TASK FORCE REPORT:

DRUNKENNESS

ANNOTATIONS, CONSULTANTS' PAPERS, AND RELATED MATERIALS

Task Force on Drunkenness
PRESIDENT'S COMMISSION ON LAW ENFORCEMENT AND ADMINISTRATION OF JUSTICE

Publications of the President's Commission on Law Enforcement and Administration of Justice

Commission Report: The Challenge of Crime in a Free Society

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- Task Force Report: Assessment of Crime
- Task Force Report: Narcotics and Drugs
- Task Force Report: Drunkenness
- Research Studies
- Selected Consultants' Papers

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Task Force on Drunkenness

THE PRESIDENT'S COMMISSION ON LAW ENFORCEMENT AND ADMINISTRATION OF JUSTICE

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Copies of other task force reports and other supporting materials can also be purchased.

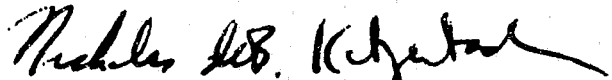
FOREWORD

In February of this year the President's Commission on Law Enforcement and Administration of Justice issued its general report: "The Challenge of Crime in a Free Society." Chapter 9 of that report made findings and recommendations relating to methods of handling drunkenness offenders. That chapter is reprinted at the beginning of this volume, with the addition of annotations to indicate source materials considered. In addition, this volume contains a number of papers and other materials which were used as background documentation in the preparation of the chapter and are believed to be of interest and value as source material.

A panel of Commission members had special responsibility for this area. Many members of the Commission staff participated in the work on this subject, and Gerald Stern of the staff devoted his primary attention to it. The inclusion of consultants' papers and other related materials does not indicate endorsement by the panel of Commission members or by the staff.

Included in this volume are three papers submitted to the Commission by outside consultants, and two proposals submitted to government agencies describing proposed treatment programs in St. Louis and New York City. Part of an article written by New York Supreme Court Justice John M. Murtagh provides some background to the New York City treatment program. The report also includes relevant portions of the recently published report by the President's Commission on Crime in the District of Columbia. A 1963 report made by Emory University, Department of Psychiatry, the City of Atlanta and Fulton County, Georgia, is also included. This report was the basis for the present treatment program in Atlanta, which is described in the Commission's chapter on drunkenness. And finally, the volume includes a paper prepared by Thomas F. A. Plaut, Assistant Chief, National Center for Prevention and Control of Alcoholism, National Institute of Mental Health, which provides a brief analysis of existing facilities for the treatment of alcoholism, based upon a recent survey by the California Cooperative Commission on the Study of Alcoholism.

As noted in the foreword to the general report, the Commission's work was a joint undertaking, involving the collaboration of Federal, State, local, and private agencies and groups, hundreds of expert consultants and advisers, and the Commission's own staff. The Commission is deeply grateful for the talent and dedication of its staff and for the unstinting assistance and advice of consultants, advisers, and collaborating agencies whose efforts are reflected in this volume.



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CONTENTS

*This section of the report is an annotated version of the chapter on drunkenness offenses appearing in the Commission's general report, "The Challenge of Crime in a Free Society."

TABLE OF RECOMMENDATIONS

This Table of Recommendations is reprinted from the General Report of the Commisison, "The Challenge of Crime in a Free Society."

Drunkenness Offenses

Two million arrests in 1965—one of every three arrests in America—were for the offense of public drunkenness.[1] The great volume of these arrests places an extremely heavy load on the operations of the criminal justice system. It burdens police, clogs lower criminal courts, and crowds penal institutions throughout the United States.

Because of the sheer size of the problem and because of doubts that have recently been raised about the efficacy of handling drunkenness within the system of criminal justice, the Commission sought to reexamine present methods of treating drunkenness offenders and to explore promising alternatives. It was not in a position to undertake a comprehensive study of the complex medical, social, and public health problems of drunkenness.

THE EXISTING SYSTEM

DRUNKENNESS LAWS

Drunkenness is punishable under a variety of laws, generally describing the offense as being "drunk in a public place," often without providing a precise definition of drunkenness itself.[2] Some laws include as a condition that the offender is "unable to care for his own safety." [3]

In some jurisdictions there are no laws prohibiting drunkenness, but any drunkenness that causes a breach of the peace is punishable. In Georgia and Alabama, for example, drunkenness that is manifested by boisterous or indecent conduct, or loud and profane discourse, is a crime.[4] Other jurisdictions apply disorderly conduct statutes to those who are drunk in public. In Chicago, for example, the police, having no drunkenness law to enforce, use a disorderly conduct statute to arrest nondisorderly inebriates.[5] Some jurisdictions permit police to make public drunkenness arrests under both State laws and local ordinances.[6]

The laws provide maximum jail sentences ranging from 5 days to 6 months; the most common maximum sentence is 30 days. In some States an offender convicted of "habitual drunkenness" may be punished by a 2-year sentence of imprisonment.[7]

THE OFFENDERS

The 2 million arrests for drunkenness each year involve both sporadic and regular drinkers. Among the number are a wide variety of offenders—the rowdy college boy; the weekend inebriate; the homeless, often unemployed single man. How many offenders fall into these and other categories is not known. Neither is it known how many of the offenders are alcoholics in the medical sense of being dependent on alcohol. There is strong evidence, however, that a large number of those who are arrested have a lengthy history of prior drunkenness arrests, and that a disproportionate number involve poor persons who live in slums. In 1964 in the city of Los Angeles about one-fifth of all persons arrested for drunkenness accounted for two-thirds of the total number of arrests for that offense. Some of the repeaters were arrested as many as 18 times in that year.[8]

A review of chronic offender cases reveals that a large number of persons have, in short installments, spent many years of their lives in jail. In 1957 the Committee on Prisons, Probation and Parole in the District of Columbia studied six chronic offenders and found that they had been arrested for drunkenness a total of 1,409 times and had served a total of 125 years in penal institutions.[9] A recent article in a Syracuse, N.Y. newspaper illustrates the point even more succinctly:

> H____ F____, 69 appeared in police court for the 277th time on a public intoxication charge. F____, who has served 16 years in the Jamesville Penitentiary in short terms on the charge, was returned there for a 6-month sentence.[10]

The great majority of repeaters live on "skid row"—a dilapidated area found in most large and medium-size cities in the United States. On skid row substandard hotels and roominghouses are intermingled with numerous taverns, pawn shops, cheap cafeterias, employment agencies that specialize in jobs for the unskilled, and religious missions that provide free meals after a service. Many of the residents—including the chronic drunkenness offenders—are homeless, penniless, and beset with acute personal problems.[11]

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[1] 1965 FBI UNIFORM CRIME REPORTS 117 (table 25). In 1965, 1,516,548 drunkenness arrests were reported by 4,043 agencies, embracing a total population of 125,139,000. Projections based upon these figures indicate that there were over 2 million arrests in the entire country during 1965. An undetermined number of additional arrests for drunkenness are made under disorderly conduct, vagrancy, loitering, and related statutes. See, *e.g.*, Foote, *Vagrancy-Type Law and Its Administration*, 104 U. PA. L. REV. 603 (1956) (discussion of interchanging of statutes for like purposes); Murtagh, *Arrests for Public Intoxication*, 35 FORDHAM L. REV. 1–7 (1966) (description of the prior New York City practice of using a disorderly conduct statute to arrest nondisorderly inebriates).

[2] *E.g.*, D.C. CODE ANN. § 25–128(a) (1961). The D.C. statute also prohibits drinking an alcoholic beverage in public.

[3] *E.g.*, WIS. STAT. § 947.03 (1955).

[4] ALA. CRIM. CODE § 14–120 (1958); GA. CODE ANN. § 58–608 (1965).

[5] See Note, *The Law on Skid Row*, 38 CHI.-KENT L. REV. 22, 42 (1964) ("they are detained, whether or not their actions fit the legal criteria of 'disorderly conduct.'"); 4 Chicago Police Dep't Training Bull. No. 9 (March 4, 1963).

[6] N.Y. PENAL LAW § 1221 (McKinney 1944); SYRACUSE, N.Y., REV. ORDINANCES, ch. 16, § 5 (1961).

[7] N.C. GEN. STAT. § 14–335 (1953). See Driver v. Hinnant, 356 F.2d 761 (4th Cir. 1966), for reversal of conviction and 2-year sentence under the North Carolina statute.

[8] Statistics gathered by the Los Angeles Police Dep't. During 1964 there were 71,494 drunkenness arrests—47,401 of which involved 13,048 offenders. In 1955, 45,743 of the drunkenness arrests in Los Angeles involved 6,665 offenders. In 1961, 12,000 individuals accounted for approximately 30,000 of the 49,000 arrests in Atlanta, Ga. Dep't of Psychiatry, Emory Univ. School of Medicine, Alcohol Study Project 5 (unpublished 1963) [hereinafter cited as Emory Dep't of Psychiatry].

[9] D.C. COMM. ON PRISONS, PROBATION, AND PAROLE, REP. 114–19 (1957).

[10] Syracuse Herald American, Aug. 22, 1965, p. 30, col. 8.

[11] BOGUE, SKID ROW IN AMERICAN CITIES 1–4 (1963).

THE ARREST OF THE DRUNKENNESS OFFENDER

The police do not arrest everyone who is under the influence of alcohol.[12] Sometimes they will help an inebriate home. It is when he appears to have no home or family ties that he is most likely to be arrested and taken to the local jail.[13]

One policeman assigned to a skid row precinct in a large eastern city recently described how he decided whom to arrest:

> I see a guy who's been hanging around; a guy who's been picked up before or been making trouble. I stop him. Sometimes he can convince me he's got a job today or got something to do. He'll show me a slip showing he's supposed to go to the blood bank, or to work. I let him go. But if it seems to me that he's got nothing to do but drink, then I bring him in.[14]

Drunkenness arrest practices vary from place to place. Some police departments strictly enforce drunkenness statutes, while other departments are known to be more tolerant. In fact, the number of arrests in a city may be related less to the amount of public drunkenness than to police policy. Some of the wide variations in police practices can be seen in the table below that compares drunkenness arrests by two police departments known to be guided by policies of strict enforcement (Atlanta, Ga., and Washington, D.C.) to arrests by a department that is considered more tolerant (St. Louis, Mo.).

In some large and medium-size cities, police departments have "bum squads" that cruise skid rows and border areas to apprehend inebriates who appear unable to care for their own safety, or who are likely to annoy others.[15] Such wholesale arrests sometimes include homeless people who are not intoxicated.[16]

OPERATION OF THE CRIMINAL SYSTEM AFTER ARREST

Following arrest, the drunk is usually placed in a barren cell called a "tank," where he is detained for at least a few hours. The tanks in some cities can hold as many as 200 people, while others hold only 1 or 2. One report described the conditions found in a tank in this way:

> Although he may have been picked up for his own protection, the offender is placed in a cell, which may frequently hold as many as 40–50 men where there is no room to sit or lie down, where sanitary facilities and ventilation are inadequate and a stench of vomit and urine is prevalent.
>
> The drunken behavior of some of the inmates is an added hazard. It is questionable whether greater safety is achieved for the individual who is arrested for his safe keeping.[17]

The chronic alcoholic offender generally suffers from a variety of ailments and is often in danger of serious medical complications,[18] but medical care is rarely provided in the tank; and it is difficult to detect or to diagnose serious illness since it often resembles intoxication.[19] Occasionally, chronic offenders become ill during pretrial detention and die without having received adequate medical attention.[20]

Comparison of Drunkenness Arrests in Three Cities

	Population 1965 estimates	Number of arrests (1965)			(Percentage of all arrests) accounted for by:	
		Drunkenness arrests	Disorderly conduct and vagrancy arrests	All arrests	Drunk arrests	Drunk, disorderly, and vagrancy arrests
Washington, D.C.	802,000	44,792	21,338	86,464	51.8	76.5
St. Louis, Mo.	699,000	2,445	5,994	44,701	5.5	18.9
Atlanta, Ga.	522,000	48,835	22,379	92,965	52.5	76.6

If the offender can afford bail, he usually obtains release after he sobers up.[21] In many jurisdictions an offender is permitted to forfeit bail routinely by not appearing in court.[22] Thus, if the arrested person has the few dollars required, he can avoid prosecution;[23] if he

[12] It is often the express policy of a police department to refrain from arresting a person for drunkenness in cases in which he may be placed in a taxicab or he is with friends who are able to escort him home. See, *e.g.*, 1 Columbus, Ohio, Police Dep't Training Bull., rev. Aug. 1958, unit 6, p. 2; PRES.'S COMM'N ON CRIME IN THE DISTRICT OF COLUMBIA, REP. 475 (1966), citing letter from District of Columbia Police Chief John B. Layton to Pres.'s Comm'n on Crime in the District of Columbia, Apr. 1, 1966.

[13] The police make this determination by observing, *inter alia*, the apparent affluence of the inebriate. Moreover, the lack of funds for transportation will influence the determination to arrest. The result is that the poor are more likely to be arrested than the well-to-do. See PRES.'S COMM'N ON CRIME IN THE DISTRICT OF COLUMBIA, REP. 475 (1966). See also Washington Daily News, Dec. 21, 1965, p. 5, at p. 35 (interview with precinct commanding officer: "We do tend to enforce the laws more rigidly on 14th Street than in, say, Crestwood, a better part of the precinct.").

[14] Interview with a police officer assigned to a large-city skid row by a staff member of the Vera Institute of Justice.

[15] LAFAVE, ARREST: THE DECISION TO TAKE A SUSPECT INTO CUSTODY 441 n.13 (1965).

[16] The Atlanta Alcohol Study Project found that there are a "significant number of individuals who are arrested for public intoxication and who are not drunk at the time of arrest." Emory Dep't of Psychiatry 18. Similar findings were reported in other cities; see, for example, reports by Klein, The Criminal Law Process vs. the Public Drunkenness Offender in San Francisco, 1964 (unpublished, on file at Stanford Univ. Institute for the Study of Human Problems), and by Nash, Habitats of Homeless Men in Manhattan, Nov. 1964 (unpublished, on file at Columbia Univ. Bureau of Applied Social Research).

[17] Comm. on Alcoholism Community Welfare Council of the Greater Sacramento Area, Inc., The Alcoholic Law Offender 4 (unpublished 1965). Another tank was described in a 1966 newspaper article:

> There are at least two men in each 4 x 8 foot cell and three in some. . . . The stench of cheap alcohol, dried blood, urine and excrement covers the cell blocks . . . . There are no lights in the cells . . . . There are no mattresses. Mattresses wouldn't last the night a policeman explains. And with prisoners urinating all over them, they wouldn't be any good if they did last. . . .

Hoagland, Cell Blocks' Common Denominator: A Stench of Alcohol and Dried Blood, Washington Post, March 29, 1966, p. A1, col. 3.

[18] Univ. of Minn. & Minneapolis Housing and Redevelopment Authority, A General Report on the Problem of Relocating the Population of the Lower Loop Redevelopment Area 170 (unpublished 1958) ("health conditions in this area are catastrophically bad"). The report provided a detailed description of illnesses which exist in skid row areas and states that the "tuberculosis rate in the lower loop is 320 times as high as the rate for the rest of the city." *Id.* at 170. See also Dep't of Psychiatry, Temple Univ., School of Medicine, The Men of Skid Row, A Study of Philadelphia's Homeless Man Population 88 (unpublished 1960) (57% of the men reported one or more serious conditions). Bogue's study, *op. cit. supra* note 11, at 222–23, depicted the great need for medical care and observed that "among the heavy drinkers, alcoholism is complicated by chronic sickness in a subtantial portion of cases."

[19] One of the biggest obstacles in handling a case of drunkenness is that it is often difficult to distinguish between effects produced by alcohol or drugs and those produced by injury or illness. For instance, a person may smell of alcohol, and he may stagger and seem drunk . . . or lie unconscious in an apparent drunken stupor. Yet he may have had only a drink or two—or none at all!! . . . CORRECTIONAL ASS'N OF N.Y. & INT'L ASS'N OF CHIEFS OF POLICE, ALCOHOL AND ALCOHOLISM, A POLICE HANDBOOK 22 (1965).

[20] *Man, 52, Dies in Court Lockup*, Washington Post, Sept. 5, 1965, p. A3; *Man Detained as Drunk Dies From Pneumonia, id.*, Dec. 15, 1965, p. D21, cols. 1–2; *Man, 63, Found Dead in Alexandria Jail Cell, id.*, Nov. 22, 1966, p. B4, cols. 1–2. In the PRES.'S COMM'N ON CRIME IN THE DISTRICT OF COLUMBIA, REP. 476 (1966), it was reported that "16 persons arrested for intoxication died while in police custody in 1964–1965."

[21] Stationhouse bail permits the release of defendants pending a subsequent court appearance. See generally FREED & WALD, BAIL IN THE UNITED STATES (1964). Outright release—with no obligation to return to court—is sometimes permitted by the police. See LAFAVE, *op. cit. supra* note 16, at 440–42, for a variety of release systems ranging from outright police discretion to a payment to the city of $4.35. In Detroit the police have a "golden rule" procedure which resulted in 1965 in the release of 2,383 offenders out of a total of 8,715 drunkenness arrests. In Omaha, Neb., the majority of offenders are released after a few hours of detention. The Omaha system includes referral to community agencies following release, in appropriate cases. The police bring some offenders to the agencies where shelter and food are provided.

[22] Bail or collateral forfeiture is common in some jurisdictions. The defendant pays $10 to $20, depending upon the stipulated amount in the jurisdiction, and he is not penalized for failing to return to court. See PRES.'S COMM'N ON CRIME IN THE DISTRICT OF COLUMBIA, REP. 477 (1966); Emory Dep't of Psychiatry 11.

[23] In Washington, D.C., for example, approximately 20,000 of the 44,218 people arrested during 1965 obtained release by forfeiting $10 collateral. PRES.'S COMM'N ON CRIME IN THE DISTRICT OF COLUMBIA, REP. 475 (1966). In Atlanta, Ga., approximately 20,000 of 49,805 arrests during 1961 resulted in ($15) collateral forfeitures. Emory Dep't of Psychiatry 11. Those who post and forfeit collateral avoid the risk of a jail sentence.

has no money, as is usually the case, he must appear in court.

Drunkenness offenders are generally brought before a judge the morning after their arrest, sometimes appearing in groups of 15 or 20. Rarely are the normal procedural or due process safeguards applied to these cases.[24] Usually defendants are processed through the court system with haste and either released or sentenced to several days or weeks in jail.[25] In some cities only those offenders who request it are jailed.[26] In others chronic offenders, who are likely to be alcoholics, are generally sent to jail.[27]

When a defendant serves a short sentence, he is fed, sheltered, and given access to available recreational facilities. In most institutions there is such a lack of facilities and financial resources that it is not possible to do more.[28] Austin MacCormick, a former New York City commissioner of corrections, noted recently:

> The appallingly poor quality of most of the county jails in the United States is so well known that it is probably not necessary to discuss this point at any great length. The fact that the majority of all convicted alcoholics go to these institutions, however, makes it imperative that the public, and particularly those thoughtful citizens who are interested in the treatment of alcoholics, never be allowed to forget that our county jails are a disgrace to the country * * * and that they have a destructive rather than a beneficial effect not only on alcoholics who are committed to them but also on those others who are convicted of the most petty offenses.[29]

After serving a brief sentence, the chronic offender is released, more likely than not to return to his former haunts on skid row, with no money, no job, and no plans.[30] Often he is rearrested within a matter of days or hours.

In a memorandum of law submitted in a recent case of a homeless alcoholic, defense counsel noted that his client had been arrested 31 times in a period of 4 months and 6 days. Counsel maintained that "it is fair to conclude [in view of three commitments during that period of time] that he must have been arrested once out of every 2 days that he appeared on the public streets of the District of Columbia." [31]

EVALUATION OF THE EXISTING SYSTEM

EFFECT ON THE OFFENDER

The criminal justice system appears ineffective to deter drunkenness or to meet the problems of the chronic alcoholic offender. What the system usually does accomplish is to remove the drunk from public view, detoxify him, and provide him with food, shelter, emergency medical service, and a brief period of forced sobriety. As presently constituted, the system is not in a position to meet his underlying medical and social problems.

EFFECT ON THE SYSTEM OF CRIMINAL JUSTICE

Including drunkenness within the system of criminal justice seriously burdens and distorts its operations. Because the police often do not arrest the intoxicated person who has a home, there is in arrest practices an inherent discrimination against the homeless and the poor. Due process safeguards are often considered unnecessary or futile. The defendant may not be warned of his rights or permitted to make a telephone call.[32] And although coordination, breath, or blood tests to determine intoxication are common practice in "driving-while-intoxicated" cases, they are virtually nonexistent in common drunk cases. Yet, without the use of such chemical tests, it is often difficult to determine whether the individual is intoxicated or suffering from a serious illness that has symptoms similar to intoxication.[33]

The handling of drunkenness cases in court hardly reflects the standards of fairness that are the basis of our system of criminal justice.[34] One major reason is that

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[24] See generally Foote, *supra* note 1; Labovitz, Some Legal Problems of Skid Row Residents, draft of report soon to be issued by the Diagnostic and Relocation Center, Philadelphia, Pa. These conclusions are supported by observations made in court during the early part of 1966 by Commission staff attorneys. The right of cross-examination, confrontation of the accuser, and the privilege against self-incrimination were repeatedly disregarded. In the absence of counsel the courts and prosecutors sometimes act sua sponte to assure that all defenses are asserted on behalf of the defendant. Chief Judge Green of the District of Columbia Court of General Sessions has concluded that "the court has the obligation to inject this issue [alcoholism] on its own motion when it appears likely from the evidence that the defense may be available." District of Columbia v. Walters, 112 CONG. REC. 22716 (daily ed., Sept. 22, 1966). See also Whalem v. United States, 120 U.S. App. D.C. 331, 346 F.2d 812 (D.C. Cir 1965) (en banc); Overholser v. Lynch, 109 U.S. App. D.C. 404, 288 F.2d 388 (D.C. Cir. 1961), *rev'd in part on other grounds*, 369 U.S. 705 (1962); Pate v. Robinson, 383 U.S. 375 (1966). With respect to the importance of prosecutors bringing potential defenses to the attention of the court, see Canon 5 of the Canons of Professional Ethics of the American Bar Ass'n, United States v. Ragen, 86 F. Supp. 382, 387 (N.D. Ill. 1949) (holding the "suppression of vital evidence [to be] . . . a denial of due process"); Jackson, *The Federal Prosecutor*, 24 J. AM. JUD. SOC'Y 18 (1940). See generally address by Peter Barton Hutt, att'y, *The Recent Court Decisions on Alcoholism: A Challenge to the North American Judges Association and Its Members*, NAJA annual meeting, Colorado Springs, Colo., Nov. 3, 1966, published as appendix H of this volume.

[25] In Portland, Ore., for example, the first offense receives a suspended sentence, the second offense brings a 2-day jail sentence, and the fifth offense within a 12-month period brings a 6-month sentence. The Sunday Oregonian, April 17, 1966, p. F4, col. 4; ORE. MENTAL HEALTH DIV., PROCEEDINGS: THE ALCOHOLIC AND THE COURT 39 (1963). In Atlanta, Ga., the fourth conviction within a 12-month period brings a fine, and the fifth conviction results in a 30-day jail sentence. Emory Dep't of Psychiatry 28. A 1957 study showed that 13,146 sentences out of 15,111 in Washington, D.C., were for 30 days or less. D.C. COMM. ON PRISONS, PROBATION, AND PAROLE, REP. 106 (1957).

[26] Labovitz, *supra* note 24. This procedure was observed by the Commission staff.

[27] See PITTMAN & GORDON, REVOLVING DOOR: A STUDY OF THE CHRONIC POLICE CASE INEBRIATE 30, 125 (1958); note 12 *supra*.

[28] Pittman & Gordon, *supra* note 27, at 140. An Atlanta study showed that the penal institution was

> primarily functioning as a punitive facility . . . . No effort is made to evaluate the physical or mental condition of the prisoners except for those who complain of ill health or show grossly abnormal behavior.

Emory Dep't of Psychiatry 50.

[29] MacCormack, *Correctional Views on Alcohol, Alcoholism and Crime*, 9 CRIME & DELINQUENCY 15, 20 (1963).

[30] He is merely transported from the workhouse to the city of Washington, dumped on the streets at 14th and Independence Avenue, S.W., with only the clothes on his back. He has no place to stay, no food to eat, and no job. It is ridiculous, under such circumstances, to expect any improvement in the problem of the "skid row alcoholic."

D.C. COMM. ON PRISONS, PROBATION, AND PAROLE, REP. 110 (1957).

[31] District of Columbia v. Strother, Motion to Reopen Proceedings, No. 25861-66, D.C. Ct. Gen. Sess., Sept. 14, 1966.

