illness	.07	.12	.08	.13	.46	NS
K Miscellaneous Diseases	.18	.09	.23	.19	.25	**NS
L Habits	.18	.21	.23	.23	.30	**NS
Ratio of "yes" answers on whole	.37	.20	.44	.26	.78	**NS

* The means are the ratio of the total number of "yes" answers to the total number of questions per section.

N = 9

** increase in mean number of "yes" answers

*** decrease in mean number of "yes" answers ("yes" answers denote physical symptoms or risks)

\+ significant at the 0.05 level; one-tailed test

Table D7

Pre-test and Post-test Comparisons of Subjects' Emotional Intimacy and Family Relationships

Variable Label and Category	Pre-test %	(N)	Post-test %	(N)	chi square x^2	Level of Significance NS=not sign.
Amount Confided in Someone						
Very Often	22	(2)	56	(5)		
Often	22	(2)	22	(2)	3.49	NS
Sometimes	33	(3)	22	(2)		
Never	22	(2)	0	(0)		
Who Confidant Is						
Friend (not from Simon House)	11	(1)	0	(0)		
Relative	11	(1)	0	(3)		
Sponsor	56	(5)	57	(4)	3.92	NS
Friend (from Simon House)	11	(1)	0	(0)		
Simon House staff	11	(1)	43	(3)		
Contact With Family						
Frequently (more than once a week)	67	(6)	33	(3)		
One to four per month	22	(2)	44	(4)		
Seldom (less than once a year)	11	(1)	0	(0)	5.00	NS
None	0		22	(2)		

Table D8

Mean Scores of Figure 5.3

A Single Subject's Pre-test and Post-test Psychological Profiles: Clinical Analysis Questionnaire (CAQ) Scores

CAQ Factors	Pre-test	Post-test
A. Normal Personality Factors		
Warmth	5	4
Intelligence	5	6
Emotional Stability	2	7
Dominance	3	6
Impulsivity	4	5
Conformity	4	6
Boldness	5	7
Sensitivity	8	8
Suspiciousness	9	4
Imagination	5	6
Shrewdness	8	10
Insecurity	9	6
Radicalism	5	4
Self-Sufficiency	5	6
Self-Discipline	3	8
Tension	6	3
B. Clinical Factors		
Hypochondriasis	7	6
Suicidal Depression	7	3
Agitation	4	3
Anxious Depression	10	7
Low Energy Depression	7	2
Guilt & Resentment	10	6
Boredom & Withdrawal	2	5
Paranoia	10	6
Psychopathic Deviation	5	4
Schizophrenia	10	9
Psychasthania	10	7
Psychological Inadequacy	8	4
C. Second-order Factors		
Extraversion	6.0	5.5
Anxiety	9.5	5.0
Tough Poise	3.8	4.3
Independence	3.5	5.0
Superego Strength	4.1	7.1
Socialization	8.2	7.7
Depression	7.0	4.3
Psychoticism	9.3	9.1
Neuroticism	7.7	4.5

Table D9
Mean Scores of Figure 5.4

Subjects' Pre-test and Post-test Psychological Profiles: Clinical Analysis Questionnaire (CAQ) Scores