[32] Some police officials told Commission staff that the defendant charged with drunkenness is not permitted to place a telephone call upon request until a 4-hour "sobering up" period following arrest has elapsed. Such policy would deny the use of the telephone to some innocent people and to others who would be physically able to confer with counsel. A Commission staff attorney observed the right denied to a person charged with drunkenness who was physically able to call counsel. In another case a 17-year-old youth with no prior criminal record was arrested at 10 p.m. and denied the right to telephone his parents until the end of the "sobering up" period. Since the call had to be placed to a neighbor's home (his parents were unable to afford a telephone), he chose not to exercise his right at what he considered an unreasonable hour. He appeared in court the following morning without counsel, pleaded guilty to public intoxication, and was sentenced to 3 months in jail. His parents were not notified of his whereabouts until after he arrived in the county penitentiary. They contacted an attorney who secured the youth's release pending appeal of the conviction. Transcript of proceedings, People v. Jones, Syracuse, N.Y., Police Ct., Sept. 13, 1965.

[33] See People v. Butts, 21 Misc. 2d 799, 804-05, 201 N.Y.S.2d 926, 932-33 (1960); DONIGAN, CHEMICAL TESTS AND THE LAW 4 (Northeastern Univ. Traffic Inst. 1957):

> Authorities in this field recognize that the most skilled physician would have difficulty in arriving at an accurate diagnosis of alcoholic influence or intoxication simply by observing outward indications—clinical or objective symptoms. Ordinarily, a lengthy and detailed clinical examination is required to rule out absolutely many of the pathological conditions which are known to produce the same symptoms.

[34] See generally Foote, *supra* note 1. Observations made in court by Commission staff attorneys support this thesis. One case observed in the early part of 1966 involved an obviously indigent defendant charged with "drinking in public." The police officer testified that a bottle containing an alcoholic beverage was in the defendant's pocket. The trial judge asked the officer whether the defendant was drinking from the bottle. The officer replied that "he must have been" since the bottle was "half empty." The defendant was found guilty and fined $30. He lacked the funds to pay the fine and was compelled to serve 30 days in jail.

counsel is rarely present.[35] Drunkenness cases often involve complex factual and medical issues. Cross-examination could be conducted on "observations" of the arresting officer such as "bloodshot" and "glassy" eyes, "staggering gait," "odor" of alcohol on the defendant's breath. The testimony of an expert medical witness on behalf of the defendant could be elicited.[36]

The extent of police time allotted to handling drunkenness offenders varies from city to city and from precinct to precinct. In most cities a great deal of time is spent.[37] The inebriate must be taken into custody, transported to jail, booked, detained, clothed, fed, sheltered, and transported to court. In some jurisdictions, police officers must wait, often for hours, to testify in court.

There is a commensurate burden on the urban courts. Notwithstanding the fact that an overwhelming caseload often leads judges to dispose of scores of drunkenness cases in minutes, they represent a significant drain on court time which is needed for felony and serious misdemeanor cases. More subtly, drunkenness cases impair the dignity of the criminal process in lower courts, which are forced to handle defendants so casually and to apply criminal sanctions with so little apparent effect.

In correctional systems, too, resources are diverted from serious offenders. After court appearance, some offenders are sent to short-term penal institutions, many of which are already overcrowded. Correctional authorities estimate that one-half the entire misdemeanant population is comprised of drunkenness offenders.[38] In one city it was reported that 95 percent of short-term prisoners were drunkenness offenders.[39]

LINES FOR ACTION

The sheer size of the drunkenness problem in relation to the very limited knowledge about causes and treatment makes it impossible to speak in terms of "solutions." There are, however, some important and promising lines that the Commission believes should be explored.

TREATING DRUNKENNESS AS NONCRIMINAL

The Commission seriously doubts that drunkenness alone (as distinguished from disorderly conduct) should continue to be treated as a crime. Most of the experts with whom the Commission discussed this matter, including many in law enforcement, thought that it should not be a crime. The application of disorderly conduct statutes would be sufficient to protect the public against criminal behavior stemming from intoxication.[40] This was the view of the President's Commission on Crime in the District of Columbia, which recommended that the District of Columbia drunkenness law "be amended to require specific kinds of offensive conduct in addition to drunkenness." [41]

Perhaps the strongest barrier to making such a change is that there presently are no clear alternatives for taking into custody and treating those who are now arrested as drunks. The Commission believes that current efforts to find such alternatives to treatment within the criminal system should be expanded. For example, if adequate public health facilities for detoxification are developed, civil legislation could be enacted authorizing the police to pick up those drunks who refuse to or are unable to cooperate—if, indeed, such specific authorization is necessary. Such legislation could expressly sanction a period of detention and allow the individual to be released from a public health facility only when he is sober.

The Commission recommends:

Drunkenness should not in itself be a criminal offense. Disorderly and other criminal conduct accompanied by drunkenness should remain punishable as separate crimes. The implementation of this recommendation requires the development of adequate civil detoxification procedures.

Among those seeking alternatives to processing drunkenness cases through the criminal system are the Vera Institute of Justice [42] in New York City and the South End Center for Alcoholics and Unattached Persons [43] in Boston. The Vera Institute has recently undertaken a project to explore the feasibility of using personnel other than the police to pick up drunks.[44] Included in the study is an attempt to determine what percentage of drunks will come to a treatment facility voluntarily. The Vera program would circumvent the criminal process by establishing a system within a public health framework to care for

[35] The assignment of counsel to skid row inebriates had a profound effect on the handling of such cases in New York City. More than 95% of the defendants were acquitted after trial on disorderly conduct charges. See Murtagh, Comments, 16 Inventory 13, 14 (N.C. Rehabilitation Program, July–Sept. 1966), for a discussion of the background and reasons for the program. In March 1966 there were 1,326 defendants arraigned in Social Court in New York City, of whom 1,280 were acquitted. In March 1965, in the absence of defense counsel, there were 1,590 arraignments, 1,259 guilty pleas, and only 325 acquittals. Address by Hon. Bernard Botein, Presiding Justice, App. Div., 1st Dep't, N.Y. Sup. Ct., April 22, 1966, in Governor Rockefeller's Conference on Crime 149 (1966); N.Y. Times, April 23, 1966, p. 14, col. 4. Court records show that in April and May 1966, 1,838 of 2,103 defendants in New York City's Social Court were acquitted. As a result of the high acquittal rate Chief Judge John M. Murtagh directed court clerks not to draw complaints on nondisorderly drunkenness. From June 1, 1966, through Sept. 30, 1966, a total of 189 cases was brought to Social Court, of which 161 resulted in convictions.

The effect of the assignment of counsel was to reduce the number of arrests in New York City's skid row. The appearance of many more inebriated people on skid row seemed to make the underlying public health problem more visible, and the establishment of alternate facilities became more urgent. See *Derelicts Dislike Non-Arrest Policy*, N.Y. Times, July 29, 1966, p. 27, col. 8.

[36] See PRES.'S COMM'N ON CRIME IN THE DISTRICT OF COLUMBIA, REP. 500 (1966), in which the following recommendation was made: "As long as drunkenness offenders remain subject to penal sanctions, the Commission believes that they should be provided with counsel."

[37] The extent to which drunkenness offenses interfere with other police activity is illustrated in Washington, D.C., where the uniformed tactical police force, a special unit used "to combat serious crime," devotes a substantial amount of time to the handling of drunks. The Washington Daily News, Dec. 1, 1965, p. 5. During one 9-month sample period, the tactical force made 14,542 arrests, of which 6,363 were for drunkenness. Statistics supplied by Washington, D.C., Police Dep't to Pres.'s Comm'n on Crime in the District of Columbia.

[38] One study showed that in August 1962, 63% of all inmates in the Monroe Cy. Penitentiary (Rochester, N.Y.) were committed for drunkenness. ROCHESTER BUREAU OF MUNICIPAL RESEARCH, MAN ON THE PERIPHERY, REPORT ON THE MONROE COUNTY PENITENTIARY 29 (1964).

[39] See Emory Dep't of Psychiatry 51.

[40] See Murtagh, *Arrests for Public Intoxication*, 35 FORDHAM L. REV. 1 (1966) (drunkenness itself should not be a crime); Murtagh, Comments, 16 Inventory 13 (N.C. Alcoholic Rehabilitation Program, July–Sept. 1966).

[41] PRES.'S COMM'N ON CRIME IN THE DISTRICT OF COLUMBIA, REP. 496 (1966). The Commission stated: "[P]ublic intoxication alone should not be a crime in the District of Columbia." *Id.* at 495. The report also provides an excellent discussion of the range of behavior which would subject an inebriate to arrest under the proposed statutory modification. *Id.* at 496–97. Comprehensive bills that would enact the recommendations of the D.C. Crime Commission into law and provide a model for new legislation in all jurisdictions have recently been introduced in Congress as H.R. 6143 and S. 1740, 90th Cong., 1st Sess.; S. 1740 is annexed to the paper by Pittman, *Public Intoxication and the Alcoholic Offender in American Society*, 1966, printed as appendix A to this volume.

[42] See *Proposal for the Manhattan Bowery Project*, printed in part as appendix E to this volume.

[43] The Boston center is seen by its administrators as an intermediate step to a multiservice center which can provide comprehensive medical care and assistance in job placement, housing, and welfare. The center does not provide many of these services at present but acts as a referral unit for existing community agencies. Address by Edward Blacker, Dir., Div. of Alcoholism, Mass. Dep't of Public Health, *Aftercare Residential Program Planning: Boston's Program for the Chronic Drunkenness Offender*, No. Am. Ass'n of Alcoholism Programs 17th Annual meeting, Albuquerque, N.M., Oct. 10, 1966.

[44] The PRES.'S COMM'N ON CRIME IN THE DISTRICT OF COLUMBIA, REP. 497 (1966), recommended "using public health personnel to take incapacitated inebriates into protective custody." An authority on alcoholism, Dr. Earl Rubington of the Rutgers University School of Alcohol Studies, has proposed what he calls a "rescue service," a type of storefront detoxication unit in skid row operated in part by a staff of skid row residents who would bring in inebriates who agree to such assistance. See Rubington's proposal submitted to Office of Law Enforcement Assistance, U.S. Dep't of Justice, Alcoholic Control on Skid Row, Oct. 14, 1965.

the immediate and long-range needs of the skid row inebriate.

The Boston program, which has received funds from the Office of Economic Opportunity, provides an alternative to the police-correctional handling of the homeless alcoholic. Staff personnel of the Boston South End Center have approached homeless inebriates in skid row and offered them assistance. An official of the program estimates that 80 percent of the people approached in this way responded willingly. The center screens and evaluates the cases and refers homeless alcoholics to appropriate community facilities. In the past year it has handled the cases of over 900 homeless alcoholics.

The importance of developing an alternative to treating drunkenness within the criminal system is underlined by court decisions in two Federal circuits holding that alcoholics cannot be convicted for drunkenness, *Easter* v. *District of Columbia* [45] and *Driver* v. *Hinnant*.[46] Pursuant to the *Easter* decision, alcoholics are no longer being convicted of public drunkenness in Washington, D.C.

DETOXIFICATION CENTERS

An alternate approach to present methods of handling drunkenness offenders after arrest and a prerequisite to taking drunkenness out of the criminal system is the establishment of civil detoxification centers. The detoxification center would replace the police station as an initial detention unit for inebriates. Under the authority of civil legislation, the inebriate would be brought to this public health facility by the police and detained there until sober.[47] Thereafter, the decision to continue treatment should be left to the individual. Experience in New York and Boston indicates that some alcoholics may be willing to accept treatment beyond the initial "sobering up" period.[48] The center should include such medical services as physical examinations, an emergency-care unit for the treatment of acutely intoxicated persons, and transportation to a hospital, if advanced medical care seems necessary.

The Commission recommends:

Communities should establish detoxification units as part of comprehensive treatment programs.

The Department of Justice has recently provided funds to establish detoxification centers as demonstration projects in St. Louis [49] and Washington, D.C.[50] The St. Louis center is already in full operation; plans for the Washington center are underway. Both units have sufficient facilities to house for a period of a few days those who are in need of "drying out." They also have "in-patient programs," in which patients are given high protein meals with vitamin and mineral supplements and appropriate medication to alleviate alcohol withdrawal symptoms. Bath and laundry facilities are available, as are basic clothing and limited recreational facilities. Regularly scheduled Alcoholics Anonymous meetings, film showings, work projects, group therapy, and lectures are part of the program. During their stay patients are counseled by social workers and other staff members.

The police might also bring to such a center intoxicated persons charged with a variety of petty offenses apart from drunkenness, with violations of administrative codes, and with such felony offenses as driving while intoxicated, assault, and larceny. If the police planned to prosecute the case, a summons could be left with the offender to appear in court at a later date. If an intoxicated defendant was charged with committing a felony, the police could make an individual determination as to the most appropriate detention facility. If he seemed likely to appear in court he might be taken to the detoxification facility. Otherwise, he would presumably be taken to the local jail, unless there were adequate detention facilities on the premises of the detoxification center.

AFTERCARE PROGRAMS

There is little reason to believe that the chronic offender will change a life pattern of drinking after a few days of sobriety and care at a public health unit. The detoxification unit should therefore be supplemented by a network of coordinated "aftercare" facilities. Such a program might well begin with the mobilization of existing community resources. Alcoholics Anonymous programs, locally based missions, hospitals, mental health agencies, outpatient centers, employment counseling, and other social service programs should be coordinated and used by the staff of the detoxification center for referral purposes. It is well recognized among authorities that homeless alcoholics cannot be treated without supportive residential housing, which can be used as a base from which to reintegrate them into society.[51] Therefore, the network of aftercare facilities should be expanded to include halfway houses, community shelters, and other forms of public housing.

The Commission recommends:

Communities should coordinate and extend aftercare resources, including supportive residential housing.

The success of aftercare facilities will depend upon the ability of the detoxification unit to diagnose problems ade-

[45] 361 F.2d 50 (D.C. Cir. 1966). In the Easter case the District of Columbia Court of Appeals ruled that alcoholism is no defense to a charge of drunkenness, 209 A.2d 625 (D.C. Ct. App. 1965), and the U.S. Court of Appeals, sitting en banc, then unanimously reversed and held that it is a valid defense. The District of Columbia did not seek certiorari in the Supreme Court. See Hutt, Testing the Legality of Public Intoxication Laws as They Relate to Alcoholism, 16 Inventory 2 (N.C. Alcoholic Rehabilitation Program, July–Sept. 1966); address by Mrs. Theresa Abbott, Exec. Dir., Washington, D.C., Area Council on Alcoholism, *Citizen Attitudes and Public Responsibility*, NAJA annual meeting, Colorado Springs, Colo., Nov. 1, 1966.

[46] 356 F.2d 761 (4th Cir. 1966). For comment on the Easter and Driver decisions, see 46 B.U.L. REV. 409 (1966); 15 CATHOLIC U.L. REV. 259 (1966); 1966 DUKE L.J. 545; 54 GEO. L.J. 1422 (1966); 4 HOUSTON L. REV. 276 (1966); 55 KY. L.J. 201 (1966); 44 N.C.L. REV. 818 (1966); 18 S.C.L.Q. 504 (1966); 3 TULSA L.J. 175 (1966); 11 VILL. L. REV. 861 (1966); 23 WASH. & LEE L. REV. 402 (1966); 7 WM. & MARY L. REV. 394 (1966). For a discussion of the application of Easter and Driver to crimes other than intoxication, see Hutt & Merrill, *Is the Alcoholic Immune From Criminal Prosecution?* 6 MUN. CT. REV. 5 (1966), reprinted in 25 LEGAL AID BRIEFCASE 70 (1966).

[47] Commission observers reported that in some instances the handling of inebriates by police was improper. Such observations included rough handling and other physical abuse. The facilities of the criminal system are not designed for patients suffering from illness. Booking, for example, takes place at a desk or a counter. Intoxicated persons were observed in some instances being compelled, sometimes by force, to stand against a counter upon being booked. The public health unit would more appropriately provide the facilities needed to handle and detoxify drunks. To the extent that the police are called upon to bring inebriates to a detoxification facility, the reported observations indicate that additional police training is required.

[48] See PRES.'S COMM'N ON CRIME IN THE DISTRICT OF COLUMBIA, REP. 499 (1966): "Experts say that the vast majority of chronic alcoholics . . . would join in an effective, comprehensive treatment program."

[49] See St. Louis Proposal for Funds To Establish a Detoxification Center, submitted to the Office of Law Enforcement Assistance, U.S. Dep't of Justice, printed in part as appendix C to this volume.

[50] See proposal submitted to the Office of Law Enforcement Assistance for funds to establish a detoxification center in Washington, D.C.

[51] PRES.'S COMM'N ON CRIME IN THE DISTRICT OF COLUMBIA, REP. 494 (1966); Wexberg, *The Outpatient Treatment of Alcoholism in the District of Columbia*, 14 Q.J. STUDIES ON ALCOHOL 514, 524 (1953). Authorities urge that such centers be located within the confines of metropolitan living and not in a rural setting away from the life to which the patient will ultimately return. See Pittman, *supra* note 41.

quately and to make appropriate referrals. A diagnostic unit attached to, or used by, the detoxification unit could formulate treatment plans by conducting a thorough medical and social evaluation of every patient. Diagnostic work should include assistance to the patient and his family in obtaining counseling for economic, marital, or employment problems. Subsequent referrals to appropriate agencies will be crucial to the success of the overall treatment plan. The diagnostic unit, through referral to a job and housing service, might also assist the patient in moving out of the deteriorating environment of skid row. Philadelphia has already established a diagnostic and relocation center, which offers diagnostic, recreational, therapeutic, vocational counseling, and housing relocation services, including training in social and occupational skills.[52]

RESEARCH

With over 5 million alcoholics in the country, alcoholism is the Nation's fourth largest health problem. Research aimed at developing new methods and facilities for treating alcoholics should be given the priority called for by the scope of the need.

The Commission recommends:

Research by private and governmental agencies into alcoholism, the problems of alcoholics, and methods of treatment, should be expanded.

The application of funds for research purposes appears to be an appropriate supplement to the proposed detoxification and treatment units.[53] Consideration should be given to providing further legislation on the Federal level for the promotion of the necessary coordinated treatment programs.[54] Only through such a joint commitment will the burdens of the present system, which fall on both the criminal system and the drunkenness offender, be alleviated.

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[52] For a description of the origin and development of the Philadelphia program, see Blumberg, Shipley, Shandler & Niebuhr, *The Development, Major Goals and Strategies of a Skid Row Program: Philadelphia*, 27 Q.J. STUDIES ON ALCOHOL 242 (1966). As depicted in the article, the Diagnostic and Relocation Center offers vocational planning, job placement, medical and psychiatric diagnostic service, and housing relocation counseling.

[53] In response to the President's Message on Domestic Health and Education urging an extended Federal effort in this field, the Department of Health, Education, and Welfare established a National Center for Prevention and Control of Alcoholism under the auspices of NIMH, HEW news release, Oct. 20, 1966; N.Y. Times, Oct. 21, 1966, p. 43, col. 1. The Alcoholism and Drug Addiction Research Foundation of Toronto, Can., conducts research programs in Canada for the treatment of alcoholism. The foundation is empowered to operate rehabilitation clinics and provide grants for demonstration and other treatment programs. A detoxification center as part of a comprehensive treatment program is being administered by the foundation in Toronto. See 1965 ALCOHOLISM & DRUG ADDICTION RESEARCH FOUNDATION ANN. REP. The foundation has undertaken comprehensive studies on the handling of the drunkenness offender which should be available for distribution in the near future. The skid row and related alcohol problems with which the foundation deals are remarkably similar to the problems confronting communities in the United States.

[54] It is appropriate in the context of a discussion on the allocation of funds to examine the present costs of operating this inefficient system.

A few cost studies have been made which indicate the tremendous expenditures made for the present method of handling drunkenness offenders. The city of Atlanta spends an estimated $427,000 each year on processing drunkenness offenders within the criminal system, Emory Dep't of Psychiatry 33–38; the above calculation includes the amount of fines collected and value of work performed by prisoners. The incarceration of 16,000 defendants in Washington, D.C., during 1956 cost in excess of $1 million, D.C. COMM. ON PRISONS, PROBATION, AND PAROLE, REP. 83 (1957); in 1964 the incarceration costs for approximately 18,000 persons were estimated at nearly $2 million, PRES.'S COMM'N ON CRIME IN THE DISTRICT OF COLUMBIA, REP. 478 n.57 (1966). Incarceration costs for 1,430 vagrants and 1,645 drunkeness offenders during 1950 in Philadelphia were over $400,000. Foote, *Vagrancy-Type Law and Its Administration*, 104 U. PA. L. REV. 603, 648 n.166 (1956). For an estimate that the arrest and short-term detention of each drunkenness offender costs the city of San Diego, Cal., $100, see Ditman & Crawford, *The Use of Court Probation in the Management of the Alcohol Addict*, 122 AM. J. PSYCH. 757 (1966).

PUBLIC INTOXICATION AND THE ALCOHOLIC OFFENDER IN AMERICAN SOCIETY

by David J. Pittman

Contents

THE PROBLEM

Public intoxication is viewed as a crime in almost every jurisdiction in this country. Laws exist on State and municipal levels prohibiting public displays of drunkenness. And although disorderliness is a prerequisite for arrest under some such laws, the homeless, skid-row inebriate faces repeated arrest for disorderly and nondisorderly drunkenness.

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He is the author, with C. W. Gordon, of the book, "Revolving Door: A Study of the Chronic Police Case Inebriate," and he served as editor of Alcoholism: An Interdisciplinary Approach. He is also coeditor, with Charles R. Snyder, of the book, "Society, Culture, and Drinking Patterns." Furthermore, he is author of over 60 articles and reports in the area of criminology, alcoholism, juvenile delinquency, and other social problems.

He is chairman of the International Congress on Alcohol and Alcoholism, which is to be held in Washington, D.C., in September 1968. He is president of the North American Association of Alcoholism Programs. Currently he is the principal investigator for the U.S. Mental Health Project, Alcoholism Treatment and Referral Demonstration Project, at Washington University. He is consultant on alcohol problems to the city of St. Louis, the State of Missouri, and the State of Illinois.

Those who are most often arrested are likely to have the most serious drinking problem. Many are confirmed alcoholics. Yet treatment for alcoholism is clearly not part of the correctional regimen. The process of arresting inebriates, detaining them for a few hours or a few days and then re-arresting them has been called a revolving door. Some have been arrested 100 to 200 times and have served 10 to 20 years in jail on short-term sentences. The recidivism rates clearly indicate the futility of the present system in dealing with the underlying sociomedical problems involved. Further, the impact of such arrests—reportedly in excess of 2 million each year—is particularly great on the institutions of the criminal justice system. The police, the courts, and the correctional institutions allocate needed manpower and facilities to handle what most people recognize as a public health problem.

A related problem to the criminal justice system is the person who consumes large quantities of alcoholic beverages and commits crimes, from petty offenses to crimes of violence. The existence of mass drunkenness arrests, crimes of violence stemming from intoxication, and other social problems, including highway fatalities and marital difficulties, lead to one conclusion: A greater effort must be made to solve the alcoholic problem and truly rehabilitate the many who now violate existing laws.

DEVIANCY REINFORCEMENT CYCLE: THE REVOLVING DOOR

Chronic drunkenness offenders are generally excessive drinkers who may or may not be alcoholics, but whose

drinking has involved them in difficulties with the police, the courts, and penal institutions. They are a group for whom the penal sanctions of society have failed and to whom existing community resources have not been applied. Although some of these men (very seldom women) are confirmed alcoholics, others are miscreants whose present use of alcohol is preliminary to alcoholism, and others are nonaddicted excessive drinkers who will never become alcoholics.

As yet no studies exist which clearly differentiate an alcoholic from a nonalcoholic in the chronic drunkenness offender group. The most widely accepted definition of alcoholism is one developed by the World Health Organization which states:

> Alcoholics are those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily and mental health, their inter-personal relations, and their smooth social and economic functioning; or who show the prodromal signs of such development.[1]

From this definition it is obvious that a history of arrests for public intoxication is indicative of a drinking problem. Repeated arrests for public intoxication are certainly a symptom of the disease of alcoholism. However, as a result the paucity of scientific research and lack of funds at the Federal, State, and local governmental levels for research and treatment studies on alcoholism, there are few clear cut answers about this disease.

Two Federal appellate courts have recently held that a person cannot be convicted for behavior which is a manifestation of a disease. It has been urged upon the courts that such individuals lack *mens rea* or criminal intent, and that "* * * any disease which deprives the individual of capacity to control his conduct will excuse conduct which would otherwise be condemned." [2] It should be recognized that the two recent decisions, which shall be discussed subsequently in this paper, deal only with the chronic alcoholic and one manifestation of his disease—public intoxication. They are aimed at helping only the chronic alcoholic, and not helping all drunkenness offenders. In short, the *mens rea* approach deals with one aspect of the chronic drunkenness offender problem. But society should be equally concerned with the individual who goes on a binge from time to time, and the drunkard whose intoxication appears to result from indolence, both of whom, through repeated arrests and incarcerations, are caught up in a deviancy reinforcement cycle or, in effect, a revolving door; this revolving door may actually contribute to an excessive drinker's becoming an alcoholic and also encourage the public inebriate to act out secondary deviances.

On the whole, Americans have a relatively tolerant orientation toward nonexcessive drinking of alcoholic beverages. On many occasions, however, it is socially permissible to drink to excess. These occasions are usually private or semiprivate, and range from fraternity "beer blasts" and debutante "coming-out parties" to office parties and conventions. However, when a person's drinking starts to interfere with his work or family life, certain negative sanctions are invoked by his friends. His wife may be ashamed to invite guests home, and, correspondingly, friends may be embarrassed to visit.

The alcoholic, as Jellinek has pointed out, "begins to drink in private * * * to conceal his drinking problem." Jellinek's description, however, applies to the middle class alcoholic. And the middle class alcoholic, as well as an excessive drinker in this class, is unlikely to come in contact with law-enforcement agencies since his behavior is concealed. The public is more likely to view him as an unfortunate, as someone who has a disease and as someone who should seek medical help, although these attitudes are intertwined with moralistic sentiments. Although the public labels these deviant middle class drinkers negatively, they do not invoke the same harsh sanctions against them as with lower class alcoholics.

On the other hand, the same public often considers lower class alcoholics and excessive drinkers as worthless derelicts and vagrants. It is highly undesirable to have men sleeping in alleys and doorways. But the present solution—using the criminal system—fails to correct the problem and is unjust. And the public's negative stereotype of the public intoxication offender is largely a result of this archaic and punitive policy.

MAGNITUDE OF PROBLEM

The more intense the enforcement of laws, the greater the effect they have on the deviancy. For the public intoxication offender, the enforcement is indeed intense. In 1964 the FBI reported 1,458,821 arrests for public drunkenness by 3,977 agencies covering a population of 132,439,000.[3] This figure accounted for over 31 percent of the total arrests for all offenses and is almost twice the number of arrests for index crime offenses. If alcohol related offenses (driving under the influence of alcohol, disorderly conduct, and vagrancy) were added to this percentage, it would constitute from 40 to 49 percent of all reported arrests in 1964.[4]

A large number of these actions involve the repeated arrest of the same men. To illustrate, let us take the case of Portland, Oreg., for 1963; in this year there were 11,000 law violations involving drunkenness or the effects of drinking, but only around 2,000 different persons accounted for these arrests.[5]

The number of police actions involving public intoxication or such legal euphemisms as disorderly conduct, vagrancy or trespassing, is phenomenal in certain cities. Washington, D.C. in 1965 reported almost 50,000 arrests for public intoxication but St. Louis, Mo., comparable in size but with different police policies and practices, reported only 2,445 arrests for drunkenness. Los Angeles reported 100,000 arrests for drunkenness in 1965, and New York City using disorderly conduct statutes arrested 50,000.[6]

The approximately 2 million arrests annually in the United States for public intoxication do not completely represent police involvement with this problem. Police

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[1] "Expert Committee on Mental Health, Alcoholism Subcommittee, Second Report," World Health Organization, technical report series, No. 48, August 1952.
[2] *DeWitt Easter* v. *District of Columbia*, appeal from Court of General Sessions Criminal Division: reply brief for appellant, Peter B. Hutt and Michael S. Horne, Covington & Burling, 701 Union Trust Bldg., Washington, D.C., Feb. 6, 1965, p. 4.
[3] FBI "Uniform Crime Reports" (1964).
[4] FBI "Uniform Crime Reports" (1964).
[5] Personal communication: Mr. R. R. Wippel, Portland, Oreg.
[6] FBI "Uniform Crime Reports" (1964).

officers in many communities use informal means of handling drunken individuals—in suburban communities they may escort the inebriated individual home, or telephone a taxicab to perform the same function, and in still others they may warn the individual about his behavior and ask his friends to escort him home. In other communities, drunks arrested may be held until sober and released without charge. In Detroit these types are referred to as "golden rule drunks." In 1956, Detroit released 5,865 "golden rule drunks" and prosecuted 8,665.[7]

Persons arrested and held for prosecution for public drunkenness are almost never represented by counsel and almost always found guilty. In 1964, 1,751 cities representing a population of 58,915,000 reported to the FBI that 89.4 percent of all persons charged with public drunkenness were found guilty. The next highest percentage was 80.4 percent, and this was for the alcohol-related offense of vagrancy.[8] This suggests that the chronic drunkenness offender frequently finds himself incarcerated. Indeed, there is strong evidence that chronic inebriates constitute one of the largest groupings of individuals incarcerated in short-term correctional institutions. Alcohol-related offenses accounted for 35 percent of the incarcerations to the St. Louis city workhouse for the period, 1957–59. Benz recently completed a study, "Man on the Periphery," [9] of the penal population in the Monroe County (Rochester, N.Y.) jail which showed that alcohol offenders accounted for 62.5 percent of the prisoners and 73.1 percent of the total commitments in the year 1962.

Recidivism is extremely high among chronic drunkenness offenders. The situation in Baltimore is fairly typical of the country as a whole. Bass and Goldstein examined the number and disposition of drunkenness offenders for the 18-month period, January 1, 1964 to June 30, 1965, in Baltimore City. There were 11,340 convictions for drunkenness in Baltimore City municipal courts which involved 7,176 different defendants resulting in 8,015 jail sentences. Specifically, 966 defendants were convicted two times within 12 months; another 369 were convicted three times; 175 were convicted four times; and 263 were convicted five or more times within a 12-month period. "A total of 148,997 prisoner-days were spent by drunkenness offenders in the Baltimore City jail during the 18-month period studied." [10]

If a conservative cost estimate of $5 a day is used, these offenders cost the City of Baltimore around $750,000 for custodial care. No treatment for the disease of alcoholism is provided in the jail and the vicious revolving door cycle is continued. In 1958, the city of Los Angeles estimated the cost of handling drunkenness offenders at $4 million annually.

Given 2 million arrests for public drunkenness, the cost for handling each case involving police, court, and correctional time can be estimated at $50 per arrest. Admittedly, some cases are disposed of without court or correctional action but maintaining a person in a county or city jail is extremely expensive. A minimal annual expenditure of $100 million for the handling of chronic drunkenness offenders is a conservative national estimate. And this heavy cost provides no expenditure of funds for treatment or prevention. It is a high cost for maintaining a system which is an abysmal failure in rehabilitating alcoholics.

It is hypothesized here that "social policies directed against a particular deviancy affect some differently than others, resulting in a corresponding effect on the larger public." The very nature of the administration of public intoxication laws excludes most middle and upper class alcoholics and excessive drinkers who typically drink in private or semiprivate surroundings. Public drunkenness laws discriminate against the lower class. There is also evidence which tentatively suggests that, within the lower class, some persons feel the brunt of the law more than others. Both Pittman and Gordon and later Benz found that in one northern community Negroes were disproportionately arrested and incarcerated. In 1958, Pittman and Gordon found in their sample of chronic police case inebriates a high proportion of Negroes (18 percent) in comparison to their representation in the general population of the county in which the jail was located (2 percent).[11] In 1962, Benz found that the jail population (both for alcohol and nonalcohol related offenses) still reflected the differential negative treatment accorded Negroes. The ratio of nonwhite prisoners to nonwhite population in Monroe County, N.Y., for 1962 was 1:16 while the comparable white ratio was 1:273.[12] The jailed intoxication offender represents social problems which encompass both social and class relations in the United States.

CULTURAL FACTORS

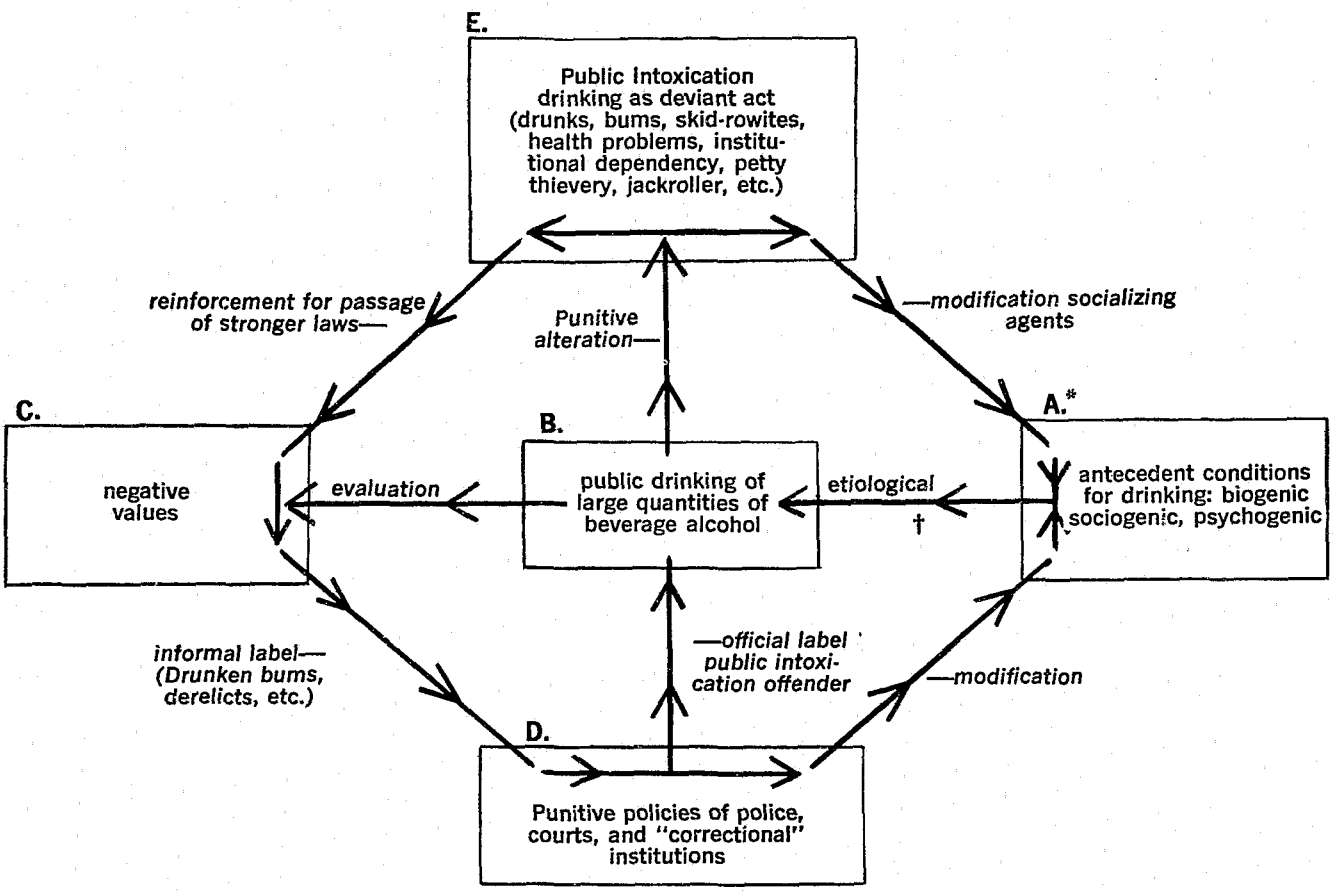
Looking at chart 1, the "Deviancy Reinforcement Cycle for Public Intoxication," we can see the ramifications of the last statement. Excessive drinking and alcoholism are considered in a moralistic and negative manner by the larger population. When the deviant behavior of excessive drinking is acted out in public "B", the larger community's sanctions become greater, especially since these individuals are much more likely to be found in the lower socio-economic class.

Indeed, there seems to be a commonly accepted notion among therapists dealing with problem drinkers and alcoholics that there are two large sub-types. First, there is the person who has a disease and must be helped (middle and upper class alcoholics and problem drinkers). Secondly, there is the drunk or skid-rowite, who is hopeless and whom few professionals care to treat. Duff Gillespie evaluated 22 followup studies of treated alcoholics. It was found that the typical population in these public treatment facilities excluded lower-lower class whites and, especially, Negroes. The public drunkenness offender often does not expect to find tolerance even among professionals who are reputed to be among the more tolerant groups.

The lower class public drunkenness offenders are drawn from those who have difficulty in interpersonal relationships, are poorly educated, are frequently from an ethnic or racial minority and are typically dependent on insti-

[7] Arthur and Norma Due Woodstone, "Death of a Skid," New York Sunday Herald Tribune Magazine, Apr. 3, 1966, p. 17.
[8] Wayne R. La Fave, "Arrest: The Decision to Take a Suspect into Custody," Boston: Little, Brown & Company, pp. 440–441.
[9] Elizabeth Benz, "Man on the Periphery," Rochester, N.Y.: Rochester Bureau of Municipal Research Inc., 1964, p. 49.
[10] Michael Bass and Gary Goldstein, "Survey of Habitual Drunkenness Offenders in Maryland," Baltimore: Department of Mental Hygiene, State of Maryland, mimeographed.
[11] David J. Pittman and C. W. Gordon, "Revolving Door: A Study of the Chronic Police Case Inebriate," Glencoe, Ill.: The Free Press; and New Brunswick, N.J.: Rutgers Center of Alcohol Studies, 1958.
[12] Benz, *op. cit.*

Chart 1.—MODEL OF THE DEVIANCY REINFORCEMENT CYCLE FOR PUBLIC INTOXICATION



* Letters indicate theoretical sequency of events.

† Arrows indicate theoretical direction of influence.

tutionalized living arrangements (such as those found in the Armed Forces, the Merchant Marine, and the Salvation Army and kindred shelters). In short, they are at a disadvantage in competing with other persons for a productive role in our society.

After repeated arrests and incarcerations, the negative effects of the above sociological variables are reinforced ("D" and "E" on chart 1). The constantly incarcerated individual finds it nearly impossible to maintain a meaningful marital and familial relationship; his ability to find employment is seriously jeopardized by his arrest record coupled with his poor education. By constantly being officially labeled by the police, the courts and correctional institutions as a public drunk, he begins to see himself as a public drunk; the jail becomes little more than a shelter to regain his physical strength. Because the public intoxication offender is usually unable to support himself, he frequently turns to petty thievery. This is especially true if he is an alcoholic. The alcoholic will go to great lengths to maintain his supply of alcohol, and frequently he spends most of his nondrinking hours finding ways to obtain money for alcohol. As a result, the alcoholic public intoxication offender frequently presents a health problem, not only from diseases associated with an excessive intake of alcohol, but also from his indifference to caring for himself physically.

Social policy has its greatest negative effect on excessive drinkers who are not alcoholics. An excessive drinker who confines his drinking to weekend bouts (a pattern not uncommon in the middle classes), but who does not drink secretively, may find himself frequently arrested and perhaps incarcerated. If this happens often enough, he may be conditioned by the enforcement, the judicial, and the correctional processes in such a way as to contribute to his drinking problem. Where before he confined his drinking to weekends and managed to hold a job and be a breadwinner, he now finds these roles increasingly difficult and harder to maintain, and crises arrive which encourage his drinking. Instead of arresting his excessive drinking, the social policies have modified (relationships between "E"—"A", and "D"—"A", chart 1) his deviant behavior and contributed to the development of a more serious deviancy—alcoholism. Thus, the public intoxication offender confronts the society with a serious social

problem which involves the total community as well as the criminal justice system.

PSYCHOLOGICAL CHARACTERISTICS OF THE CHRONIC DRUNKENNESS OFFENDERS

The hard core of alcoholic offenders today is found in the 10 to 15 percent of the alcoholic population residing on skid rows. The term, skid row, appears to have originated in Seattle at the turn of the century. Yessler Street, which sloped to Puget Sound, was greased, and logs were skidded down into the water. Along this "skid road" were many taverns, amusement places, and hotels frequented by the men who came to Seattle during the log-shipping season. Yessler Street has formed the prototype of skid rows which include New York's famed Bowery, Chicago's West Madison Street, St. Louis' Chestnut and Market Streets, and similar areas in Copenhagen, Helsinki, Amsterdam and Paris.

Skid row is usually located near the city's central business district in what the urban sociologist calls the "zone of transition." It is an area characterized by severe physical deterioration—most of the commercial establishments and dwellings are substandard. Hotels and "flophouses," inexpensive restaurants, pawn shops and clothing stores, religious missions, men's service centers and bars are the usual establishments in the area.

PERMANENT RESIDENTS

The stereotype of the homeless man in the 1920's was the "hobo." During the depression of the 1930's homelessness and wandering were far from uncommon and indeed were the normal condition for a sizeable portion of the poor.

Since then the skid row population has declined in number and is no longer the mobile group it used to be when the hobo was a familiar sight on the American landscape. A large proportion of the men are now permanent residents living impoverished, homeless lives in numerous missions, cheap hotels, and flophouses, and working when they can as casual laborers.

Though Donald J. Bogue, in his study of Chicago's Skid Row found that the majority of the men could not be defined as alcoholics, the incidence of "problem drinkers" is high in skid row.

Skid-row alcoholics compose the largest portion of the 2 million public drunkenness arrests made annually in the United States. A large number of these are the repeated arrests of the same men. These chronic drunks are arrested, convicted, sentenced, jailed, and released—only to be rearrested, often within hours or days. They are the men from skid row for whom the door of the jail is truly a "revolving door."

THE CHRONIC DRUNKENNESS OFFENDER

The most systematic study of chronic drunkenness offenders completed in the United States is reported in Pittman and Gordon's "Revolving Door," [13] published in 1958. The findings were based upon an analysis of 187 case studies of a random sampling of all men who had been sentenced at least twice to a penal institution in New York State on a charge of public intoxication and who were incarcerated in the county jail when the investigation was conducted. The research was concerned with a group of excessive drinkers who may or may not have been alcoholics, but whose drinking had involved them in difficulties with the police, the courts, and penal institutions. They were a group for whom the penal sanctions of the society had failed along with existent community resources for rehabilitation.

The extensive case histories of the chronic intoxication offenders may be analyzed in terms of three major sets of factors which are crucial for the development of career patterns in public intoxication. These are: (1) sociocultural determinants; (2) socialization determinants; and (3) alcohol as the adaptive or adjustive mechanism in the life career.

SOCIOCULTURAL DETERMINANTS

The chronic police case inebriate category consists of individuals with definable sociocultural traits as age, nationality background, race, marital status, religion, educational attainment, occupational skills, and previous criminal record.

Age is one of the crucial attributes that differentiates these men from all other offender groups. Their age curve is skewed toward middleage brackets, whereas commitments for such offenses as automobile theft, robbery, and burglary chiefly involve individuals under age 25. Their mean age of 47.7 years is higher than those of the general male population, of arrested inebriates, and of patients seen in the alcoholism clinics. The sample was one of the oldest problem drinking groups to be studied, in that 45 percent were over 50 years of age.

This sample was marked by a high proportion of Negroes (18 percent) in comparison to their representation in the general population of the county in which the jail is located (2 percent). Negro and white offenders were marked by age differentials: Two-thirds of the Negroes were under 45 years of age, compared to 30 percent of the whites. The Negroes were primarily from a rural or small-town, Southern, lower-class background and were having severe difficulties adjusting to the Northern urban pattern.

The most frequently represented nationality groupings were English and Irish. Irish ethnics composed 35 percent of the sample, but there was an increasing number of Irish with advancing age, especially after 45. Italians, although represented in significant number in the county's general population, composed only 2 percent of the sample.

In the related area of religious affiliation, the sample consisted of 42 percent Protestants, 40 percent Catholics, and 18 percent who professed no affiliation. There were no Jews. Religion, except in the case of groups such as the Jews who exhibit a specific culture pattern, appeared

[13] David J. Pittman and C. W. Gordon, "Revolving Door:" A study of the chronic police case inebriate, Glencoe, Ill.: The Free Press; and New Brunswick, N.J.: Rutgers Center of Alcohol Studies, 1958.

less important as an identifying sociocultural determinant of inebriation than nationality or ethnic status.

The marital status of these men was one of their most important attributes. Forty-one percent never married, 32 percent were separated, 19 percent were divorced, 6 percent widowed and 2 percent were living with their spouses before the current incarceration. Thus for these offenders, 96 percent of those who had married reported broken marriages, whereas the expectancy is only 11 percent, using the general male population of the county, corrected for age disparities.

The relationship which exists between marriage stability and problem drinking is a complex one. Many persons do not possess the competences in interpersonal relationships or in personality traits that are associated with entrance into marriage; or, once involved in marriage, these individuals do not possess requisite skills for continuing the marriage. Excessive drinking, which eventually causes severe disruptions in the individual's life, is destructive of the marriage relationship itself.

On the whole, the offenders were an educationally disadvantaged group. Seventy percent of the sample did not go beyond the eighth grade of school as compared to 40 percent of the county's general population. This educational impoverishment was reflected in their low order of primary occupational skills. Sixty-eight percent were unskilled workers, mainly laborers, 22 percent skilled workers, and 3 percent professional and allied workers, compared to 13, 46, and 22 percent, in the respective categories, in the general population.

Experience with the legal process in terms of arrests and incarcerations was another determinant of the career pattern in public intoxication. As a group, the inebriates exhibited a wide variety of criminal histories. The mean number of arrests for all causes was 16.5; the median was 10.2. For public intoxication only, the mean number of arrests was 12.8 and the median was 6.0. The "average" chronic drunkenness offender had experienced some 10 arrests on all charges, and the offender with 30, 40, or more arrests was atypical, though composing a sizeable portion of the total.

The sample can be divided into three subgroups by previous criminal record: (a) 31 percent who had been arrested only for public intoxication; (b) 32 percent who had been arrested, in addition, on charges probably related to the excessive use of alcohol; and (c) 37 percent who had been involved in serious violations such as homicide, rape, robbery, or burglary. Men in the latter group showed a tendency to abandon the criminal career after the age of 33 or 40 with an intensified pattern of public intoxication thereafter.

Institutionalized living was a typical pattern of selective adaptation among the chronic police case inebriates. Tendencies toward dependency inherent in the experience of childhood, youth, and early adulthood were reinforced and supported through a selective adaptation to life in the semiprotective environments of the Civilian Conservation Corps, the Army, the railroad gang, the lake steamer, the jail, lumber and fruit camps, hospitals, Salvation Army and kindred shelters. The minimum requirements for living were met through institutional organizations which relieve the incumbents of individual responsibility to cope with food, housing, and related needs. They became habituated to dependent living which further limited their capacity to reestablish independent modes of life.

In summary, lower class individuals of Irish ethnic status and Negroes in the age bracket 40–49 with previous extensive arrest histories were most vulnerable to repeated arrests for drunkenness.

SOCIALIZATION DETERMINANTS

Within this framework of sociocultural determinants are a series of socialization experiences which are conducive to the development of a career pattern in inebriation. The structural continuity of the family units was broken by death, divorce, or separation before the inebriate's 15th birthday in 39 percent of the cases. This seems to be an extremely high percentage of families whose structure collapsed.

On a more qualitative level, mother-son and father-son relationships evidenced a trend in the direction of serious deprivations for the inebriates in meeting their basic emotional, social, and psychological needs. Thus, the sense of belonging, achieved by membership and acceptance in a social unit larger than the individual himself, such as the family primary group, was only partially attained by most of the inebriates.

An objective index to evaluate adolescent socialization experience and the significance of these situations for positive identity formation was constructed by the following criteria: (a) Participation in a clique or close friendship groups of boys; (b) heterosexual participation as reflected in an established dating pattern; (c) existence of goals and aspirations, whether middle class nature or not; (d) family integration as reflected in the individual's sense of belonging to the family unit; and (e) positive school adaptation as reflected in attendance and performance. If all these factors were found in a case, the socialization experience was scored as good or above average; the presence of four was scored adequate or average; and the presence of three or fewer was rated as poor or below what would be desired for adequate socialization. The results of these classifications indicated that the symptoms which warn of difficulties in assuming adult social roles are already present in these men at the end of the adolescent development era. By the index of the adolescent adjustment, 86 percent of our sample rated poor, only 10 percent could be rated adequate or average, and in 4 percent the index could not be applied because of incomplete data. In only one case were all five factors present.

Thus, the chronic police case inebriates were undersocialized, as determined by other quantitative and qualitative indexes for their original families and the adolescent sphere of development. This deficit was reflected in the adult inebriate career in his inability to perform two of the most demanding secondary task roles, i.e., occupational and marital roles.

ALCOHOL AS THE ADJUSTIVE MECHANISM IN THE LIFE CAREER

The career of the chronic drunkenness offender was one in which drinking serves the socially handicapped individuals as a means of adapting to life conditions which are otherwise harsh, insecure, unrewarding, and unproductive of the essentials of human dignity. This type of career was, however, only one of the possible patterns of adjustment, given the combination of conditions in the early life of these men. Repeated incarceration for drunkenness was the terminal phase of a complex process in which the interplay of sociocultural and personality factors have combined to produce this long-run adaptation.

Using the age at which a man was committed the second time for public intoxication or a drinking-involved offense as a breakpoint, the study group fell into two types which we shall designate the "Early Skid" and the "Late Skid" careers.

The "Early Skid" career pattern involved approximately 50 percent of the offenders. In this group two-fifths of the men experienced their second incarceration in their twenties and the rest in their early thirties. Only a few had their second imprisonment in the age period 36–39.

The "Early Skid" career pattern was thus one in which the individual established his record of public intoxication in his twenties or early thirties. It represented serious social and/or psychiatric maladjustment to early adulthood which extended into middle adulthood. There was an absence of adult occupational adjustment independent of institutional living. The period of alcohol dependency formation was not associated with such stable marital adjustment as may be found in some of the "Late Skid" career pattern.

The "Late Skid" career pattern was defined by the postponement of the minimum record of two incarcerations for public intoxication until the forties or even fifties. The career type encompassed 50 percent of the men in the group if the age 37 (for experiencing the second arrest) is used as the dividing point.