Variable Labels (CAQ Factors)		Pre-test		Post-test		Difference*	t Value	P Value
		$\bar{X}$	SD	$\bar{X}$	SD			
A. Normal Personality Factors								
Warmth	(A)	6.0	1.8	5.3	0.8	.67	1.07	NS
Intelligence	(B)	4.7	1.0	4.6	1.8	.11	.22	NS
Emotional Stability	(C)	4.9	1.6	5.0	1.7	-.11	.23	NS
Dominance	(E)	4.9	1.6	5.0	1.7	-.11	.23	NS
Impulsivity	(F)	4.6	1.2	4.8	2.3	-.22	.27	NS
Conformity	(G)	4.2	4.0	4.6	1.0	-.33	.60	NS
Boldness	(H)	4.7	0.9	4.9	1.0	-.22	.69	NS
Sensitivity	(I)	5.9	1.3	6.7	1.0	-.78	1.67	NS (.06)
Suspiciousness	(L)	5.7	1.9	5.3	0.9	.33	.42	NS
Imagination	(M)	5.1	1.0	6.3	1.1	-1.22	2.23	.03*
Shrewdness	(N)	6.4	1.3	7.4	1.9	-1.00	2.00	.04*
Insecurity	(O)	6.2	2.1	6.0	2.1	.22	.45	NS
Radicalism	(Q1)	4.7	1.8	4.6	1.3	.11	.21	NS
Self-Sufficiency	(Q2)	6.0	1.3	5.6	0.7	.44	1.18	NS (.14)
Self-Discipline	(Q3)	3.4	1.3	4.4	1.6	-1.00	1.66	NS (.07)
Tension	(Q4)	7.1	1.4	6.7	1.8	.44	.94	NS
B. Clinical Factors								
Hypochondriasis	(D1)	6.7	0.8	6.6	1.0	.11	.32	NS
Suicidal Depression	(D2)	7.6	0.7	7.2	2.0	.33	.53	NS
Agitation	(D3)	3.7	1.2	2.8	1.4	.89	1.83	.05*
Anxious Depression	(D4)	8.8	1.3	8.8	1.4	.00	0.00	NS
Low Energy Depression	(D5)	6.1	0.9	5.6	1.4	.56	.92	NS
Guilt & Resentment	(D6)	8.6	1.5	8.1	1.6	.44	.94	NS
Boredom & Withdrawal	(D7)	5.6	1.3	6.1	0.9	-.56	1.25	NS (.12)
Paranoia	(Pa)	8.4	1.6	8.1	1.6	.33	.67	NS
Psychopathic Deviation	(Pp)	2.8	1.1	2.9	0.7	-.11	.43	NS
Schizophrenia	(Sc)	9.2	0.9	8.8	1.2	.44	1.83	.05*
Psychasthania	(As)	5.3	1.6	5.2	1.1	.11	.17	NS
Psychological Inadequacy	(Ps)	8.2	1.4	7.4	1.8	.78	1.57	NS (.07)
C. Second-Order Factors								
Extraversion	(Ex)	4.9	1.0	5.0	0.7	-.10	.33	NS
Anxiety	(Ax)	7.4	1.7	7.2	1.9	.20	.30	NS
Tough Poise	(Ct)	4.7	1.2	4.5	0.7	.21	.84	NS
Independence	(In)	5.3	1.2	5.8	1.1	-.56	1.20	NS
Superego Strength	(Se)	3.7	1.2	4.5	1.3	-.81	2.25	.02*
Socialization	(So)	7.6	0.6	8.2	0.7	-.58	1.46	NS (.09)
Depression	(D)	7.3	0.9	6.7	1.5	.59	1.29	NS (.12)
Psychoticism	(P)	9.4	1.0	9.1	1.5	.29	.77	NS
Neuroticism	(Ne)	5.9	1.4	5.6	1.8	.24	.43	NS

* significant at the .05 level.

Appendix E

Explanation of Ongoing Assessment Form (Figure E1)

This form is to aid in collecting information about residents' functioning throughout their stay in the program. It should be used in conjunction with the existing admission form, and instead of daily narratives on each individual. It should be completed by staff only.

If comments about particular incidents or changes are lengthy, they can be continued on the back of the form.

Only changes in previous functioning should be documented; however, regular reviews of residents' functioning are warranted.

Category labels may need expansion, or may need to be changed as the application of the form proves them to be inappropriate.

Some categories will be commented on more than others. In this event, the spacing on the form could be altered. If the space needed varies greatly from category to category, comments may need to be moved to a separate page, leaving this form to designate change only.

Figure E1

Ongoing Assessment Form

- to be completed in full within two weeks of admission
- changes in any category to be noted as they occur
- where appropriate, rate functioning as good (1), fair (2), or poor (3)

Resident's Name ______________________________

Date of Admission ____________________

	Rating & Date	Comments	Rating & Date	Comments
Physical Functioning				
Health status				
Personal health care/grooming				
Medical care received				
Eating habits				
Exercise				
Psychological Functioning				
Health status (state abnormalities)				
Ability to express thoughts and feelings				
Appropriate display of thoughts and feelings				
Sleeping Patterns				
Decision-making				
Self-disclosure				
Addiction Problem (Yes/No)				
Alcohol				
Drugs				
Treatment Program Involvement				

	Rating & Date	Comments	Rating & Date	Comments
Social Functioning				
Appropriate use of leisure time				
Interaction with other residents				
Interaction with family				
Interaction with non-Simon House friends				
Employment (include reason not working)				
Financial Situation				
Source of Income				
Budgeting				
Illegal Activity (Yes/No)				
Use of Simon House Services				
Participation				
Accepting Responsibilities				
Following Rules				
Referrals made (by staff)				
Referrals followed through				
Discharge				
Planning done (by resident)				
Appropriateness				
Length of Stay in Simon House				