The period of alcohol dependency development was often marked by extended periods of occupational and family stability. Since this period was accompanied by drinking, it must be regarded as part of the conditioning period of alcohol dependency. More apparent in the "Late Skid" career was the physical decline of the man who experienced great difficulty in maintaining his economic needs through marginal types of employment. Younger men replaced him on the casual day-labor jobs. His drinking increased and finally his tolerance for alcohol declined.

In summary, the "Early Skid" career pattern was one in which drinking served as the primary means of adjustment to original social and/or psychiatric disability; whereas the "Late Skid" career pattern was secondary to failure in secondary role performance.

This study has shown the chronic drunkenness offender to be the product of a limited social environment and a man who has never attained more than a minimum of integration in society. He is and has always been at the bottom of the social and economic ladder; he is isolated, uprooted, unattached, disorganized, demoralized and homeless, and it is in this context that he drinks to excess. As such, admittedly through his own behavior, he is the least respected member of the community, and his treatment by the community has at best been negative and expedient. He has never attained, or has lost, the necessary respect and sense of human dignity on which any successful program of treatment and rehabilitation must be based. He is captive in a sequency of lack or loss of self-esteem producing behavior which causes him to be further disesteemed. Unless this cycle is partially reversed positive results in treatment will be difficult to attain.

ALCOHOLISM AND CRIME

INTRODUCTION

There are certain criminal categories that are intimately related to the use of alcoholic beverages. Most clearly involved are violations of public intoxication statutes and closely related charges of disorderly conduct, vagrancy, trespassing, and peace disturbance. These charges have been discussed in previous sections of this report.

Two major research approaches have characterized the investigation of the relationship of crime and alcohol use. First, what is the drinking behavior or status of the individual when he commits a crime? Second, what is the correlation between long-standing abuse of alcohol (alcoholism) and criminality?

THE COMMISSION OF CRIMES

In determining the drinking status of the individual at the commission of the crime, two research techniques have been used. Illustrative of one approach is Marvin E. Wolfgang's [14] study of homicides committed in Philadelphia in 1948–1952, composed of 588 victims (cases) and 621 offenders. He reports that "either or both the victim and offender had been drinking immediately prior to the slaying in nearly two-thirds of the cases."

A second, more accurate research technique is to analyze the blood or urine of the individual for alcohol content immediately after the commission of the crime. Illustrative of this approach is the program in Columbus, Ohio, where urine analysis for alcohol concentration was reported in a study by Shupe [15] on "882 persons picked up during or immediately after the commission of a felony" during the period March 1951 to March 1955. Shupe states:

> The figures show that crimes of physical violence are associated with intoxicated persons. Cuttings (11

[14] Marvin E. Wolfgang, "Patterns of Criminal Homicide," University of Pennsylvania, 1958.

[15] Lloyd M. Shupe, "Alcohol and Crime: A Study of the Urine Alcohol Concentration Found in 882 Persons Arrested During or Immediately After the Commission of a Felony," Journal of Criminal Law, Criminology and Police Science, 44:661–664, 1954.

> to 1 under the influence of alcohol), the carrying of concealed weapons (8 to 1 under the influence of alcohol) and other assaults (10 to 1 under the influence of alcohol) are definitely crimes of alcohol influence, even crimes of true intoxication.[16]

Thus, the closest relationship between intoxication and criminal behavior (except for public intoxication) has been established for criminal categories involving assaultive behavior. This relationship is especially high for lower-lower class Negroes and whites. More than likely, aggression in these groups is weakly controlled and the drinking of alcoholic beverages serves as a triggering mechanism for the external release of aggression. There are certain types of key situations located in lower class life in which alcohol is a major factor in triggering assaultive behavior. A frequent locale is the lower class tavern which is an important social institution for this class group. Assaultive episodes are triggered during the drinking situation by quarrels that center around defaming personal honor, threats to masculinity, and questions about one's birth legitimacy. Personal quarrels between husband and wife, especially after the husband's drinking, frequently result in assaultive episodes, in the lower-lower class family.

Shupe's conclusion that 64 perecnt of his sample of 882 individuals were "under the influence of alcohol to such an extent that their inhibitions were reduced" is of major significance to American criminologists. Excessive drinking of alcoholic beverages is a significant fact in the commission of crimes. However, there are as yet no data that demonstrate that alcoholism is a significant factor in the commission of crimes.

HIGHWAY ACCIDENTS

The Congress currently is very concerned, as is the country, with reducing the horrible toll of deaths on the nation's highways. Unfortunately, very little attention has been directed by the Federal Government to a significant factor in vehicular accidents—drunkenness and alcoholism. Mr. Pyle, director of the National Safety Council, estimates that perhaps one-half of those involved in fatal automobile accidents are under the influence of alcohol. This can be confirmed by spot studies by scientists throughout this country. For example, of the first 43 individuals killed in motor vehicle accidents in St. Louis County, Mo., in 1966, 30 had alcohol-blood levels of 0.15 or higher, which is indicative of heavy intoxication. The New York Times, March 13, 1966, reports that in San Antonio in the last 9 years 61 percent of the drivers and pedestrians killed have been intoxicated. The blood alcohol levels were 0.15 or higher. The research of Selzer[17] in Michigan confirms that a sizeable proportion, 40 percent of those drivers responsible for fatal motor vehicle accidents, can be diagnosed as alcoholics.

CORRECTIONAL INSTITUTIONS

Between 40 to 50 percent of those incarcerated in penal institutions for felonies in the United States have a drinking problem. The most systematic study of a prison population is one completed by a team of Washington University psychiatrists, headed by Sam Guze,[18] who examined psychiatrically a series of 223 consecutive criminals, including probationers, parolees, and "flat-timers" at the Missouri State Penitentiary at Jefferson City. Although 48 percent of the sample were diagnosed as having no psychiatric disorder, 43 percent were diagnosed as alcoholics, the largest percentage by far in any psychiatric category.

CRIMINAL CAREERS

Another relationship between intoxication and criminality is found in the factors associated with continuation of a criminal career. Previous criminological studies have indicated that the major variable correlated with drop-out from criminal activity is increasing age.

A recent study at the Institute of Criminology at the University of Copenhagen, Denmark, however, indicates that drop-out from criminal activity is correlated with increasing age, unless the individual has an alcoholic problem. If he has an alcoholic problem there is a strong tendency for the individual to maintain his criminal pattern in the middle years of life. Furthermore, as Pittman and Gordon have noted in "Revolving Door," there is a tendency for certain criminals, who earlier in their criminal careers were involved in complex forms of crime, to become petty criminals with alcoholic complications in their middle and later years. These kind of criminals may be referred to as double failures since earlier in their life they used crime as a vehicle for social mobility, achievement and success but failed to make the grade in high level criminal activity. These are the men who do not become successful criminals. In later life they experience a second failure by being unsuccessful, petty criminals and frequently use a retreatist form of adaptation—chronic drunkenness.

RECENT LEGAL DECISIONS

Two monumental legal decisions in 1966 affecting the public intoxication offender have been rendered. First, a three-judge panel of the United States Court of Appeals for the Fourth Circuit in Richmond on January 22, 1966, found in favor of the appellant, Joe B. Driver[19] of North Carolina, who had been arrested more than 200 times for public intoxication. Judge Bryan stated:

> The upshot of our decision is that the State cannot stamp an unpretending alcoholic as a criminal if his drunken public display is involuntary as the result of disease. However, nothing we have said precludes detention of him for treatment and rehabilitation so long as he is not marked a criminal.

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[16] *Ibid.*, p. 663.

[17] Melvin L. Selzer and Sue Weiss, "Alcoholism and Fatal Traffic Accidents—A Study in Futility," The Municipal Court Review, 5:15–20, 1965.

[18] Samuel B. Guze, Vincent B. Tuason, Paul D. Gatfield, Mark A. Stuart and Bruce Picken, "Psychiatric Illness and Crime with Particular Reference to Alcoholism: A Study of 223 Criminals," Journal of Nervous and Mental Disease, 134, 512–513, 1962.

[19] *Driver* v. *Hannant*, 356 F. 2d 761 (4th Cir. 1966).

On March 31, 1966, all eight judges of the United States Court of Appeals for the District of Columbia ruled unanimously in favor of the appellant, DeWitt Easter.[20] The decision of the judges was that "chronic alcoholism is a defense to a charge of public intoxication, and therefore is not a crime in violation of section 25–128(a) of our Code * * *."

These legal decisions that repeated intoxication cases must be handled medically and socially, not criminally, will require the implementation of a crash program, at the Federal, State, and local level, for alcoholism control. Thus, in five States and the District of Columbia chronic alcoholics cannot be treated as criminals for being inebriated; these alcoholics will no longer be the responsibility of penal authorities but of health authorities and health institutions.

CURRENT INSTITUTIONAL INNOVATIONS IN HANDLING THE PUBLIC INTOXICATION OFFENDERS

Prior to the decisions in the *Driver* and *Easter* cases, attempts at planned intervention in the revolving door cycle of public drunkenness offenders had been made. Various institutions which execute social policy have a certain degree of autonomy and are able informally to alter social policies. The best way to illustrate how this can be done is to cite examples of how the three institutions (police, courts, and correctional institutions) have, in fact, altered punitive social policies so that they have become therapeutic policies.

POLICE INTERVENTION

Law enforcement officers in American communities have differential awareness of the magnitude of this problem and varying policies towards the publicly intoxicated person. However the police are charged by their communities to manage and control the intoxicated person on the street. Almost all communities treat the "drunk on the street" as one who is violating misdemeanor statutes or ordinances which make this behavior a crime. Thus, the publicly intoxicated person is frequently arrested and sent to the municipal court for processing. This is done despite the fact that most police officers realize that a holdover or jail is not the appropriate facility for a sick person such as the alcoholic.

In certain cities the police have attempted to intervene in the revolving door process. When the rehabilitation function has not been performed by other community agencies, the police have at times attempted intervention. Two notable examples are found in St. Louis and Seattle.

In 1962 and 1963 many key St. Louis police personnel visited the alcoholism treatment and referral demonstration project at the Malcolm Bliss Alcoholism Treatment and Research Center and held many information conferences with staff members. As a result of these conferences and further studies, in 1963 the St. Louis Board of Police Commissioners instituted a major policy change in reference to intoxicated persons on the street. The St. Louis Metropolitan Police Department made it mandatory for all individuals suspected of intoxication on the streets of St. Louis to be taken to the emergency rooms of the two city hospitals for physical examination. This means that routine physical evaluation is provided all inebriates processed by the police; if these individuals are in need of medical care, they are hospitalized instead of being jailed. If medical care is deemed unnecessary, the intoxicated person may be held until sober—not more than 20 hours—and released into the community. St. Louis is one of the few American cities in which this innovation in the handling of the public intoxication case has occurred. It squarely places the locus of responsibility for the alcoholic in the treatment sphere and is in keeping with modern practices toward the publicly intoxicated person found in Sweden, Norway, West Germany, Poland, and Czechoslovakia. Hopefully, this breakthrough will be followed by abandoning the current primitive and punitive process of jailing public intoxication offenders in the United States.

Another notable example of police intervention was the Seattle Police Department's Rehabilitation Project for Chronic Alcoholics,[21] now defunct. Officially opened in August, 1943, it was established by the Police Division which felt that prolonged incarceration of alcoholics did not provide rehabilitation. The chief concern of the project was to allow the alcoholic a chance to reflect about and make changes concerning his drinking problem. The avenue of entry to the project was through the courts. As Jackson, Fagan, and Burr have noted:

> Due to the system of graduated sentences in effect in Seattle, the alcoholic tends to have been arrested five or more times within the year before he becomes eligible for admission to the project. Upon removal to the city jail, the prisoner can ask to be transferred to the rehabilitation project if he sincerely wishes to do something about his drinking problem. All admissions are voluntary. His wish to be transferred is discussed with a police officer who makes a judgement as to whether the man is sincere and would be benefited by this type of project.[22]

Within the project the prisoner became a patient, and his daily routine was based on a semimilitary model. Counseling, lectures, and films concerning alcoholism were provided. A followup of men treated within the project indicated that there was a significant reduction in the number of times arrested for public intoxication in the 6 months following release compared to the 6 months prior to entry into the project.

Studies in Seattle, Portland, and elsewhere show that intervention by both the police and the courts in the deviancy reinforcement cycle can reduce the number of arrests of the chronic offenders. This occurs without there being any apparent conscious collusion by the police or courts to produce reduced rates for drunkenness. When a program such as that in St. Louis is effected, the

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[20] *Easter* v. *District of Columbia*, 361 F. 2d 50 (D.C. Cir. 1966).

[21] For complete details see Joan K. Jackson, Ronald J. Fagan, and Roscoe C. Burr, "Seattle Police Department Rehabilitation Project for Chronic Alcoholics," Federal Probation, 22:36–41, 1958.

[22] *Ibid.*

police become more understanding of the problem with which they are dealing, and also many other professionals become aware of and begin to treat the alcoholic offender.

COURT INTERVENTION

Many municipal judges have become cognizant of the responsibility of the court to public intoxication offenders. Innovations in court processing of inebriates are found in the work of Judge Harrison of Des Moines and Judge Burnett of Denver. Judge Harrison sponsors for court inebriates his Des Moines Court Honor Class which meets every Wednesday night; this is basically a "group-therapy" session of alcoholics and problem drinkers organized by the judge of the court. By 1966, there were over 75 judges who had adopted this Court Class Program.

Another treatment technique utilized is that of the Half-Way House in Rochester, New York, which was created in response to the Pittman and Gordon Study previously cited. A small group of men, instead of being sentenced to the county jail by the Rochester City judges, are sent to Reception House, a special rehabilitation center in that community. Men for this project are carefully screened for rehabilitation potential by the judges and their staff. Unfortunately, this program covers only a small number of offenders since the rehabilitation staff is unable to absorb more than a few dozen a year. The major purpose of the program is to break the pattern of institutional dependency of court inebriates, which has been referred to previously in this paper.

CORRECTIONAL INSTITUTIONAL INTERVENTION

A critical stage in America's deviancy reinforcement cycle (chart I) for the chronic drunkenness offender is the workhouse or city jail. Previous research studies have shown that repeated incarceration does not act as a deterrent to the chronic inebriate's behavior. Repeated jailing, as a socially and legally accepted philosophy in the community for reforming the chronic drunkenness offender, has been and will continue to be a failure from the rehabilitation point of view. The emphasis in most jails is upon custodial care rather than any systematic treatment for these inebriates. It should be noted, however, that custody does perform certain humanitarian functions. Sentences for public intoxication do fulfill the men's basic needs of shelter and food, and enforce sobriety. Thus, the physical resources of the men are repaired during incarceration, but they can be debilitated at release during another intoxication bender.

Despite the inappropriateness of jails and workhouses, attempts have been made in this setting to rehabilitate public intoxication offenders. In 1954, for example, the District of Columbia workhouse was the setting for a two and one-half year project, utilizing a treatment clinic within the penal institution. Both individual and group therapies were used, but the prisoners participating had been screened; therefore, the improvement rate—one-third of those participating—was higher than would be expected for an unselected sample in such a program.

True, these few examples of policy changes have not affected the overall problem of the public drunkenness offender, but these attempts do show that intervention is possible, although not easy. Current institutions which handle the problem (jails, workhouses, and municipal courts) may have a vested interest in the maintenance of the status quo. In some communities the emphasis is on the economic contributions of the offenders through their work on local roads and civic projects. There are American municipalities which actually budget the expected services of the offenders to their local civic projects.

COMMUNITY INTERVENTION

Planned intervention occurs at this stage through social welfare agencies, mental health services, and rehabilitation and hospital facilities before arrest or incarceration. The locale for these services would be on skid row, in the low income and poverty areas of the city. Historically, these areas have been given only minimal attention by traditional health and welfare services, whether private or public, in American communities.

These community programs must recognize that a common theme emerges from any study of the public intoxication offender. This person is a product of the culture of poverty, an individual who has never attained more than a minimum of economic and social integration within the society. Thus, his position is one of low status and neglect by the traditional agencies. From this position, he is perhaps the most ignored member of the community. The implication derived from his status position is that rehabilitation is doubly complex.

First, there is his drinking problem. Secondly, his limited social and economic resources place him in the poverty class in American society. As has been recognized by the Tennessee Alcoholism Program, there is an intimate relationship between poverty and drunkenness for the chronic intoxication offender. Any systematic program for this group must combine a retraining program to provide basic economic skills necessary in an urban society as well as therapies to combat the excessive drinking of the offender. The programs currently being developed in the nation's "war on poverty" should be extended to this group. Hopefully, the Office of Economic Opportunity will become involved in creating programs to aid this group of unskilled and dependent men.

A specific example of community intervention is a rehabilitation project conducted by the Volunteers of America in Los Angeles for this problem group while they were residents in the community.[23] This demonstration project was carried out on Los Angeles' skid row and was designed to meet the problems of the men by providing a multidisciplinary staff drawn from medicine, psychiatry, social service, vocational rehabilitation, and religious counseling. Furthermore, an outpatient program was created to be utilized by the men. It was found that this type of program should not only decrease the men's drinking, but lessen their number of incarcerations for public intoxication. Furthermore, the staff hoped to help make the men more employable and self-maintaining, financially and socially.

[23] Walter Hart, "Potential for Rehabilitation of Skid Row Alcoholic Men," Los Angeles: Volunteers of America of Los Angeles.

A group of 953 men came for treatment during the year 1959–60. Of these men, 86 percent considered their main problem to be drinking, and they were similar in most respects to the sample of chronic intoxication offenders studied by Pittman and Gordon. It should be noted that 70 percent had been jailed for public intoxication from six to more than 150 times.

A sizable proportion of the men, 45.5 percent, dropped out of the program after their first visit, but 41 percent made three or more contacts with the program's staff. Of the original group, at least 15 percent (142), were considered by the professional staff to be moving toward rehabilitation, viewed in terms of the criteria of economic and social functioning. Furthermore, there was a significant reduction in the number of times this latter group has been incarcerated for public intoxication.

On first blush the rehabilitation proportion of 15 percent appears to be very low. In fact, is this a low rate? In terms of relapses for various other disorders, the rate is not unreasonable. Somewhat over 90 percent of narcotics addicts relapse, and the relapse rate among chronic smokers is quite high—85 to 90 percent. Moreover, the program was limited—far from the comprehensive approach needed. But before we have expectancies for rehabilitation proportions of 50 to 60 percent, we should be realistic about the fact that we are coping with a chronic illness, the pattern of which is deeply imbedded in the individual's personality.

SUGGESTED INNOVATIONS IN THE HANDLING OF PUBLIC INTOXICATION CASES

INTRODUCTION

The major problem confronting us in dealing with the chronic drunkenness offender, however, is the lack of a focus of community, State, and Federal responsibility for this problem group. Many conventional social and medical agencies state that the problem is not their responsibility. These offenders are on skid row; therefore they are considered to be the responsibility of the Salvation Army or the Volunteers of America. The police frequently say it is the responsibility of the courts; the courts counter with the duty of the penal institutions; and the latter counterattack with the responsibility of health and mental hygiene agencies. The net result is that no suitable institution or person assumes responsibility for the social problems of these men. Thus, America continues to clutter its courts and jails with individuals whose "crime" is a physicial and social illness.

Bold and imaginative aproaches to handle the public drunkenness case and to bring American communities into compliance with the Driver and Easter decisions are needed. Time is of essence, for the current situation in Washington, D.C., indicates that referrals of chronic alcoholics from the General Sessions Court to the District of Columbia Alcoholic Rehabilitation Clinic have overwhelmed these facilities.

A MODEL PROGRAM

Briefly outlined, a comprehensive program to deal with the chronic drunkenness offender would be composed of the following parts:

1. *Routine Medical Evaluation of All Individuals Suspected of Intoxication and Taken Into Custody by the Police.*

This procedure of providing mandatory medical evaluation of all suspected cases of public intoxication at hospital facilities is necessary if needless deaths are to be prevented. The appropriate place for treating alcoholism is in a hospital, not a jail.

2. *Routine Training of Police Officers in Handling Public Intoxication Cases.*

A large number of police academies currently include training sessions for their recruits in this area of alcoholism. Routine coverage of alcoholism in police training courses is highly recommended.

3. *Repeal of Drunkenness Statutes.*

In the absence of disorderly conduct, public drunkenness should not be a crime.

4. *Establishment of Detoxification Stations (Sobering-up Stations).*

It was stated by Attorney General Nicholas deB. Katzenbach, while testifying before the Ad Hoc Subcommittee of the Senate Judiciary Committee on the Law Enforcement Assistance Act of 1965, that:

> We presently burden our entire law enforcement system with activities which quite possibly should be handled in other ways. For example, of the approximately six million arrests in the United States in 1964, fully one-third were for drunkenness. The resulting crowding in courts and prisons affects the efficiency of the entire criminal process. Better ways to handle drunks than tossing them in jail should be considered. Some foreign countries now use "sobering-up stations" instead of jails to handle drunks. Related social agencies might be used to keep them separate from the criminal process.

Sobering-up stations have become an integral part of the network of alcoholism services in Poland and Czechoslovakia. For example, in Warsaw any person found drunk on the street or lying in a doorway is taken by the police to a sobering-up station. Many of these stations are located in wooden-frame buildings (probably former army barracks) in Warsaw and in hospital facilities in Prague. Basically, the routine is as follows: The intoxicated person is registered by a clerk at the station, undressed, examined by a physician or intern, given a

shot of vitamins or other medication, given a shower, and put to bed for eight to 24 hours. These sobering-up stations provide for treatment of acute alcoholism and early case detection of alcoholics.

In Czechoslovakia, patients from the station are referred to lectures on alcoholism and its effects (called "Sunday Schools" since the lectures are held on Sunday). Generally when the individual appears a second or third time at the sobering-up station, a full scale medical and social evaluation begins and a plan for therapeutic intervention is worked out. A police-sponsored detoxification center has recently been started in St. Louis, Missouri. This unit is apparently the first of its kind in the country.

The establishment of sobering-up stations in major urban centers of America would be a forward looking step of bringing medical and social responsibility into play for the chronic drunkenness case and would relieve police, court, and correctional personnel of this group of chronic alcoholics.

5. *Communities Will Need To Develop Effective Referral Systems for Alcoholics From the Detoxification Stations To Other Community Resources for Treating Alcoholics.*

The greatest deficiencies in current alcoholism treatment activities in the United States are the lack of programs which conceptualize that alcoholism is a long term chronic illness. With the development of better pharmacological agents and a greater understanding of the physiological, psychological, and social effects of alcoholism, the treatment of patients in the acute stages of the disease can be handled with minimal difficulties by qualified personnel. For example, at the Bliss Alcoholism Unit in St. Louis the length of stay for patients in the acute treatment room has averaged 1.7 days; this indicates that alcoholics without severe complications can regain a degree of physical and social functioning within a short period of time; thus the acute phase of treatment is not as difficult as long term comprehensive care for alcoholics.

The main method employed in the United States for long term care for alcoholics consists essentially of keeping the patient institutionalized for long periods of time; this treatment approach is not particularly effective if one considers that the primary goal of treatment is to enable the patient to function in productive roles in the community. It is true that institutionalization generally insures the sobriety of the patient, but it does not necessarily assist him in making the requisite adjustments for becoming a responsible member of society. Indeed, patients may become so dependent on the institution that adjustment to the outside world is extremely problematic. Too, the longer the stay in an institution, the greater the financial burden is on the state and/or the patient. There are, of course, a few alcoholic patients who must remain institutionalized because of serious complications, such as severe chronic brain syndromes. However, in most cases the alcoholic patient should receive intense short term treatment such as would be provided at the the sobering-up station. Buttressing these stations would be a network of aftercare facilities which would be comprehensive in nature. Supportive residential housing is a necessary component to any rehabilitation plan. And it has long been apparent that such housing must be located in the heart of the city.

The aftercare program must employ a multitude of different approaches for the following reasons:

- ☐ The etiology of alcoholism is unknown. Therefore there is no single variable to which one type of aftercare treatment can be addressed. Rather there are numerous variables with which one type of aftercare facility would find it impossible to contend.
- ☐ The term, "alcoholism," encompasses a diversity of subtypes of the disease. Jellinek, for example, suggested five different types of alcoholism. Different types of aftercare facilities would handle various types of alcoholism.
- ☐ Some alcoholics, because of greater mental and physical deterioration, will need more supervision than alcoholics who stopped their drinking at an earlier stage in the disease process.
- ☐ The personal and social resources of alcoholics are different. For example, education, job experience, age, and health vary greatly among alcoholics, and as a result some will be able to increase the level of social functioning more readily than others.

Because of the diversity inherent in chronic drunkenness cases, it is improbable that any single type of aftercare facility can adequately assist all these alcoholics. This diversity and complexity can be dealt with by the establishment or strengthening of six kinds of aftercare facilities. They are:

a. Out-patient Clinics
b. Domiciliaries
c. Community Houses
d. Halfway Houses
e. Foster Homes
f. Social Centers

a. *Outpatient Clinics:* It is highly presumptuous to conclude that chronic alcoholics will be able to change a life pattern of drinking after a few months of treatment. Rather, it is more plausible to note that they will need some degree of reinforcement of new behavior patterns in the form of easily accessible therapeutic treatment. Therefore outpatient clinics for alcoholics should be strengthened in American communities and created where they do not currently exist.

Blanket referral of all patients from the detoxification centers to the outpatient clinics will not be effective for a sizeable number of alcoholics. An evaluation of the type of patient for whom the out-patient clinic is not effective should be made, and such patients should be referred to other programs (domiciliaries, community houses, halfway houses, or foster homes).

b. *Domiciliaries:* Unfortunately, full rehabilitation for many chronic drunkenness offenders will be impossible because of the individual's age, physical, or mental health, or other reasons. Such persons may not need the extensive treatment of a hospital, but yet they are unable to become integrated into society. Such persons should be placed in voluntary domiciliaries rather than be institutionalized in a State hospital. Careful and periodic evaluations of the domiciliary patients should be made in order to ascertain that the individuals should be in the facilities. Certain domiciliaries have the reputation of being a home for the "living dead." Such a stereotype can be avoided under proper supervision and by utilizing domiciliaries only when all other aftercare programs prove unfeasible.

c. *Community Houses:* One portion of the alcoholic population is characterized by certain attributes which inhibit their total functioning in society. Although such persons, illustrated by chronic brain syndrome cases, have lost a significant degree of their psychological and social functioning ability, they can work. In some cases it requires a relatively long period of sobriety for the person to regain full use of all his facilities. A community home would serve as a shelter for these individuals and also offer some professional help to the patient.

In effect, the community house offers an intermediate facility between the hospital and/or sobering-up station and halfway houses; the professional personnel involvement would be less than that found in the hospital, but more than is typical of halfway houses. Community houses probably would require State and Federal funds. A facility such as this would have to be created in several urban centers on a pilot basis. A research evaluation of the patients' program and progress is essential to learn when they are capable of moving to other aftercare facilities which entail more freedom and less supervision.

d. *Halfway Houses:* As is often the case in therapeutic innovation, private interests pioneered in establishing halfway houses for alcoholics as a result of the indifference of professional and governmental agencies. Halfway houses are usually self-supporting and offer the alcoholic a place to live until he can establish himself in the community. Under private administration halfway houses have been fairly successful. Examples of such halfway houses are found in most American urban centers. These houses are self-supporting and offer at a modest cost to alcoholics a clean and supportive home which reinforces their endeavors to adjust in the larger community. However, there are far too few of them, and they are occasionally beset with financial and managerial difficulties. The scarcity of halfway houses can mainly be attributed to the large initial investment necessary to establish one. Therefore, Federal and State financial and administrative assistance is essential for the expansion of centrally-located halfway houses throughout the country. As with the community houses, halfway houses should receive funds from the State and Federal government in their initial phase. An evaluation of the therapeutic procedures of halfway houses is indispensible.

e. *Foster Homes:* A new concept in aftercare treatment, that was begun in Pennsylvania in the early 1950's, is the use of foster homes for alcoholics.[24] In the Pennsylvania model, patients were placed in foster homes as an alternative to long term hospitalization. The patients were still under the control of the hospital staff and could be withdrawn from the homes if their adjustment were not satisfactory. The goal of the program was "to place the man in a congenial environment in accord with his own expressed wishes." The "foster-care mother" need not have professional training but should have a "tolerant attitude toward aberrant behavior." Too, professional supervision was freely given on request by the "foster-care mother" or the patient. The Pennsylvania program proved very successful; in a study of a portion of foster home patients, 72 percent of the men made "successful adjustments" within a year. The possibility of such a program on a nationwide basis should be seriously considered, given Pennsylvania's success.

f. *Social Centers:* A sizable number of drunkenness offenders belong to a "tavern culture"; drinking at the neighborhood bar becomes an important part of their social life. In Vienna, Austria, the government has established social centers (especially in working class housing projects) where alcoholics can find recreational facilities and companionship. Thus, the social center becomes the functional equivalent of the tavern. It then offers the alcoholic a positive alternative to the tavern. Such centers should have easily-met membership requirements which would admit problem drinkers who are unable to gain entrance into restrictive private clubs.

It should be remembered that the aftercare facilities are not isolated autonomous agencies; i.e., it is quite likely, indeed advisable, that the patients should participate in more than one of the facilities. This statement implies the need for a central locus of responsibility on the local or state level which would coordinate the efforts of all aftercare facilities and make possible quick and accurate referrals for patients who need the assistance of various facilities.

A comprehensive treatment program of this type does not exist anywhere in the United States today. Senator Tydings of Maryland has recently introduced a bill in Congress that would establish such a program in the District of Columbia. (See Attachment I.) This proposed legislation provides an excellent model for other States and communities.

The economic advantages for the United States as the result of the implementation of these aftercare facilities are obvious. In all but one case (the domiciliaries) the main goal of the aftercare agency is the social functioning of the alcoholic, which includes the individual's employment. As a result, much of the expense of aftercare facilities will be repaid by the alcoholics themselves in increased employment.

[24] "Foster Homes Give Aid to Alcoholic Mental Patients," Target, Department of Health, Harrisburg, Pa., Vol. XXII, Sept., 1962, p. 1-2.

Perhaps a more important product of a comprehensive aftercare program will be the alleviation of the strain which currently exists on the limited treatment facilities for alcoholics. By offering the hospital and/or detoxification staffs treatment alternatives, alcoholics may be referred to treatment facilities which are not only more conducive to their rehabilitation but also are less expensive for the State to operate. Thus, the unpleasant experience of refusing admission to treatment facilities will, hopefully, be less prevalent than is presently the case.

Currently, in the United States there is no semblance of an effective referral system, either on the local or on the State level, effectively to utilize the limited treatment facilities for alcoholics. Along with the development of new and various kinds of treatment facilities for alcoholics, it is imperative that there be a parallel development of a referral system. There are three basic reasons for this need:

a. Experience has shown that often an alcoholic seeks assistance but is discouraged because the personnel involved either are unaware of available facilities or merely steer the alcoholic, instead of directing him, to the appropriate treatment facility. Referral personnel must not assume that their clients will follow their suggestions; rather, they should take an active and aggressive approach in their referrals. The South End Center in Boston, for example, makes provision to transport people in need of existing services.

b. As various approaches to the treatment of alcoholics are initiated in the United States, scientific evaluation will show that certain types of alcoholics respond better to particular forms of treatment. Therefore, referral personnel should not only be aware of the available facilities, but also know which portions of the alcoholic population are best suited for specific modes of treatment. Of course, such referral information is possible only if careful analyses are undertaken of all treatment facilities.

c. The alcoholics treated (or seeking treatment), under the State alcoholism program will typically be from the lower socio-economic strata of society. As a result of this characteristic, many will need assistance outside the scope of the aftercare facilities of the State alcoholism program. Consequently, the referral system should include information relating to other Federal, State, local, and private agencies that might help the client establish himself in the community.

In summary, the model referral system would entail having comprehensive information on all resources available to the alcoholic, both within the alcoholism program and in related programs, including the character and goals of these programs. Too, the State program must keep abreast of all current developments affecting the treatment and rehabilitation of alcoholics, and aid in creating new referral sources where appropriate.

A diagram, "Proposed Organization of State Services for Alcoholics," is presented in chart II.

6. *Alcoholism Treatment Programs Should Be Created and/or Strengthened in the Nation's Correctional Institutions.*

As has been previously stated in this report, a significant number of individuals committed to correctional institutions are suffering from alcoholism. Treatment of their alcoholism should be an essential part of the institution's therapeutic regimen. This can be accomplished through the establishment of Alcoholics Anonymous groups within the setting. The practice is widespread with groups well established in the penal systems of North Carolina, Illinois, and Missouri, to mention only three. Furthermore, alcoholics should be encouraged to attend special group-therapy sessions conducted by professional personnel in the institutions. Even with the repeal of drunkenness laws, correctional institutions house a range of offenders with serious drinking problems.

7. *Probation and Parole Services Should Incorporate Special Treatment Services for Alcoholic Offenders*

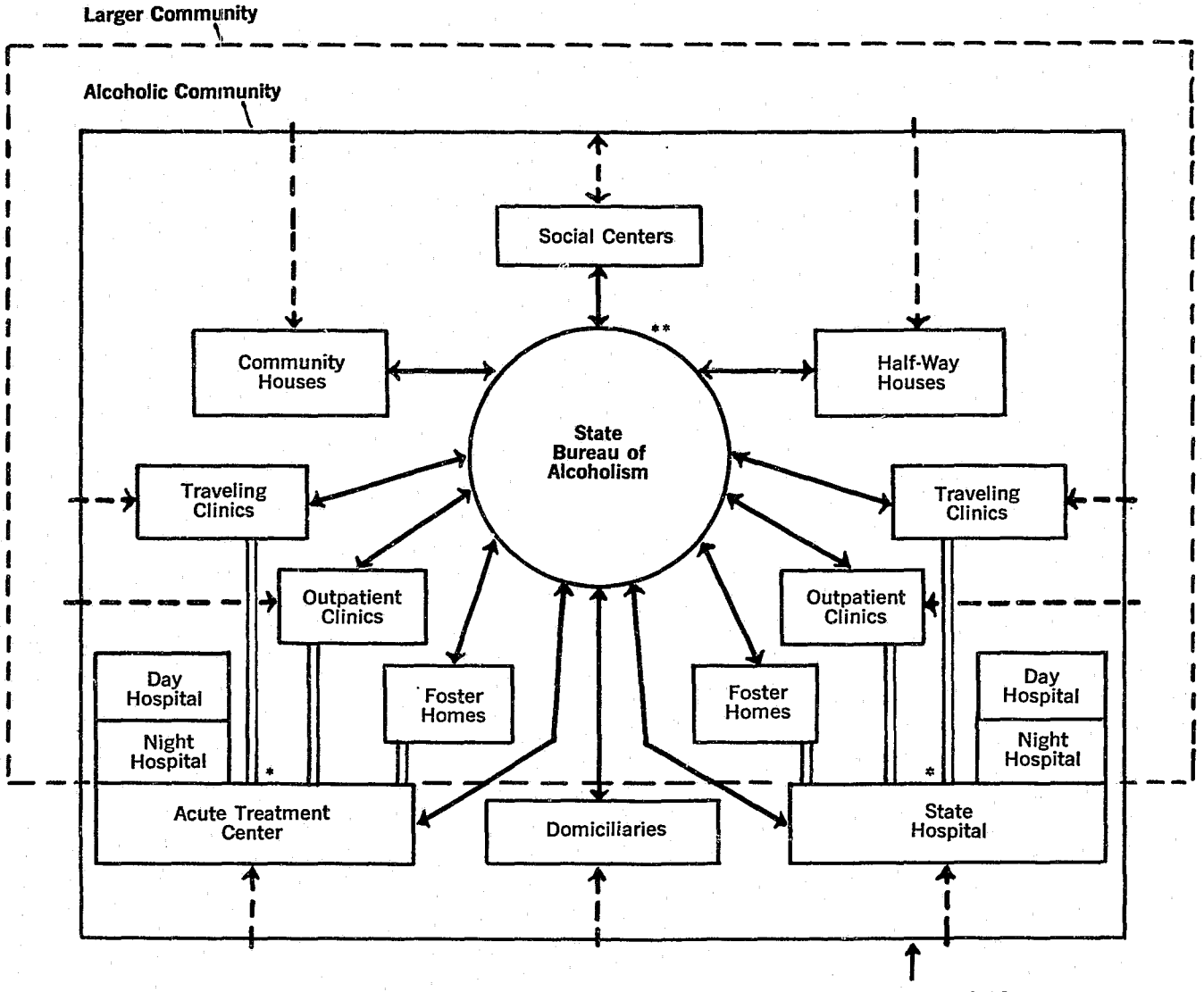
Services for alcoholic offenders, with required outpatient treatment, have become an integral part of the probation and parole services in many States and cities such as Illinois, and High Point, N.C. Encouragement and support should be given to probation and parole units who wish to construct special units on alcoholism for convicted offenders with drinking problems. Such programs are appropriate—even if drunkenness statutes are repealed—for the range of offenders placed on probation and parole.

8. *Proposed Federal Action in the Area of Alcoholism Control*

The problem of alcoholism is so extensive in the United States (the second highest rate in the world) that current efforts at the local, State, and Federal governmental levels do not really represent a major national attack on this problem. However, beginning with the convening of the 89th Congress in January, 1965, a ground swell of interest in alcoholism control at the Federal level has been evidenced in the Congress as well as in the nation at large.

In September 1965, the House Committee on Interstate and Foreign Commerce held hearings on H.R. 781, a bill to establish a Federal Commission on Alcoholism. Joint position statements were drafted by the North American Association of Alcoholism Programs, Smithers Foundation, and National Council on Alcoholism concerning the need at the Federal level as seen by these national organizations. The recommendations were fourfold:

Chart 2.—PROPOSED ORGANIZATION OF STATE SERVICES FOR ALCOHOLICS



* Constellation of treatment facilities with strong administrative ties (illustrated by double lines ═══).

** State Bureau which would coordinate and collect information essential for an effective referral system.

←– – – Broken arrows illustrate possible avenues through which alcoholics may enter system of services.

←——— Solid arrows show exchange of referral information between various agencies and the State Bureau.

a. That there be established an identifiable unit with substantial funding for alcoholism activity coordination within the Department of Health, Education, and Welfare.

b. That there be a substantial funding program earmarked to assist communities and State agencies responsible for alcoholism in the development and coordination of comprehensive services related specifically to alcoholism.

c. That there be provided substantial financial support earmarked for national agencies and centers working in the field of alcoholism.

d. That there be substantial funds earmarked for research and training in this field.

These objectives which remain unfulfilled, must be realized before there will be any major impact on the problem of alcoholism.

In March, 1966, President Johnson became the first President in history to include a significant comment about alcoholism in his health and education message to Congress. The President's message to Congress generally outlines the Administration's position on various health matters and is viewed by the Federal establishment as a guide to the Administration's priorities in terms of Governmental activity. That part which pertained to alcoholism is quoted here in full.

> The alcoholic suffers from a disease which will yield eventually to scientific research and adequate treatment. Even with the present limited state of our knowledge, much can be done to reduce the untold suffering and uncounted waste caused by this affliction.
>
> I have instructed the Secretary of Health, Education, and Welfare to:
>
> —appoint an Advisory Committee on Alcoholism;
>
> —establish in the Public Health Service a center for research on the cause, prevention, control and treatment of alcoholism;
>
> —develop an education program in order to foster public understanding based on scientific fact;
>
> —work with public and private agencies on the State and local level include this disease in comprehensive health programs.

Current efforts to cope with the chronic drunkenness offender and the alcoholic in general at the Federal level are fragmentary and do not represent a national attack on alcoholism. In 1965 the Federal Government spent only $7 million on alcoholism control and treatment despite the fact that alcoholism ranks fourth among the most prevalent diseases, despite the fact that over one-third of the arrests are for public drunkenness, and that 40 to 50 percent of all traffic accidents are caused by people who are drinking. This inadequate expenditure of funds at the Federal level is one of the significant factors in creating what the Washington Post has referred to as "the alcoholism void."

Immediate enactment by the Congress of significant funding legislation would be a major step forward in helping the local communities and states to solve the chronic drunkenness offender problem. One potential source for funds is the Office of Economic Opportunity.

ATTACHMENT I

S. 1740

90TH CONGRESS, 1ST SESSION

IN THE SENATE OF THE UNITED STATES

May 10, 1967

Mr. TYDINGS introduced the following bill; which was read twice and referred to the Committee on the District of Columbia.

A BILL

To provide a comprehensive program for the control of drunkenness and the prevention and treatment of alcoholism in the District of Columbia.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

TITLE I—FINDINGS AND DECLARATION OF PURPOSES

SEC. 101. The Congress hereby finds that—

(a) Dealing with public inebriates as criminals has proved expensive, burdensome, and futile. The attendant expenditure of law enforcement resources is clearly excessive. The criminal law is ineffective to deter intoxication and to deal with what is basically a major problem of human degradation and chronic alcoholism. Criminal punishment of inebriates has helped to perpetuate the chronic drunkenness offender problem.

(b) Removal of public intoxication from the criminal system and establishment of a modern program for the rehabilitation of chronic inebriates facilitate early detection and prevention of alcoholism and effective treatment and rehabilitation of alcoholics. Handling of chronic inebriates through public health and other rehabilitative procedures relieves police, courts, correctional institutions, and other law enforcement agencies of an onerous and inappropriate burden that undermines their ability to protect citizens, apprehend law violators, and maintain safe and orderly streets.

SEC. 102. The Congress declares that—

(a) To control public intoxication and chronic alcoholism requires a major commitment of effort and re-

sources by both public and private segments of the community. An effective response to these problems must include a continuum of detoxification, inpatient, and outpatient treatment programs, and supportive health, welfare, and rehabilitation services, coordinated with and integrated into a comprehensive community health plan. The District of Columbia shall establish and maintain a comprehensive model alcoholism program to which other communities may turn for study, guidance, and advice.

(b) Conduct that threatens physical harm to any member of the public or to property cannot be tolerated. The police shall continue to be empowered to handle as criminal any conduct by inebriates that endangers the safety of other citizens or of property, but persons who are intoxicated shall not be subject to arrest unless they are conducting themselves in a manner which endangers the safety of other persons or of property.

TITLE II—DISORDERLY INTOXICATION

SEC. 201. Section 25–128 of the District of Columbia Code is hereby amended to read as follows:

"§ 25–128. Drinking of alcoholic beverage in vehicle or unlicensed public place forbidden—Disorderly intoxication in public forbidden—Creating public disturbance by drinking of alcoholic beverage in public forbidden—Penalty

"(a) No person shall in the District of Columbia drink any alcoholic beverage in any vehicle that is in or upon any street, alley, park, or parking; or in or upon any premises where food, nonalcoholic beverages, or entertainment are sold or provided for compensation not licensed under this chapter; or in any place to which the public is invited for which a license has not been issued hereunder permitting the sale and consumption of such alcoholic beverage upon such premises except premises licensed under section 25–111(1); or in any place to which the public is invited (for which a license under this chapter has been issued) at a time when the sale of such alcoholic beverages on the premises is prohibited by this chapter or by the regulations promulgated thereunder; or in any place for which a license under section 25–111(1) has been issued at a time when the consumption of such alcoholic beverages on the premises is prohibited by regulations promulgated under this chapter.

"(b) No person in the District of Columbia shall be intoxicated and endanger the safety of another person or property.

"(c) No person in the District of Columbia shall drink any alcoholic beverage in any street, alley, park, or parking, and cause a public disturbance: *Provided*, that any such person shall first be requested by the police or authorized personnel of the Bureau of Alcoholism Control to discontinue his drinking and public disturbance, and that no such person shall be charged with a violation of this subsection if he promptly discontinues such drinking and public disturbance upon the first such request.

"(d) Any person violating the prohibitions of this section shall be punished by a fine of not more than $100 or by imprisonment for not more than ninety days, or both: *Provided*, That other misdemeanor provisions shall not be used, as substitutes for the former public intoxication statute, to arrest intoxicated persons who are not endangering the safety of any other person or of property."

SEC. 202. Section 4–143 of the District of Columbia Code is hereby amended to add the following: *"Provided,* that any member of the police may, in lieu of making an arrest for violation of sections 25–128, 22–1107, 22–1121, 22–3302 through 22–3305, or related misdemeanor provisions, take or send an intoxicated person to his home or to a public or private health facility."

TITLE III—PREVENTION OF ALCOHOLISM AND REHABILITATION OF ALCOHOLICS

SEC. 301. Chapter 5 of title 24 of the District of Columbia Code is hereby repealed.

SEC. 302. A new chapter 14 is hereby added to title 6 of the District of Columbia Code, to read as follows:

"Chapter 14.—Prevention of Alcoholism and Rehabilitation of Alcoholics

"§ 6–1401. Purpose

"The purpose of this chapter is to establish a comprehensive program for the prevention of alcoholism and the rehabilitation of alcoholics, discourage abuse of alcoholic beverages, and provide for the medical, psychiatric, vocational rehabilitation, and other scientific and humane rehabilitative treatment of chronic alcoholics; to minimize the process of social degradation that leads to, and the deleterious effects of, excessive drinking; to reduce the financial burden imposed upon the people of the District of Columbia by the abuse of alcoholic beverages, as is reflected in accidents, personal inefficiency, absenteeism, poverty, and worsening slum conditions; and to establish methods of handling intoxication and alcoholism that will benefit the individual involved and more fully protect the public. In order to accomplish this purpose and alleviate intoxication and chronic alcoholism, all public officials in the District of Columbia are hereby authorized and directed to take cognizance of the fact that public intoxication shall be handled as a public health and rehabilitation problem rather than as a criminal offense, and that a chronic alcoholic is a sick person who needs, is entitled to, and shall be provided appropriate medical, psychiatric, institutional, advisory, and rehabilitative treatment services of highest caliber for his illness.

"§ 6–1402. 'Chronic alcoholic' defined

"The term 'chronic alcoholic' means any person who chronically and habitually uses alcoholic beverages (a) to the extent that it injures his health or interferes with

his social or economic functioning, or (b) to the extent that he has lost the power of self-control with respect to the use of such beverages.

"§ 6–1403. Bureau of Alcoholism Control

"The Commissioners of the District of Columbia are hereby authorized and directed to establish a Bureau of Alcoholism Control within the Department of Public Health, under a qualified program administrator who shall be a physician, and to establish and maintain an effective public health and rehabilitation program providing a continuum of appropriate services to inebriates and chronic alcoholics. The Bureau shall be responsible for coordinating all District of Columbia services, including but not limited to health, welfare, job counseling, social centers, and vocational rehabilitation, for inebriates and chronic alcoholics. The programs and facilities of the Bureau shall be staffed with an adequate number of personnel, who shall possess the highest professional qualifications and competence. Any person assisted under this chapter may be required to contribute toward the cost of his subsistence, care, or treatment, to the extent that he is financially able to do so, under regulations promulgated by the Bureau. The Bureau's treatment and rehabilitation program shall include at least the following components, wherever possible, utilizing the facilities of and coordinated with the programs of the community mental health center, available to both males and females:

"(a) One or more detoxification centers, all of which shall be located within the District of Columbia so as to be quickly and easily accessible to patients, with a total capacity of at least 150 beds, to provide appropriate medical services for intoxicated inebriates, including initial examination, diagnosis, and classification. Each detoxification center shall be affiliated with, and coustitute an integral part of the general medical services of a general hospital.

"(b) An inpatient extended care facility for intensive study, treatment, and rehabilitation of chronic alcoholics, with a capacity of at least 500 beds, *Provided,* That the inpatient facility shall not admit intoxicated persons and shall not be part of or at the same location as a correctional institution.

"(c) Outpatient aftercare facilities, all of which shall be located within the District of Columbia, including but not limited to clinics, social centers, vocational rehabilitation services, and supportive residential facilities such as hostels and halfway houses with a total capacity of at least 1,500 beds."

"§ 6–1404. Detoxification

"(a) Any person who is intoxicated in public or in any vehicle or in any place to which the public is invited may be taken or sent to his home or to a public or private health facility by the police or authorized personnel of the Bureau of Alcoholism Control: *Provided,* That the police may take reasonable measures to ascertain that public transportation used for such purposes is paid for by such person in advance.

"(b) Any person who is intoxicated in public or in any vehicle or in any place to which the public is invited, and either incapacitated or whose health is in immediate danger, shall, if not handled under subsection (a), be taken by the police or authorized personnel of the Bureau of Alcoholism Control to a District of Columbia detoxification center. A person shall be deemed incapacitated when he is unable to make a rational decision about accepting assistance. Any intoxicated person may voluntarily come to a center for medical attention, but incapacitated persons and others in immediate medical danger shall be given priority. The medical officer in charge of the center shall have the authority to determine whether a person shall be admitted to the center as a patient, or whether he should be referred to another appropriate facility for care and treatment. If he is admitted as a patient the medical officer in charge of the center shall have the authority to require him to remain at the center until he is sober and no longer intoxicated or incapacitated, but in any event no longer than 72 hours after his admission as a patient. A patient may consent to remain at a detoxification center for as long as the medical officer believes warranted. If the medical officer concludes that the person should receive treatment at a different facility, he shall arrange for such treatment and for transportation to that facility. If the person is not admitted either to a detoxification center or to another facility and has no funds, authorized personnel of the Bureau of Alcoholism Control shall offer to take him to his residence if he has one or, if he has residence, shell offer to attempt to find and to take him to some other facility where he may obtain shelter. A center may provide medical help to a person who is not admitted as a patient.

"(c) Any intoxicated person taken into custody by the police under sections 25–128 (b) or (c), 22–1107, 22–1121, 22–3302 through 22–3305, or related misdemeanor provisions of the D.C. Code, shall immediately be taken by the police or authorized personnel of the Bureau of Alcoholism Control to a detoxification center where he shall either be admitted as a patient or transported by the Bureau to another appropriate facility for care and treatment. After he is sober, he shall be detained as long as is necesary to conduct a diagnosis for possible alcoholism, except that this period shall not exceed an additional 24 hours. If he is diagnosed as a chronic alcoholic the medical officer shall, after a review of the patient's record, recommend to the Corporation Counsel whether a criminal charge should be filed in order to institute civil commitment proceedings under sec. 6–1407. A decision not to follow the recommendation of the medical officer may be made only by the Corporation Counsel and may not be delegated. If Corporation Counsel concludes that civil commitment proceedings should be instituted under section 6–1407 a criminal charge shall be filed. If the patient is not diagnosed as a chronic alcoholic he shall, after he is released by the center, be handled as in any other criminal case.

"(d) Any person charged with violation of any criminal provision other than these referred to in section 6–1404(c) and who appears to be intoxicated shall first be brought by the police to a detoxification center where he shall be admitted as a patient for an immediate medical evaluation of his condition. As soon as it is determined that he is not in medical danger he shall be handled by the police as in any other criminal case. If his health is in danger he shall be detained at an appropriate medical facility until the danger has passed, and he shall then be handled as in any other criminal case. Such security conditions shall be maintained as are commensurate with the seriousness of the offense.

"(c) The police shall make every reasonable effort to protect the health and safety of intoxicated persons, in accordance with the intent of this section. In situations where, at the recommendation of the medical officer in charge of a detoxification center, no charge is filed under section 25–128, no entry shall be made on the person's arrest or other criminal record. The registration and other records of a detoxification center and of the Bureau of Alcoholism Control shall remain confidential, and may be disclosed without the patient's consent only to Bureau personnel, to police personnel for purposes of investigation of criminal offenses and of complaints against police action, and to court personnel to determine whether a defense of chronic alcoholism may be available and for presentence reports; and with the patient's consent only to medical personnel for purposes of diagnosis, treatment, and court testimony, and to no one else.

"(f) The Bureau of Alcoholism Control shall promptly develop, in cooperation with the police, procedures for taking or sending an inebriate to a detoxification center or to his residence or to a public or private health facility by authorized Bureau personnel. It is the intent of Congress that the functions of the police under this section shall be reduced to a minimum in the shortest time possible.

"§ 6–1405. Diagnosis and Inpatient Treatment

"(a) A patient in a detoxification center shall be encouraged, on his first stay, to consent to an intensive diagnosis for possible alcoholism and to treatment at the inpatient and outpatient facilities provided for under sections 6–1403 (b) and (c) of this chapter. Any person may voluntarily request admission to this inpatient center, and no person committed under section 6–1407 shall take precedence over a person who voluntarily requests admission unless he is found by a court to endanger the public safety. The medical officer in charge of the inpatient center is authorized to determine who shall be admitted as a patient. A complete medical, social, occupational, and family history shall be obtained as part of the diagnosis and classification at the inpatient center, and an effort shall also be made to obtain copies of all pertinent records from other agencies, institutions, and medical facilities in order to develop a complete and permanent history on each patient. A person who has previously been diagnosed and treated at the inpatient center may again be admitted for further diagnosis and treatment at the discretion of the medical officer in charge of the center.

"(b) If a patient is not diagnosed as a chronic alcoholic he shall be so informed. An attempt shall be made to utilize appropriate preventive techniques, such as educating him about the seriousness of the illness and the dangers of excessive consumption of alcoholic beverages.

"(c) If a patient is diagnosed as a chronic alcoholic he shall be so informed. If he consents, intensive treatment for the illness shall begin immediately at the inpatient center while a comprehensive plan is being made for his future outpatient treatment.

"(d) No patient may be detained at the inpatient center without his consent except under the provisions of section 6–1407 of this chapter: *Provided,* That reasonable regulations for checking out of the center and for providing transportation may be adopted by the Bureau. Once a patient has checked out of the center against medical advice he may be readmitted at the discretion of the medical officer in charge of the center, and he may not be denied readmission because he left against medical advice.

"§ 6–1406. Outpatient and aftercare treatment

"(a) A chronic alcoholic shall be encouraged to consent to outpatient and aftercare treatment for his illness and rehabilitation at the types of facilities, and utilizing the broad spectrum of services, provided for under section 6–1403(c) of this chapter. Any person may voluntarily request admission to outpatient treatment, and no person committed under section 6–1407 shall take precedence over a person who voluntarily requests admission unless that person committed was found to contribute an immediate and continuing danger to the safety of another person, as described in section 6–1407. The medical officer in charge of the outpatient treatment is authorized to determine who shall be admitted to such treatment. There shall be one central outpatient treatment office which may be located in a mental health center or a detoxification center, to be open 24 hours every day, which shall coordinate the operation of all outpatient facilities, and particularly shall be responsible for locating residential facilities for indigent inebriates and alcoholics.

"(b) Because of the nature and seriousness of the disease, a chronic alcoholic must be expected to relapse into intoxication one or more times after the onset of therapy. No alcoholic shall be dropped from outpatient treatment because of such relapses, but all reasonable methods of treatment should be used to prevent their recurrence.

"(c) There are some chronic alcoholics for whom recovery is unlikely. For these, voluntary supportive services and residential facilities shall be provided so that they may survive in a decent manner.

"(d) The Bureau of Alcoholism Control shall be responsible, through its outpatient treatment programs, for coordinating all public and private community efforts, including but not limited to welfare services, vocational rehabilitation, and job replacement, to integrate chronic alcoholics back into society as productive citizens.

"(e) No patient shall be required to participate in outpatient treatment without his consent except under the provisions of section 6–1407 of this chapter: *Provided,* That reasonable requirements may be placed upon such a person as conditions for his participation in such treatment. Once a patient has withdrawn from outpatient treatment against medical advice he may be readmitted at the discretion of the medical officer in charge of outpatient treatment, and he may not be denied readmission because he withdrew against medical advice.

"§ 6–1407. Civil commitment

"(a) A judge of the District of Columbia Court of General Sessions may, on a petition of the Corporation Counsel on behalf of the Bureau of Alcoholism Control, filed and heard before the 72-hour period of detention for detoxification expires, order a person to be temporarily committed to the Bureau for inpatient treatment and care for a period not to exceed 30 days from the date of admission to a detoxification center if, sitting without a jury, he determines that the person (1) is a chronic alcoholic, and (2) as a result of chronic or acute intoxication is in immediate danger of substantial physical harm, and (3) is unable to make a rational decision about accepting assistance. A patient so committed shall be released by the Bureau, without the necessity of court permission, as soon as he is once again able to make a rational decision about accepting assistance, unless he chooses voluntarily to remain. He shall be encouraged to consent to further treatment and rehabilitation.

"(b) The courts in the District of Columbia are authorized and directed to take judicial notice of the facts set out in this chapter and to exercise their judicial responsibilities in a manner consistent with them. The courts shall commit to the Bureau for treatment and care for up to a specified period of time a chronic alcoholic who:

"(1) is charged with a misdemeanor and who, prior to trial, voluntarily requests such treatment in lieu of criminal prosecution; or

"(2) is charged with a felony and is acquitted on the ground of chronic alcoholism; or

"(3) is the subject of a criminal charge filed as provided in section 6–1404(c) and is found to be an immediate and continuing danger to the safety of another person in that he is likely to injure another person if allowed to remain at liberty.

"(4) *Provided,* that no term of commitment shall be ordered for a period longer than the maximum sentence that could have been imposed for the offense for which he was charged, but a patient may voluntarily remain for treatment for as long as the Bureau believes warranted.

"(c) Prior to the commitment of any person under subsection (b) the court shall, after diagnosis by the Bureau of Alcoholism Control, hold a civil hearing and must make the following findings:

"(1) The person is a chronic alcoholic; and

"(2) Commitment is for treatment that has a substantial possibility for success for the person and is not for custodial care; and

"(3) Adequate and appropriate treatment is available to the Bureau for the person; and

"(4) In the case of a person described in subsection (b)(3), he constitutes an immediate and continuing danger to the safety of another person in that he is likely to injure another person if allowed to remain at liberty.

"(d) The Bureau shall immediately inform the court whenever in its opinion any one of the findings required by subsection (c) is no longer applicable, or for any other reason the person should be released, and the court shall review the facts and enter an appropriate order. A committed person may, upon the expiration of 90 days following the commitment order, and not more frequently than every 6 months thereafter, request the Bureau in writing to have a current review of the required findings, and if the request is timely it shall be granted. The patient may, at his own expense, have one or more qualified physicians participate in the review or conduct an independent review. The Bureau shall, upon the written request of an indigent patient, assist him in obtaining a qualified physician to participate in the review, and such a physician shall be compensated for his services by the Bureau in an amount determined by it to be fair and reasonable. The Bureau shall report the result of its review to the patient. If the patient is not released as a result of this review he may petition the court for an order directing his release and the court shall consider all pertinent testimony and evidence and enter an appropriate order. Notwithstanding this right of review upon a patient's written request, the Bureau shall as often as practicable, but not less often than every 6 months review a patient's status under the required findings. Any right available to him for obtaining release from confinement, including the right to petition for a writ of habeas corpus, shall also be retained.

"(e) *Provided,* that no chronic alcoholic shall fail to be committed under subsection (c), and no person shall be released from commitment under subsection (d), if he is found to constitute an immediate and continuing danger to the safety of another person and if the Bureau has made a good faith attempt to comply with subsection (c)(3), but the likelihood that a person may become intoxicated and exhibit the usual characteristics of an inebriate does not constitute a threat to the safety of another person.

"(f) The Bureau may transfer a committed person who has been adjudged an immediate and continuing danger to the safety of another person from inpatient to outpatient status only with court permission. The Bureau may transfer any other committed person from inpatient to outpatient status, and any committed persons from outpatient to inpatient status, without court permission, but may not release a committed person without court permission. The Bureau shall make every reasonable effort to place a committed person on outpatient treatment, and to return him to the court with a recommendation for release, as quickly as is consistent with sound medical practice and with the safety of other persons.

"(g) If the respondent in any proceeding under this chapter does not have an attorney and cannot afford one, the court shall appoint one to represent him. Counsel so appointed shall be compensated for his services by the Bureau in an amount determined by the court to be fair and reasonable.

"(h) Neither mail nor other communications to or from a person committed pursuant to this section may be read or censored, except that reasonable regulations regarding visitation hours and the use of telephone and telegraph facilities may be adopted.

"(i) Upon instituting proceedings for the commitment of a person under this section the Bureau shall give him and his nearest known adult relative a written statement and explanation outlining in simple, nontechnical language the procedures and rights set out in this section. Upon commitment the Bureau shall give him and his nearest known adult relative a further written statement and explanation outlining all release procedures and other rights provided by this section as well as under other statutes and general legal principles.

"§ 6–1408. This chapter inapplicable to the mentally ill

"The provisions of this chapter shall apply to chronic alcoholics who have not been determined to be mentally ill. The handling of a chronic alcoholic who is also mentally ill shall be governed by the provisions of chapter 5 of title 21 of the D.C. Code.

"§ 6–1409. Retention of civil rights and liberties

"Any person treated under the provisions of this chapter shall retain his civil rights and liberties, including but not limited to the right not to be experimented upon with treatment not accepted as good medical practice without his fully informed consent, the right as an ill person to refuse treatment for an ailment that presents no danger to the safety of other persons, the right as a patient to maintain the confidentiality of health and medical records, the right as a person detained for medical purposes to receive adequate and appropriate treatment, and the right to vote.

"§ 6–1410. Contract with other agencies

"The Commissioners of the District of Columbia may contract with any appropriate public or private agency, organization, or institution that has proper and adequate treatment facilities, programs, and personnel, in order to carry out the purposes of this chapter.

"§ 6–1411. Alcoholism policy for District of Columbia employees

"(a) The Bureau of Alcoholism Control shall be responsible for developing and maintaining, in cooperation with other District of Columbia agencies and departments, an enlightened policy and appropriate programs for the prevention and treatment of alcoholism and the rehabilitation of alcoholics among District of Columbia employees consistent with the intent of this chapter. Employees of the District of Columbia afflicted with alcoholism shall retain the same employment benefits as other persons afflicted with serious illnesses while undergoing rehabilitative treatment, and shall not lose pension, retirement, or medical rights because of their alcoholism.

"(b) The Bureau shall also be responsible for fostering alcoholism rehabilitation programs in private industry in the District of Columbia.

"§ 6–1412. Alcoholism program in Department of Corrections

"The Bureau of Alcoholism Control shall be responsible for establishing and maintaining, in cooperation with the Department of Corrections, a program for the prevention and treatment of alcoholism and the rehabilitation of alcoholics in correctional institutions.

"§ 6–1413. Alcoholism program for juveniles

"Because of the increasing public concern about intemperance, intoxication, and incipient alcoholism among juveniles, the Bureau of Alcoholism Control shall be responsible for establishing and maintaining, in cooperation with the schools, the police, the courts, and other public agencies, an effective program for the prevention of intemperance and alcoholism, and the treatment and rehabilitation of incipient alcoholics, among juveniles and young adults.

"§ 6–1414. Reports of the Bureau

"(a) The Bureau of Alcoholism Control shall submit an annual report to the director of public health, which shall be forwarded to the Commissioners and shall be made public.

"(b) The Bureau shall maintain a continuing evaluation of its programs and shall conduct pilot and demonstration projects to improve its programs, and shall from time to time submit to the director of public health and to the Commissioners such recommendations as will further the rehabilitation of chronic alcoholics, prevent the excessive and abusive use of alcoholic beverages, and promote moderation.

"(c) The Bureau shall prepare and publish materials, data, information, and statistics that relate to the problems of intoxication and alcoholism in the District of Columbia and that may be used in a program of public education directed toward the prevention of the excessive and abusive use of alcoholic beverages.

"§ 6–1415. Alcoholism advisory and consulting committees

"(a) The Commissioners shall appoint an alcoholism advisory committee, to consist of five qualified residents of the Washington metropolitan area who have knowledge of and an interest in the subject of alcoholism, to

advise and consult with them and to assist them in carrying out the provisions of this chapter. This committee shall be maintained as a separate advisory committee, with responsibilities solely in the field of alcoholism. The members of the committee shall elect the chairman of the committee, who shall serve a one-year term but may be reelected. The members of the committee shall serve without compensation for terms of five years, staggered so that one vacancy occurs each year, and may be reappointed. The committee shall meet at regular intervals with the Commissioners and representatives of the Bureau of Alcoholism Control, the judiciary, the Departments of Corrections, Probation, Vocational Rehabilitation, and Public Welfare, the Board of Parole, and such other agencies as may become involved in a total community effort to control intoxication and alcoholism.

"(b) Upon the recommendation of the alcoholism advisory committee, the chairman of that committee shall appoint one or more technical consulting committees from experts throughout the country to assist in making certain that the District of Columbia has the best possible programs for alcoholism care and control."

TITLE IV—COMPREHENSIVE INTOXICATION AND ALCOHOLISM CONTROL PLAN

SEC. 401. (a) The Bureau of Alcoholism Control shall immediately develop a detailed and comprehensive intoxication and alcoholism control plan (the "plan") for the District of Columbia to implement the objectives and policies of this Act. The plan shall be submitted to the Secretary of the Department of Health, Education, and Welfare (the "Secretary") as soon as possible, but not later than six months after the enactment date of this Act.

(b) The Secretary shall promptly review the plan and must approve it before it becomes effective. The Secretary may, as part of his review, consult with the Bureau and with other public and private District of Columbia departments, agencies, institutions, and organizations, and may work with the Bureau to revise the plan prior to approval.

(c) Notwithstanding subsections (a) and (b) the Bureau shall proceed to implement title III of this Act as quickly, efficiently, and effectively as possible under an interim program pending approval of the final plan. As soon as the plan is approved all efforts shall be directed to implementing it.

SEC. 402. (a) The Bureau shall, in developing this comprehensive plan, consult and collaborate with appropriate public and private departments, agencies, institutions, and organizations in the District of Columbia, including but not limited to the following: the Departments of Corrections, Occupations and Professions, Recreation, Licenses and Inspections, Vocational Rehabilitation, Insurance, Veterans Affairs, and Public Welfare, the Board of Parole, the Office of Urban Renewal, the Court of General Sessions, the Board of Education, the United States District Court, the AFL–CIO, the Metropolitan Police Department, the Commissioner's Youth Council, the Juvenile Court, Saint Elizabeths Hospital, the Alcoholic Beverage Control Board, the Civil Service Commission, the Commission on Mental Health, the Veterans' Administration, the bar associations, the medical associations, the psychological associations, District of Columbia General Hospital and all other public and private hospitals, health and life insurance companies, the Salvation Army and other community missions, Alcoholics Anonymous, the United Planning Organization, the United States Employment Service for the District of Columbia, the National Capital Housing Authority, the Neighborhood Legal Services Project, the Legal Aid Agency, the clergy, the Judicial Conference, and the Washington, District of Columbia, Area Council on Alcoholism and other voluntary community health and welfare agencies. The plan shall specify how these and other resources are to be utilized. The Bureau shall also utilize to the fullest extent possible in preparing the plan the expertise of the National Center for Prevention and Control of Alcoholism.

(b) The plan shall be coordinated with and integrated into the District of Columbia planning under the Comprehensive Health Planning and Public Health Services Amendments of 1966, the Mental Retardation Facilities and Community Mental Health Construction Act of 1963, and the report on Comprehensive Mental Health Services in the District of Columbia.

(c) The plan shall make every effort to utilize funds, programs, and facilities authorized under current Federal legislation, and shall specify the extent to which such legislation may be utilized, including but not limited to the following Acts as amended: Vocational Rehabilitation Act, Manpower Development and Training Act, Older American Act of 1965, Law Enforcement Assistance Act of 1965, Health Research Facilities Act of 1956, Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, Heart Disease, Cancer, and Stroke Amendments of 1965, Health Professions Educational Assistance Act of 1963, Hospital and Medical Facilities Amendments of 1964, Social Security Act, Community Health Services Extension Amendments of 1965, Economic Opportunity Act of 1964, Comprehensive Health Planning and Public Health Services Amendments of 1966, Elementary and Secondary Education Act of 1965, Highway Safety Act of 1966, the civil service laws, and laws providing for the treatment and discharge of members of the Armed Forces and the support and treatment of veterans of the Armed Forces.

TITLE V—EFFECTIVE DATE

SEC. 501. Titles II and IV of this Act shall become effective immediately.

SEC. 502. Title II of this Act shall become effective no later than three months from the date of enactment of this Act.

MIND-ALTERING DRUGS AND DANGEROUS BEHAVIOR: ALCOHOL [1]

by Richard H. Blum

assisted by Lauraine Braunstein

Contents

Drug Class: Alcohol. Specifically—distilled spirits, wine and beer, and other prepared beverages which contain alcohol as well as other ingredients.

Distribution. The distribution of alcoholic beverages is worldwide, although there are cultural pockets where no alcoholic consumption occurs or where drinking is forbidden even though it may occur (as in Moslem countries, India, prohibition regions in the United States). The use of distilled spirits is presently associated with the presence of technological society or urban centers in underdeveloped countries.

EXTENT OF USE

In the case of alcohol use, unlike the situation with other drugs, we are fortunate to have recently completed national survey data on drinking practices which allow excellent estimates of who drinks how much in the United States. There are also a number of supplementary studies which provide information about local variations in use and about user characteristics. There is general agreement among these studies about the extent of use by various population groups, the details of which will be presented in the discussion of user characteristics. From a methodological standpoint it is necessary to realize that descriptions of use will vary for alcohol as with other drugs depending on whether one measures the frequency of either drinks or drinking occasions, the prevalence of drinkers (how many persons admit to drinking), the amount drunk by occasion, the kinds of alcohol used, or the timespan to be covered during the period covered by the inquiry. When one is interested in identifying drug abuse, in this case problem drinking or alcoholism, measurement becomes more complex as we shall note in the discussion of user characteristics.

On the basis of the work of Cisin and Cahalan, who have done a national study (1966).[2] It can be said that 68 percent of all American adults have had at least one drink within the past year. Twenty-two percent of the population report they have never tried an alcoholic bev-

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[1] This is one of four papers prepared by Dr. Blum in collaboration with others on mind-altering drugs and dangerous behavior. The introduction to the series appears in the paper on dangerous drugs in the appendix to the Task Force Report on Narcotics and Drug Abuse. The other two papers also appear in that appendix.

[2] References are listed at the end of the paper.

erage. With reference to alcoholism, detailed estimates of which appear in the next section, the number of Americans who are alcoholics probably ranges between 4,500,000 (by the Jellinek formula, Jellinek, 1959) and 6,800,000 escapist heavy drinkers (Cisin and Cahalan). The "actual" number of alcoholics may be less or greater than the foregoing range, depending on the definition of alcoholism employed and the estimation method.

In regard to estimates of drinking prevalence among children there are no national studies. A number of excellent local surveys have been done. Maddox (in Pittman and Snyder, 1962) reviews those describing high school age drinking and finds that estimates of high school use—at any frequency—range from 3 in 10 students (Utah, Michigan) to 8 in 10 (New York). Low alcohol content beverages such as beer and wine are most typically consumed and frequent use is rare. Maddox suggests that the range of teenagers having one drink or more a day is between 2 and 6 percent. Straus and Bacon review college age drinking findings. Patterns vary by college but combining data from a number of colleges (Straus and Bacon, 1953) they arrive at an estimate of less than half of the students drinking more than once a month, fewer than one-fifth of the men and one-tenth of the women drinking more than once a week. Alcoholism as such does not ordinarliy occur among youth.

It must be kept in mind that the extent of use varies considerably over time. For example, it is estimated (Jellinek, 1959) that a century ago most Americans were either heavy drinkers or abstainers; the drink of choice being distilled spirits. Present drinking is more extensive but also more moderate; beer and wine now account for more than half of the per capita consumption (Leake and Silverman, 1966). As our population and society change, alterations in the extent of alcohol use must continue to be expected.

CHARACTERISTICS OF USERS

BACKGROUND CHARACTERISTICS

Differential drinking patterns occur among various groups. On the basis of the national Cisin and Cahalan study it is found that the largest proportions of drinkers are among males, younger persons in their twenties and thirties, and among people of higher socioeconomic status. Among young well-off males 88 percent drank. In contrast among poor, old women only 34 percent have had a drink during the year prior to interview. Regional differences in drinking occur: New England and Middle Atlantic States having the highest proportion of drinkers, the east south central region the lowest. Religious differences also obtained: Jews, Episcopalians, Catholics, and Lutherans drank more than Baptist and other anti-alcohol religious groups.

Cisin and Cahalan show a marked difference between the characteristics of drinking groups as such and the groups composed of persons who are heavy drinkers and also the groups that are "problem" drinkers. Using a complex drinking measurement method which included frequency of drinking, amount drunk per occasion, and the variability in drinking, they found that heavy drinking takes place among persons of low socioeconomic status, especially older men and in particular ones of Puerto Rican or Latin extraction, Negroes, and Protestants not affiliated with churches, and among service workers. Heavy drinking occurs most often among big city dwellers and in the more urbanized regions of the country. The investigators call attention to the fact that the heavy drinkers are found among groups with overall low rates of drinking (e.g., fundamentalists) meaning that moderation is not the drinking style, but rather either high or low extreme drinking patterns prevail. That is the same pattern of extremism that characterized last century's U.S. drinking and which allowed temperance workers to describe a high rate of alcoholism for those who did drink. It is noteworthy that the contemporary high-risk groups are not socially integrated into the American moderation mainstream which has developed during this century, especially after prohibition. As these groups are successfully integrated into American life—which is the historical pattern for urban immigrants—their second and third generation offspring should show moderate drinking and reduced alcoholism risk. Such "integration" not only aims at reducing the strains associated with vulnerability to drug abuse, but at learning cultural techniques of moderation in alcohol use per se, this necessarily resting upon a more cohesive family life in which drinking as well as other conventional behavior can be transmitted.

In other as yet unpublished findings, kindly made available to the Commission by Cisin and Cahalan, it is seen that heavy drinking occurs most often among dwellers in the big cities, and that the prevalence of heavy drinking varies for persons in interaction with such factors as sex, single and divorce status, religion, activities, age at first drinking, separation from parents as a child or adolescent, and—for women only—a felt sense of being a nonparticipant in or not sharing community values (anomie scale). The results suggest that when males have begun drinking early (outside of the family), have been separated from one or both parents as children, have been "active" Catholics or, as older persons, Protestant fundamentalists, one or more out of every three such persons runs the risk of being a heavy drinker. It is among heavy drinkers that all involved and also escape problem drinkers are to be found.

Among the 12 percent of the total population classified as heavy drinkers, 6 percent were found to be escape-oriented heavy drinkers or problem drinkers. Not all of these are alcoholics as such. These escapist drinkers were older, of lower socioeconomic status and included more than an expected number of Negroes. They were people not well integrated in society. They were also people who worried about their drinking, who said they had more than their share of problems, who had unhappy childhoods, who claimed poor health, and who were dissatisfied with their achievements in life.

Cisin and Cahalan asked people what they did to relieve tension and anxiety. They found first, on a scale meas-

uring tension, worry, depression, and the like, that women reported being more upset than men and that persons in lower socioeconomic situations had more tension than upper level people. When men are upset they say they drink; women use tranquilizers or other pills more often (as noted in another section of this report). Generally, low status persons use more drugs and smoking—as well as eating—to relieve tension. In discussing their findings the authors observe that (social) drinking is an approved behavior among groups high in the power structure but that escape drinking is permitted, at least in the sense that others are indifferent to it, in low power groups.

The Cisin and Cahalan work is the basic national study. From other local inquiries one affirms that there are clear drinking pattern differences between ethnic groups (Knupfer and Room, 1966), for example between Irish Catholics (high), Protestants (middle), and Jews (low drinking rate) (Skolnick, 1954), that women drink less than men (Knupfer, Fink, Clark, and Goffman, 1963), that younger people drink more than older but that heavy drinkers are older (Knupfer et al., 1963), that frequency of drinking increases with family income, and that variability in drinking behavior is greater within the lower income groups than within higher income groups (Knupfer et al., 1963). It has also been found that expressed attitudes toward drinking are associated with actual drinking patterns (Knupfer et al.), that drinking to escape or relieve tension is associated with heavy drinking, that alcohol dependence is highly correlated with heavy drinking, and that emotional distress is related to heavy drinking only when the motivation of escape is offered by the drinker; that is, escape heavy drinkers do report other emotional distress, nonescape drinkers do not. So it is that problem drinking must be linked to escape motivation as well as to amount of alcohol used. Heavy drinking by itself does not mean that any psychological or social problems are present; it is often just part of a middle and upper class male way of life. The authors (Knupfer et al., 1963), wisely note that "behavior is influenced, not determined, by social pressures."

Clark (1966) in unpublished material, kindly made available for use by the Commission, has attended to alcoholism in a study of a western city. He suggests that alcoholism definitions share four elements: Excessive intake, mental disturbance due to drinking, disturbed social and economic behavior, and loss of control over drinking. Constructing a measure which includes all these items, he found among a representative adult city dweller sample that alcoholism prevalence varies depending on the kind of index constructed but that by any measure men are more often alcoholic than women. Women and men were more nearly equal in the matter of using alcohol to excess in coping with tensions, but men much more than women were likely to get into trouble with other people and with public agencies, for example the police. Plaut, in an unpublished paper (1965), has set forth an alternative complex definition for alcoholism; his key point is social behavior, not drug ingestion per se, as the criteria for the judgment of alcoholism (or drug abuse as such). Plaut describes the steps to the development of drinking behavior as these can be derived from epidemiological and clinical studies; the period from beginning drinking to identification as an alcoholic takes from 9 to 15 years, with alcoholism usually emerging between the years of 35 and 55.

How children are introduced to drinking depends upon the ethnic group of which they are members, and on the correlated fact of the cohesiveness of families and the extent to which families "teach" drinking behavior. Most studies are in agreement (Plaut, 1965; Knupfer et al., 1963) that within the United States, Italian, Greek, and Jewish families introduce their children to wine—and other mild beverages—early in life and as part of family dining or in religious rituals and festivals. Irish and Yankee offspring begin their drinking later in adolescence, more often use hard liquor, more often do their drinking outside of the home, and learn to attach different significance to drinking as such. When these findings for groups within the United States are combined with a number of cross-cultural studies (Child, Bacon and Barry, 1965; Blum and Blum, 1964; Sadoun, Lolli, and Silverman, 1965; Jellinek, 1960; Leake and Silverman, 1966) a very consistent picture is presented. When drinking is part of an institutionalized set of behaviors which include important other people in roles of authority and when drinking is part of ritualized or ceremonial activities (e.g., family meals, festivals, religious occasions, etc.) as opposed to leisure time or private use, it is not likely to be associated with high individual variability (unpredictability, loss of control) in conduct nor with the growth of drug dependency nor with the judgment by observers of "abuse" or "alcoholism." Further, when parents themselves reflect safe or model drinking behavior (i.e., are not problem drinkers), when drinking occurs shortly before or with food taking, and when the drinks used are wine or beer, the risks of either long- or short-term adverse effects are quite slim. Adverse effects nevertheless can still occur.

Plaut, in a careful review of epidemiological work (1965, unpublished) examines various estimates of alcoholism prevalence in the United States. The best known method is based on the Jellinek formula (Jellinek, 1959) which in turn rests on cirrhosis liver deaths per annum. That formula, although subject to later criticism by Jellinek himself (see also Leake and Silverman, 1966), remains an estimation device which is still of considerable usefulness according to Keller (Keller, M., in Pittman and Snyder, 1965). The Jellinek formula, as applied recently by Keller in 1960, gives an estimated 4½ million alcoholics in the United States. Most critics of the Jellinek formula contend that it underreports alcoholism. Plaut reviews the local and regional studies which compare other casefinding methods with the Jellinek estimation and finds that these either support the Jellinek estimate or, as critics anticipated, yield higher rates. Some of the higher regional rates show nearly twice as many alcoholics as would the Jellinek formula, for example rates of 43 per 1,000 as opposed to about 25 per 1,000. Bailey, Haberman, and Sheinberg (1966) in a New York City study obtained an initial rate of alcohol-

ism of 19 per 1,000 for adults, but found that the survey method led to underreporting. Changes over time in individual reporting also occurred, but these tended to cancel each other out so there was no major rate change. The highest rates for alcoholism were among men as opposed to women, among divorced or separated males (68 per 1,000) among Negro fundamentalists (40 per 1,000), and among poorly educated persons (33 per 1,000). Alcoholics were found to be more emotionally upset, to be poorer, to have greater occupational and residence mobility, and to have more illnesses. Regarding illness, Ullman and Urbanowitz (1958) have shown that alcoholics are much more likely to have tuberculosis than would be expected. Alcoholic tuberculars compared to other TB cases are less well educated, have less satisfactory job histories, and have more disrupted marriages. An unpublished work by Newman confirms other findings of higher alcoholism rates among men, middle-aged people, divorced males, metropolitan dwellers, and lower class persons, especially the unemployed. Newman also finds their rates of death from cardiovascular disease and accidents to be higher than for nonalcoholics. An unpublished Frontenac County survey cited by Plaut reveals a rate of alcoholics of 21 per 1,000, with middle-aged persons (37 per 1,000), city dwellers (17 per 1,000), divorced males (90 per 1,000), poorly educated and unskilled males having the highest rates. A San Mateo County, Calif., study (unpublished, 1966) yields a rate of 50 per 1,000, which is the same as the Jellinek estimate for that wealthy suburban region. A study of correlates of problem drinking in industry (Warkov, Bacon, and Hawkins, 1965) shows alcoholic workers to be low status, poor performing workmen.

SUMMARY OF BACKGROUND CHARACTERISTICS

Alcohol use is greatest among well-educated younger males. Alcohol abuse (alcoholism, problem drinking, involved or escapist drinking) is centered in poor metropolitan populations, particularly in older males, Negroes, and those of Latin extraction, persons who are divorced, badly educated, with low occupational status. Fundamentalists and Catholics are overrepresented.

CHARACTERISTICS OF USERS: PERSONALITY

Studies of personality in relation to alcohol use have mostly been confined to the clinical cases which come to the attention of psychiatrists and psychologists in treatment or incarceration situations. Such studies do not usually have the chance to compare these identified cases with heavy drinkers as such; the kind of comparisons which are built into the survey studies of Cisin and Cahalan, or of Knupfer and her colleagues. Clinical population studies also suffer from the fact that alcoholics who come to the attention of clinical professionals have usually been drinking for years, many of them being chronic cases. Their common experiences in drinking—and the common long-term effects of that drug—lead to similarities in behavior which may not be due to any prealcoholic personality traits. The study of such persons is difficult because chronic alcohol use masks what may be underlying traits. An additional problem is that findings are often predicated on theroetical expectations, for example that alcohol abuse is associated with dependency so that dependent personalities are then identified. Other methodological deficiencies that have plagued clinical studies of all types of drug dependent persons include small sample studies without statistical tests of the data, failure to control experimenter bias, and lack of reliability shown for diagnoses employed.

It can also be awkward trying to divorce the personality traits of individuals from the social environments in which these personalities have emerged. We may infer from the survey studies of Cisin and Cahalan, from the work of Knupfer and her colleagues, and from the other studies cited that "involved" or "escapist" heavy drinking, or alcoholism otherwise defined, is most frequent among poor and disadvantaged city dwellers who see themselves as failures—which is as others see them too. These suffering souls report themselves, in contrast to nonproblem drinkers, as more unhappy and as having more personal problems. The feelings of misery so common in that group of socially maladjusted persons are very likely to be reflected on diagnostic measures as one or another kind of psychopathology. Review of clinical reports finds that to be the case (Jones, unpublished, 1965). This is not to say that chronic drinkers are not psychopathological; to the contrary their backgrounds and presenting symptomatology (alcoholism) almost demand such a diagnosis. So it is that Jones (1965) in her review of prior work, summarizes as "well worn" the following descriptions of alcoholics: Restless, angry, insecure, depressed, conflicted, anxious, deeply guilt ridden, lacking in self-esteem and self-assertion with emotional instability, low frustration tolerance, and high but unfulfilled aspirations. One cannot know, on the basis of most of the present work, whether the same descriptions would have been offered had well-designed observations been made during the early years before these patients or inmates—and their cohort controls—either began to drink, or after they began drinking, before they became identified as alcoholics.

Two longitudinal studies throw a little light on the childhood characteristics of persons who later develop alcoholism compared to their peers who do not. The McCords (1962) did an after-the-fact study using records of children described as part of the Cambridge-Somerville youth study. A search found 29 boys who had become alcoholics to compare with 158 from the same neighborhood who had become neither alcoholic nor criminal. Compared to these latter, the alcoholics had been described when they were children as more "self-contained," outwardly more self-confident, indifferent toward their siblings, disapproving of their mothers, more unrestrained in their aggression, and more anxious about sex. These findings, limited as they were by the nature of the original records, do not indicate any earth-shaking differences. They do suggest that psychological differences exist to predispose one but not another person to later alcoholism. A more extensive study by Mary Jones (unpublished,

1965) followed up normal public school children over a 30-plus-year period. In their forties their drinking behavior was observed. Done in a metropolitan area, nearly half of the men and more than one-third of the women were heavy drinkers (every day). Less than 10 percent did not drink. As adults, the problem drinkers were aggressive, attention seeking, acting out, socially extroverted, lacking impulse control, resentful of authority, and lacking feelings for others; power-seeking and self-destructive impulses were also noted. At the other extreme, abstainers were lacking in social poise, the males were more feminine, and they were rigid and self-righteous. When they were children, the persons now defined as problem drinkers had mothers who were indifferent or rejecting and lived in families that lacked warmth and understanding. From early life they had more tensions, less satisfactions, and fewer ways of handling life difficulties. Moderate drinkers, compared either to problem drinkers or to abstainers, were better adjusted children, adolescents, and adults. The Jones study has the advantage of comparing nonclinic cases of adults showing a range of drinking behavior. It shows that persons who become problem drinkers could be distinguished from others on psychological traits and family circumstances as children. It also calls attention to the other extreme of drug behavior, alcohol abstinence, finding that abstainers also have—in a metropolitan "drinking culture"—more maladaptive personality features than do moderate drinkers.

As is the case with any study of a specially selected population, the differences observed in the longitudinal work between problem drinkers and others cannot be generalized to all alcoholics. These studies, when combined with the more usual clinical observations, do reinforce the notion that personality problems precede problem drinking for at least some portion (what Jellinek called the "alpha species") of the alcoholic population. Using this finding as an hypothesis for experimental studies, some exciting recent research by Karp, Witkin, and Goodenough (1965) shows that personality factors related to ways of perceiving the world ("field dependent" versus "field independent") are stably related to differences between alcoholics and others. Such studies, along with advances in the personality research areas of cognition, perception, and psychophysiology in predicting individual drug responses, suggest that better understanding of the role of personality and perhaps neurophysiological structures as predisposing to alcoholism will be forthcoming in the next decade.

There is an understandable desire among scientists and clinicians to identify single variables or common constellations as determinants of alcoholism or of other types of drug dependency. On the other hand, given the millions of people who become alcoholics under differing circumstances of use and presumed motivation, it is not likely than any one factor will be found to be the predisposing or necessary personality trait or psychodynamic constellation. Syme's review (1957) comes to the same conclusion, "there is no warrant for concluding that persons of one type are more likely to become alcoholics than persons of another type." Jones (1965), with Armstrong (1958), is more optimistic, subscribing to the possibility at least of identifying common personality disorders or psychodynamic features predisposing to alcoholism among various subgroups defined by bisocial characteristics.

SUMMARY OF PERSONALITY CHARACTERISTICS

Observations on clinical or offender populations are in general agreement that alcoholics suffer personality disorders. These disorders are thought to be the consequences of alcohol use itself but themselves to be predisposing to alcoholism. Several limited before-and-after (longitudinal) studies offer some support for that expectation. It does not seem likely that any one personal characteristic is necessary before alcoholism can occur. It is likely that among various subgroups (age, sex, ethnic, socioeconomic class, etc.) with equivalent life experiences and exposure to alcohol use that those who become drug dependent will more often than their better adjusted peers show preexisting as well as alcohol-caused personality defects. One cannot conclude that personality disorders must exist in order for alcoholism to occur; one can propose that among populations subject to high risk of alcoholism many disordered personalities will be found and that the specific expression of their disorder (crime, psychosis, drug dependency, etc.) will be associated with psychodynamic factors.

THE DISEASE CONCEPT OF ALCOHOLISM

Jellinek, the acknowledged dean of alcohologists, has proposed that alcoholism is best understood as a disease, one in which various body systems are progressively involved, and one in which the etiology varies depending upon the alcohol-use syndrome presented by the alcoholic. These syndromes (a group of signs and symptoms appearing together and associated with etiology and prognosis as well as being prime diagnoses) are referred to by Jellinek (1960) as "species." They include "alpha alcoholism" which is characterized by "a purely psychological continual dependence * * * to relieve bodily or emotional pain." Alpha drinking is not associated with loss of control nor is there any progressive process. "Beta alcoholism" occurs where there are organic complications (cirrhosis, polyneuritis, etc.) but where dependence is either physical or psychological; drinking may occur as a result of group customs; withdrawal symptoms do not appear. "Gamma alcoholism" involves tolerance to alcohol (need for increasing dosage), adaptive cell metabolism, withdrawal symptoms and craving, and loss of control over the amount of drinking. It is progressive disorder moving from psychological to physical dependency; it is the species of use leading to the greatest damage to health and interpersonal relations. Jellinek sees gamma alcoholism as the predominant type in the Anglo Saxon countries. "Delta alcoholism" is like gamma, but

instead of loss of control of the amount of intake on any given occasion, there is inability to abstain even for a day or two without withdrawal symptoms appearing. "Epsilon alcoholism" is periodic alcohol overuse as in "dipsomania." The Jellinek classification is one of drinking patterns, progression, and effects; one assuming a disease process, but not assuming a common psychological substrate. Only the alpha species implies that initial psychological addiction involves dependency and relief of emotional (or physical) pain. Jellinek himself concludes that all psychological formulations attributing alcoholism to underlying personality pathology are limited to the alpha species.

His contention is that these formulations do not recognize that psychological vulnerability can be minor but that cultural or socioeconomic factors lead to drinking and the alcohol itself leads to the observed effects. It is a point well made, for with large and frequent alcohol intake, for whatever reasons, exposure to the risk of dependency (or addiction) becomes great. As alcohol use continues, it can produce liver damage and reduced adrenocortico (stress) responsiveness.

Chronic use is strongly associated with nutritional deficiencies—since alcohol supplies calories but not nutritional needs—and these deficiencies lead to diverse organic pathology (Leake and Silverman, 1966). Much cirrhosis, for example, may be attributable to nutritional deficiency in combination with alcohol toxicity. In any event the direct toxic effects of alcohol plus the associated consequences of an alcohol-centered life style (insufficient food, exposure to trauma, etc.) are productive of further disorder; Jellinek suggests that this vicious circle leads to further (defective) alterations in central nervous system functioning. There is also further reduction in the capacity of the liver to detoxify alcohol and, Jellinek hypothesizes, additional susceptibility to neural tissue degeneration and to uptake of alcohol as part of cell metabolism, a process biochemically intrinsic to physical dependency and demonstrated, in vitro, for morphine.

If genetic or preexisting illness factors account for initial organ or metabolic deficit, then stress due to alcohol can be less well handled and a quicker addictive process (i.e., a faster disease progression) is to be expected. Similarly, on the basis of a growing literature showing how stress responses are interrelated, it can be expected that chronic environmental stress (as in crowding, continual threat, heavy noise levels, hostile interpersonal relations) may predispose an organism to reduced capabilities (defined physiologically and endocrynologically as well as in terms of performance) under a new stressor. If one conceives of the life of the metropolitan poor as heavily loaded with such environmental stress (a reasonable hypothesis which also relates to population rates for many other diseases), and if one conceives of continued alcohol ingestion (regardless of the circumstances or motives associated with initial or developing use) as a stress, then the risk of alcohol addiction for such exposed populations is better understood.

USER CHARACTERISTICS: GENERAL SUMMARY

In the United States, since the majority of persons drink alcoholic beverages, use itself is normal, and persons with widely differing personal and social characteristics employ—and enjoy—the drug (wine lovers naturally prefer for wine to be called a "food"; others prefer it to be called only a beverage). Heavier alcohol use without frequent problem drinking is concentrated in well-off younger males; heavy use itself does not imply an alcohol problem. Alcoholism as such is concentrated among the poor and disadvantaged older males in metropolitan areas, most often persons with histories of work and family troubles and with personality defects. After alcohol use has begun, especially among persons who have not learned to use it in family settings and where use is unusual among the person's social peers, a chain of events leading to dependency or sporadic problem drinking can be set in motion. These events include the discovery by the drinker that he can relieve his emotional tensions and "escape" through alcohol, or he may find that physical pain relief or simply the prevention of withdrawal symptoms (the "abstinence syndrome" of opiate users) can be prevented through further alcohol use. Alcohol itself, perhaps in combination with preexisting or associated psysiological disorders, plays a role as a disease or toxic agent, being capable of producing further metabolic and tissue pathology as well as disordering personality and social relations. The social background, residential, and psychological characteristics of persons with alcohol problems are very similar to the features of persons who suffer high probabilities of other forms of medical or mental health disturbance, and who, as groups "at risk," challenge the Nation with high rates of crime, welfare needs, unemployment, and the abuse of mind-altering drugs other than alcohol.

Emphasis on the association between alcoholism and general misery should not let us overlook that alcoholism can also occur among the better off citizenry and that it is not just a disease of the poor.[3]

ALCOHOL EFFECTS

As with any powerful mind-altering agent with a long history of use, there are beneficial and adverse effects attendant upon alcohol ingestion. Leake and Silverman (1966) provide an excellent summary of the therapeutic benefits derived from alcohol as well as its acute and chronic toxic effects. Therapeutically it is valuable as a tranquilizer and sedative, as a (controlled) potentiating agent for narcotics, barbiturates, and tranquilizers, as a food for nutritional use, in the treatment of disorders of appetite, obesity, diabetes, nutritional deficiencies, cardiovascular disease and, to a lesser extent, with other disorders. Its beneficial social and psychological effects, including tension reduction, social interaction facilitation, and direct euphoria, are better known.

The effects of alcohol, as with other mind-altering drugs, depend upon the circumstances of use, past drug

[3] Blane, H. P., Overton, W. F., and Chafetz, M. E., in a Boston study found that physicians were more likely to diagnose alcoholism (i.e., identify it) when the patient was a skid-row derelict or obvious social misfit than when the patient was well-groomed, lived with his spouse, and had no police record. Thus there is a danger of "false negatives" in identification which arises from the association between alcoholism and social misery. A "false positive" danger also exists, for not all skid-row types are alcoholics. Straus and McCarthy (1951) showed that only 43 percent of New York's Bowery homeless men were alcoholics.

experience and personality of the individual, concurrent physiological status, dosage per body weight, rate of absorption (in turn dependent upon simultaneous food use, the other constituents of the alcoholic beverage employed, and the condition of the stomach and intestine) and the rate of excretion and detoxification. Route of administration matters as well, but since alcohol is usually taken by mouth this factor does not affect most calculations. In considering acute effects, blood alcohol levels are most clearly associated with its effects. For example at blood levels of 0.20 percent, depressed sensory and motor functions are marked, and loss of some social control occurs. At 0.50 percent drunkenness occurs, at 0.60 percent unconsciousness, and at 0.70 percent death. There are, of course, individual variations in this picture. A later effect, occurring several hours later and in conjunction with lowered blood sugar levels, is the well-known hangover, the causes of which are unknown (Leake and Silverman, 1966).

The prediction of chronic adverse effects is more difficult, for these are interrelated, as we have discussed, with nutrition, exposure to stress, and a variety of other social and physiological circumstances. Alcoholism itself is associated with earlier than expected deaths and a high frequency of cardiovascular disease, tuberculosis, and cirrhosis of the liver. Accidental deaths will also occur at a higher than average rate, these frequently involving persons other than the drinker. We shall discuss in more detail below the high risk of the alcoholic as perpetrator and victim in accidents, suicide, and crime.

Attention to the acute physical effects and chronic social and physical consequences should not allow us to overlook the adverse social effects arising from either occasional or frequent use when no alcoholism as such is present. One of the best illustrations of these hazards comes from a study of college drinking (Straus and Bacon, 1962). Alcoholism, because it takes some years to develop, is not found in college youth, but social complications and psychological distress do occur, most often among those drinking the most. On the basis of a questionnaire study, Straus and Bacon report that 17 percent of the men and 8 percent of the women have failed in a social obligation because of drinking, 11 percent of the men and 8 percent of the women have suffered damaged friendships because of alcohol, 4 percent of the men and 1 percent of the women have had an accident or injury attributable to drinking, and 2 percent of the men have experienced formal punishment or discipline (including arrest, expulsion, etc.) because of drinking. These foregoing are essentially progressive troubles; that is, the 2 percent disciplined are part of the 4 percent with accidents and part of the 11 percent with disrupted friendships. It is to be noted that 17 percent of the men and 10 percent of the women reported anxiety over their drinking, fearing dependency. Jellinek (1960) gives as warning signs of progressive alcoholic disease the presence of blackouts, getting drunk when alone, early morning drinking, and being aggressive or destructive when drunk. Given the collegians' fears about their drinking future, it is interesting to learn that 18 percent of the men had had blackouts, 13 percent of the men had become drunk when alone, 16 percent of the men had drunk before or instead of breakfast, and 11 percent had behaved destructively at least once when drunk. Eight percent of the males reported two or more of these warning signs as did 1 percent of the females.

ALCOHOL EFFECTS: GENERAL STATEMENT

The evidence is overwhelming that alcohol use is strongly associated with both acute and long-term adverse physical effects, and with acute and long-term adverse social and psychological ones. Because of the high prevalence of alcohol use, the resulting frequency of adverse effects will also be great. On the other hand, its neutral or benign effects—socially, psychologically, and medically—are preponderant.

ALCOHOL AND SUICIDE

From a theoretical as well as a factual standpoint, excess alcohol use has been linked to suicide. Psychiatric formulations emphasize the self-destructive component among depressed persons, "depression" in turn being a diagnostic feature of an unknown, but likely high, number of alcoholics. Karl Menninger (1938) has considered alcoholism itself as a form of "chronic suicide," a view that implies the exposure to toxic effects and social degradation is a willful—even if unconscious effort—at slow self destruction. Sociologists, since the work of Durkheim linking suicide with apartness from the mainstream of social life and values (anomie), have emphasized the risk of suicide in persons whose life patterns show them to be unaffiliated, cast off, or otherwise unintegrated with important groups of other people. Finally, Shneidman has emphasized among other possibilities the link between suicide and other kinds of awareness—eliminating or forestalling behavior in anticipation of pain. Shneidman suggests that drug use, and by extension alcoholism, can have this cessation-seeking character.

The practical man's question is, are the links present which the theoreticians propose to exist between alcohol and suicide? The answer is "Yes." Palola and his colleagues (Palola, Dorpat, and Larson, in Pittman and Snyder, 1962) have shown in a study of Washington State attempted suicide cases that 23 percent were alcoholics at the time of hospital admission and that 31 percent of the completed suicides were alcoholics. These figures are, the investigators warn, underestimates. In both the attempted and completed suicide groups, the alcoholics had made more past suicide attempts than had the nonalcoholic cases. (It is important to keep in mind that threats of and attempts at suicide are predictive of later suicide itself.) Comparing alcoholic versus nonalcoholic cases there were no differences in the means or settings of suicidal efforts, nor were there differences in psychiatric diagnosis, for nearly all cases were diagnosable as depressed and unable to function. On the other hand, four times as many alcoholic cases had jail records as the

nonalcoholic cases. Given the Washington State prevalence rates of alcoholics in the general population (4.2), it is dramatically clear that their presence in the suicide attempt population of 0.23 plus and in the completed suicide population of 0.31 plus represents a greater than expected number.

Palola et al. (1962), having described alcoholics in a suicidal population, then examined suicide efforts in an alcoholic population. They found that 17 percent of a sample of alcoholics drawn from a skid row, a county hospital, and an Alcoholics Anonymous chapter admitted to past suicide attempts. The skid row cases had the least frequent suicide attempt history—a finding which the authors suggest may mean that skid row provides a supportive haven for alcoholics which they do not get elsewhere.

Other studies confirm the findings set forth above. Schmidt and O'Neal (1954) found 13 percent of a St. Louis sample of suicide attempts to be alcoholics, the age group most heavily represented in both alcoholic and nonalcoholic cases being 60 and over. In a sample of completed St. Louis suicides, Robins and his colleagues (Robins, Murphy, et al., 1959) found 23 percent to be alcoholics, 77 percent of whom had given warning of suicidal intentions. Palmer (1941) examined 25 attempted suicide cases and found seven (28 percent) were alcoholics. Among these seven several took such large quantities of alcohol that Palmer considered their drinking a direct effort to kill themselves through acute alcohol poisoning. In a Scottish study, Batchelor (1954) examined 200 consecutive cases of attempted suicide and found 21 percent with a history of excessive drinking; half of these were separated or single people and nearly half were sober when they tried to kill themselves. That is unlike Palola's study where nearly all of the alcoholics were drinking at the time of the suicidal effort. Batchelor suggests that although his alcoholism itself may be of such significance to the user that it leads him to suicide, more often the etiology of both suicide and alcoholism is the same. What that would mean is that alcoholism does not "cause" suicide but that both suicide and alcoholism are expressions of the same kind of social and personal disorder, either one being a (almost interchangeable) response of the person to these very serious troubles. The same reasoning may be applied to the psychiatric depression found in alcoholic and nonalcoholic suicides, to the "cessation" behavior of drug users and suicidal persons, and to the various expressions of social maladjustment found in persons expressing anomie or separateness from important social values and activities.

Further studies include those of Ringel and Rotter (1957) showing that 15 percent of a sample of 1954–55 suicide attempts in Vienna were made when the person was intoxicated; over half of whom were alcoholics. About one-quarter of the nonalcoholic intoxicated cases were said to have drunk in order only to screw up their courage to kill themselves. In a Finnish study, Saarenheimo (1952) found 25 percent of autopsied suicides to have been under the influence of alcohol. He suggests that building courage for the act and response to painful hangovers may be motives. Verkko (1953) in a further study in Finland finds that suicides do occur during the hangover phase (unlike the Batchelor or Palola findings). Volbert (1956) examined blood levels among 100 suicide cases and found alcohol present in 60 percent of the cases. Most cases had blood levels below 0.12, a level ordinarily associated with the release of inhibitions but not with drunkenness. Only four cases had levels over 0.20 which is compatible with mild drunkenness. One can suggest that for a successful suicide, by means other than acute alcohol poisoning (none of which were found in the Volbert sample), that the person cannot be too drunk. We shall see that the same consideration applies to criminal acts; when control or skill are necessary the person committing the act cannot be drunk.

Reviewing the findings on suicide and alcohol use, alcohol is clearly implicated in both suicide attempts and completed suicide. Alcoholics are more likely to commit suicide than nonalcoholics. However, nonalcoholics may also use alcohol in connection with their suicidal efforts. As a tentative finding one adds that when alcoholics commit suicide they are likely to have a history of prior suicide threats or attempts, to be depressed, not to be living in skid row or some other supporting-accepting environment but to lack any close or important relations with other people, and to be in older age brackets. There is not agreement among studies as to whether suicidal efforts occur most often among alcoholics when they are sober, slightly tipsy, intoxicated, or during the hangover phase. Except for cases of intentional acute alcohol poisoning, there are grounds for arguing—on insufficient evidence—that blood levels of alcohol will not be high since to succeed at suicide requires the capacity for muscle control and planful action. It is also reasonable to expect that the presence of alcoholism itself, along with its often disastrous social consequences, is of importance as a crucial element—in the mind of the alcoholic—in the suicide decision. On the other hand, viewed etiologically, the type of life events which lead to alcoholism per se are also likely to lead to suicide per se; or to be associated with a variety of other unhappy choices of conduct. Given this probability, it may be oversimplifying to say that alcoholism or alcohol use is *the* critical factor in suicides by drinking people. Nevertheless the presence of alcoholism and alcohol use is so great as to demand the conclusion that alcoholism or alcohol use are at least one critical factor in producing suicidal behavior.

SUICIDE AND ALCOHOL USE: SUMMARY

Alcoholics attempt and also complete suicide at a rate much higher than the nonalcoholic population. Drinking by nonalcoholics also appears to precede much suicidal behavior. Although alcoholism itself may not cause suicide—since the history and life circumstances of the drinker undoubtedly are necessary elements for a suicidal outcome—the presence of alcoholism is a strong warning of suicidal risk. Before suicide is accomplished, many alcoholics will themselves give warning of their intention, either through threats or attempts. There is a possibility

that suicide will best be accomplished only when the drinker is not seriously intoxicated (blood level below 0.20) unless his choice of "weapons" is acute alcohol poisoning itself.

At the present time data on poisoning is insufficient to allow national estimates of the frequency with which alcohol is used as an intentional poison. One can call attention to the value of gathering national statistical data on poisoning by type of person, setting, poison, and outcome. One can also point to the need for considerably more information on the suicidal efforts among "normal" persons and the role that drugs, including alcohol, play therein.

ALCOHOL AND TRAFFIC ACCIDENTS

The results of work on alcohol and vehicle accidents are consistent and reveal a definite relationship between accident involvement and alcohol consumption. Two comprehensive articles by McFarland (1964) and Plaut (1962) present a review of the most relevant and better controlled investigations.

Estimates on the percentage of accidents caused by drinking drivers compared to nondrinking drivers vary considerably, the range being from 1 to 50 percent (Heise in Andréasson, 1959; Andréasson, 1959). Unfortunately, sufficient care is not exercised in many studies in separating cause from involvement. In any case, alcohol is only a conditional variable among a number of other possible causative factors. Andréasson (1962) presents statistics as follows for various countries on the percentage of total traffic accidents where alcohol was involved: Spain, 1.5 percent; Belgium, 2.5 percent; France, 2 percent; Sweden, 2.9 percent; Israel, 0.2 percent; Finland, 7.6 percent; and Switizerland, 6.0 percent. In 25.4 percent of the fatal accidents in 1951 in California, a driver or pedestrian had been drinking (Plymar, 1955).

The time at which the alcohol-related accidents are occurring is a relevant condition. Jeffcoate and Spriggs (in Andréasson, 1960) find that in accidents occurring after 10 p.m. alcohol is an associated factor in 50 percent of the cases. It is to be noted that many investigators hold that present police report statistics do not present an accurate measure of the extent of road accidents caused by drunken driving (Andréasson, 1962). Data derived from studies using chemical tests and controlled experimental methods reveal that the figures on alcohol involvement are much higher than conventional statistics suggest. The remainder of our alcohol and accidents discussion will confine itself to the controlled surveys and studies done under specified conditions.

Ethyl alcohol can impair sensory, perceptual, psychomotor, and mental functions. Impairment is visible even at very low concentrations of alcohol in the blood. Laboratory tests and actual operation of motor vehicles on experimental field courses show that deterioration of performance occurs in many persons at blood levels previously considered minimal: i.e., 0.03 to 0.04 percent. Impairment becomes increasingly severe with increasing amounts of alcohol in the blood (Drew; Loomis and West; Vamosi; Bjerur and Goldberg; in Andréasson, 1962). At 0.10 percent, significant effects reportedly occur with all drivers.

The following table represents the relationship between concentration of alcohol in the blood and approximate number of drinks one must imbibe to reach that level of blood alcohol (State of California Transportation Agency, 1965).

Table 1

Alcohol level, percent by weight/volume	Approximate number of drinks (1 fluid ounce of 86 proof spirits)	Alcohol level, percent by weight/volume	Approximate number of drinks (1 fluid ounce of 86 proof spirits)
0	0.	0.20 to 0.24	11 to 14.
0.01 to 0.04	Up to 2.	0.25 to 0.29	14 to 16.
0.05 to 0.09	3 to 5.	0.30 to 0.34	17 to 19.
0.10 to 0.14	6 to 8.	0.35 to 0.39	20 to 21.
0.15 to 0.19	9-to 11.		

Bjerver and Goldberg (1950) find with alcohol an increase in number of driver errors: e.g., more frequent stalling of the engine at a critical moment, greater carelessness, and reduced exactitude in steering and braking. Graf (in Andréasson, 1962) found that 0.5 percent alcohol in the blood made a tendency to drive toward the ditch in 82 percent of the cases. With levels higher than 0.10 percent alcohol, deviation from the traffic lane, average speed deviations and increased time to return to the correct lane were common occurrences. Loomis and West, basing estimates on results of experimental driving test "estimates," believe at 0.10 percent blood levels, driving ability deteriorates by 15 percent. At 0.15 percent blood alcohol level, driving performance deficit is 30 percent compared to the driver's normal performance.

Deterioration in judgment can occur at levels below 0.05 percent. A study on Manchester, England, bus drivers (Cohen et al. in Andréasson, 1962) revealed that conscious efforts to counteract the effects of consumption of even small quantities of alcohol did not prevent deterioration. Efficiency is reduced at the same time that the driver's confidence in his own ability increases. Here in this gap between euphoric confidence and performance lies a great danger to road safety. Andréasson sums up the dispute over acceptable level of blood alcohol that is compatible with "safe" driving as follows: "The results of researches of a more recent date show that it is misleading to establish that 0.05 percent is safe—0.0 percent is safe!"

ACCIDENT INVOLVEMENT AND ALCOHOL

Adequate studies in this area determine the blood alcohol levels of drivers involved in traffic accidents (personal injury and fatal motor and pedestrian accidents) and compare these figures with the blood alcohol levels of a control group of drivers or pedestrians who were not involved in the accident but were passing the accident site either at the time of the accident or at a later date. In

addition, Smith and Popham (1951) contend it is ideal to sample only those drivers who are responsible for their accidents, differentiating out those who were innocent victims of someone else's error. We suspect that innocence is hard to establish, especially because defensive driving abilities may also be reduced by alcohol.

Results of investigations agree that there is an excess of drivers in accidents with levels of blood alcohol beginning at 0.04 to 0.05 percent as compared with now-accident controls. As alcohol level increases the percentage of such drivers included in accidents increases sharply (Lucas and Kalow in Fox, 1963; Indiana University Department of Police Administration, 1964; Borkenstein, Crowther, Shumate et al., 1964; McCarroll and Haddon, 1961). Smith and Popham state that drivers with 0.15 percent and over were present eight times more often in the accident than in the control group. On the basis of their findings, it was estimated that accident involvement with blood alcohol levels between 0.05 and 0.10 percent is 1½ times greater than below 0.05 percent and beyond 0.15 percent is approximately 10 times greater. Relative contribution scores were tabulated for each driver based on the degree to which he was responsible for the accident. Results showed the 21/22 drivers who had blood alcohol concentrations of 0.15 percent or higher were considered to be almost entirely responsible for their accidents. In this alcohol group (0.15 percent or higher) there were 43 times more drivers than would be expected with high accident contribution scores compared to the distribution of accident responsibility scores among nondrinking accident-experiencing drivers. In this Indiana University study, nearly 6,000 persons having accidents were investigated. At levels of blood alcohol of 0.08 percent and higher, factors such as race, estimated annual mileage, age, occupational status, etc., that had shown significance at levels below 0.08 percent, no longer were accident-related factors. The one factor that continued to show a relationship to accidents was blood alcohol level. Also, blood alcohol level was positively correlated with extent of damages, expense of damage and severity of injury (Indiana University, 1964; Borkenstein et al., 1964; State of California Transportation Agency, 1965). As regards severity of accident, a California (1965) study revealed that the characteristics of two driving populations—(*a*) those persons involved in general single car accidents of lesser severity, and (*b*) those persons involved in fatal traffic accidents—were similar with regard to percent married, convictions, police contacts, etc. However, the fatal accident group had significantly higher levels of blood alcohol—0.10 percent and over. Using interview material with airmen, Barmark and Payne found that preaccident drinking occurred among 64.4 percent of the accident drivers and it occurred among only 5.3 percent of controls.

Coroners' reports on levels of blood alcohol found in autopsies reveal high concentrations of blood alcohol concentration in fatal accident victims. Among drivers rated as probably responsible for their accidents, 73 percent had been drinking to some extent whereas only 26 percent of the similarly exposed (site-matched controls) had been drinking. Forty-six percent of the accident responsible group had blood alcohol concentrations in the very high 0.25 percent and over range. In contrast, not a single one of the drivers in the large control group had a concentration in this range (McCarroll and Haddon, 1961). In the Haddon and Bradess (1959) study, having the same basic design as McCarroll and Haddon's, 50 percent of the fatally injured drivers had blood alcohol levels of 0.15 percent or more at the time of death. The late night hours and early morning hours and weekends are particularly high in traffic fatalities. These correspond to the peak hours in drinking in our country (Andréasson, 1962) and of homicides involving alcohol as well. In accidents in which pedestrians are killed or injured, a high proportion of the victims are under the influence of alcohol at the time of the accident (Haddon, Valien, and McCarroll, 1960). The sample consisted of pedestrians all over the age of 18 whose survival did not exceed 8 hours. They were 50 in number; a 200-member control group was obtained using pedestrians who were at the accident site at the time when conditions were similar to those at the time of the accident. The presence or absence of alcohol in the blood proved to be one of the major discriminants between the fatal-accident-involved and noninvolved groups. Of those dying within 6 hours of the accident, 74 percent had been drinking in comparison with 33 percent of the controls sampled at the same accident site. The disproportion between cases and controls in the numbers with given alcohol level became greater at the higher concentrations. One-third of the fatality group had blood alcohol levels greater than 0.15 percent—only one-sixteenth of the controls had this much blood alcohol. Only one-fourth of the accident group had no alcohol in their blood, while two-thirds of the control group were free of alcohol. It appears clear that drinking is a factor not only in driver accidents but also in pedestrian (victim) fatalities. An Australian study (Bowden and Wilson, 1958) confirms that finding. Again the correspondence to homicide is noted, for there too victims tend to have been drinking.

What are the characteristics of the accident-involved "drinking and driving" population? Although popular belief has it that most alcoholic drivers are but social drinkers (normal, moderate, or heavy) the high levels of blood alcohol concentration present in the fatal car drivers and fatally injured pedestrians might lead one to wonder whether a sizable subgroup are not problem or pathological drinkers (Bjerver and Goldberg in Andréasson, 1962; McCarroll and Haddon, 1961). From a statistical standpoint it is unlikely that most drinking drivers are alcoholics—only 1 out of every 14 to 20 citizens (+/−) is an alcoholic. Moreover some alcoholics rapidly become so drunk that they are unable to drive (Plaut, 1962), or knowing themselves, take care not to drive (Trice, H., in Pittman and Snyder, 1962). However, numerous studies analyzing the drinking patterns of accident-involved drivers reveal that a large proportion of them do have alcohol problems (Bjerver and Goldberg, in Andréasson, 1962; Goldberg, 1955; Selzer, Payne, Gifford, and Kelly, 1963; Schmidt, Smart, and Popham,

1962; Selzer and Weiss, 1965; Barmack and Payne, 1961). Goldberg (1955) examined a group of arrested Swedish drunken drivers who were convicted for the second time on a drunken driving charge; 45.4 percent had alcohol problems compared to a problem rate of 8.8 percent for the general Swedish population. Selzer and Payne et al. (1963), investigated 67 persons arrested for driving while intoxicated in Ann Arbor, Mich. They found that 37 were alcoholics (55 percent), 10 were borderline cases (15 percent), and 4 were prealcoholic (6 percent)—a total of 76 percent with alcohol problems. Selzer and Weiss (1965) determined the incidence of chronic alcoholism in drivers responsible for fatal (nonpedestrian) traffic accidents in Washteran County, Mich. (1961–64). Of the 72 drivers, 40 percent were alcoholic, 10 percent were prealcoholic, and 50 percent were nonalcoholic. Of the 64 percent of the drivers who had been drinking prior to the accident, 75 percent were alcoholics or prealcoholics who usually had blood alcohol levels in excess of 0.14 percent. Forty-five of the alcoholic drivers had at least one prior arrest for drunk driving or drunk and disorderly conduct, and 16 had at one time driven with revoked licenses including 3 who had no license at the time of the accident. Also, alcoholic drivers were responsible for significantly more prior serious accidents and moving traffic violations than the nonalcoholic drivers. Two of the other alcoholic drivers had killed other persons in prior traffic accidents while driving in an intoxicated state!

Thus, accident records of known alcoholics reveal that alcoholics are involved in more total accidents and were more frequently convicted for drunken or impaired driving than the population at large (Schmidt, Smart, and Popham, 1962; State of California Transportation Agency, 1965; Schmidt and Smart, 1959; Selzer and Weiss, 1965; Goldberg, 1955). A study by the State of California Transportation Agency correlated the drunken drivers' alcohol level at the time of the fatal accident with their previous number of drunkenness arrests. The correlation was 0.92. That means that a drinking driver with high blood alcohol levels who kills someone nearly always (over 80 percent of the time) had prior drunk driving arrests. It is noteworthy that studies of the characteristics of problem drinkers involved in accidents show them as would be expected (Cisin and Cahalan, 1966) to be heavily drawn from the lower class. The chances are that this group is least likely to carry liability insurance and least able to pay indemnities to accident victims or their families. So it is that problem drinkers not only cause the most suffering and loss but are least likely to be able to make reparations. It would be useful to know what the actual insurance coverage of such drivers is. Such a study recommends itself.

ALCOHOL AND TRAFFIC ACCIDENTS: SUMMARY

Drivers who drink are more likely to be involved in traffic accidents than those who don't drink. Drinking drivers account for a high percentage of all accidents, including fatal accidents. Control studies (an inadequate number thereof) show that these same drivers when not drinking do not cause accidents. The role of alcohol as a cause of accidents is strongly implicated. It is further found that a considerable proportion of drinking drivers are simply not normal drinkers "with a heat on," but problem drinkers as such. The problem drinkers are strongly implicated in serious and fatal accidents. Reviews of the histories of drinking drivers killing people show that many or nearly all of them have had previous arrests for drunken driving. These problem drinkers—and problem killers—are poor people who are assumed to be (evidence is lacking) less likely to carry insurance and less likely to be insured, thereby compounding the disasters they create.

Work on blood alcohol and performance shows that drinking even small amounts can interfere with driving. As blood alcohol levels rise performance decrement is greater. This greater likelihood of driver error corresponds to increasing severity and frequency of accidents as blood levels increase. There is probably no other area in the field of drug research and related dangerous behavior where the role of a drug as a precipitating factor in dangerous behavior is so clear. Given the 49,000 deaths and 1,800,000 injuries during 1965 in motor vehicle accidents (National Safety Council figures) this is also one of the prime areas where remedial action is dictated.

ALCOHOL AND OTHER ACCIDENTS

We have not attempted to review the literature relating alcohol to nontraffic accidents. However, a few facts and figures of interest are presented. An Australian study (Bowden and Wilson, 1958) showed that in a majority of their small sample of deaths by burning, drowning, and falls, blood alcohol levels exceeded 0.15 percent in the victims. Spain, Bradess, and Eggston (1951) examined body alcohol content (brain and liver) in nonindustrial nontraffic accidents (home, sports, etc.) in one city. In 24 percent of the accident victims alcohol was present. Trice (cited in Pittman and Snyder, 1962) conducted two studies of Alcoholics Anonymous members, examining their on-the-job lost-time accidents. Eighteen percent of the 200 sample members had at least one lost-time accident connected with drinking. In a second inquiry directed to 552 AA members, 21 percent reported lost-time accidents. The interpretation of these figures requires knowledge of expected rates of accidents by industry and occupation within industry. Trice, comparing the reports of lost-time accidents among AA members to other groups, feels that these AA accidents are not high. Previous studies of accidents experienced by alcoholics, the findings of which Trice reviews, indicates alcoholics do have higher risks than others. Trice calls attention to the fact that chronic drinkers may take extra precautions to avoid accidents by staying home when drinking, by avoiding dangerous jobs, and by developing routine or automatic safety behavior on the job which protects them in spite of drinking. Supervisors and

fellow workers also protect the alcoholic from danger. (It is to be noted that the drinker-driver cannot have any of these accident-preventing devices.)

ALCOHOL AND CRIME

The basic question is, is alcohol related to crime? The basic answer is, "yes." When one gets away from the basic question and begins to seek an understanding of the many ways in which alcohol is implicated in criminality, the questions become more complex. The first requirement in approaching these questions is to begin to speak, not of alcohol, but of people using alcohol. The second is not to speak of crime, but to say what types of crime.

In terms of the work done to date, five major approaches may be identified. The broadest approach is to present data on all crimes and to state what proportion are offenses for alcohol use as such. The second approach is to categorize crimes and to study persons charged, or their victims, to see in what proportion alcohol use was involved. A third approach is to study a population of offenders, as for example prison inmates, to find out how many of them are incarcerated for offenses involving alcohol or to find how many of them have alcohol problems. A fourth approach is to study chronic alcoholics, particularly alcohol offenders, to learn what their particular criminal histories are. A fifth approach is methodological and/or theoretical; it critically examines the data, the logic, the correlations among findings, and it discusses the complexity of relationships among what has been observed. There are, of course, approaches which combine several of the foregoing emphases or which present variations.

DRUNK-RELATED CRIMES IN THE UNITED STATES

Various statutes prohibit intoxicated behavior, as for example in a public place, in or around an automobile, or when driving. Other statutes are often employed against intoxicated persons, as for example, vagrancy, public nuisance, or disturbing the peace. Another set of offenses are violations of alcohol control laws, for example selling alcoholic beverages to minors, minors purchasing or possessing alcoholic beverages, employing female bartenders, etc. Given present reporting systems, whose weaknesses are discussed in the Commission's general report, it is obviously not possible to know exactly how many arrests for drunkenness or alcohol control offenses occur in the United States, in any 1 year, nor is it possible to know how many different persons out of all those arrested were involved in an alcohol use offense. Nevertheless, present statistics do provide good estimates of the magnitude of alcohol use offenses as a proportion of all reported offenses. For example, in 1961 (FBI, "Uniform Crime Reports") 55 percent of all arrests in the United States reported to and by the FBI were for alcohol-related offenses—drunkenness, liquor law violation and drunk driving—or for offenses which often involve drinking—disorderly conduct and vagrancy. In 1963 the proportion out of total offenses was the same (55.2 percent), and in 1965 the proportion was 52.6 percent. There can be no question that the burden of alcohol use offenses is a grave one in terms of frequency of arrest, constituting, as it does, the majority of all reported in the United States.

Alcohol Implication by Type of Crime

In addition to the 55 percent of arrests that are for alcohol use offenses per se, a considerable number of other offenses are committed by persons—or suffered by victims—who have been drinking just prior to the commission of the offense. Some crimes show a high frequency of alcohol involvement; others a low one. Homicide for example is an alcohol-related crime; Cleveland (1955) in a Cincinnati study found that 44 percent of a sample of homicide victims had blood alcohol levels over 0.15 percent. Bullock (1955) in a Texas study found that 28.5 percent of a time sample of homicides took place in public places where liquor was served. Fisher (1951) in a Baltimore report states that 69 percent of homicide victims there had been drinking. Bowden and Wilson (1958) found 47 percent of homicide victims in Australia had been drinking. Shupe (1954) in an Ohio study found 43 percent of the homicide offenders had been drinking. Spain et al. (1951) found 87 percent of a small sample of homicide offenders had been drinking. The most comprehensive study of homicides is that by Wolfgang (1958; see also Wolfgang and Strohm, 1956). Among 588 Philadelphia cases alcohol was *absent* from both victim and offender in only 36 percent of the cases. In 9 percent of the cases alcohol was present in the victim only; in 11 percent of the cases it was present in the offender only. In 44 percent of the cases it was present in *both* the victim and offender. Consequently in 64 percent of the homicide cases alcohol was a factor; and in the majority of these alcohol was present in both parties to the crime.

Examining participant characteristics, it was found that Negro males had the highest incidence of alcohol presence. When there was a white female victim alcohol presence was low, occurring in only 3 percent of the cases. Wolfgang found an important association between the presence of alcohol and the homicide method; for example 72 percent of the stabbings involved the presence of alcohol, as did 69 percent of the beatings, 55 percent of the shootings, and only 45 percent of the "miscellaneous" methods. Among Negroes alcohol is likely to be present regardless of the means of killing; among whites it was present in the majority of killings only when the method was beating. Wolfgang gives careful consideration to the fact that murder is often the end result of an exchange to which both parties contribute. When the murder has been victim-precipitated, alcohol is more often present (70 percent) than when the victim does not precipitate it (60 percent). Wolfgang calls attention to a number of supporting findings elsewhere, for example in Finland and Norway among manslaughter cases, and among homicide cases in Alabama and New

York City. From an ideal methodological standpoint, one would be pleased to have additional information on alcohol use patterns of Wolfgang's sample, for example on the use of alcohol on those occasions when subjects in the sample were not killing or being killed. The reason of course is to learn if the homicide occasion was a special one from the standpoint of amount of alcohol in the blood or whether drinking was a commonplace thing, whereas the incitement to violence rested on other special events. The reasonable conjecture, one in keeping with Wolfgang's material, is that it was the combination of alcohol plus the "special events" of the interpersonal scene, which led to murder.

On the basis of the present data one can say that there is a strong link between alchohol and homicide and that the presumption is that alcohol plays a causal role as one of the necessary and precipitating elements for violence. Such a role is in keeping with the most probable effects of alcohol as a depressant of inhibition control centers in the brain—leading to release of impulses. One must keep in mind that even if alcohol is a necessary element for some murders, it is not necessary for all of them and further that alcohol use quite obviously does not necessarily lead to violence. An additional point is that alcohol use is likely to be but one element in a life pattern which increases the risk of being a homicide offender or victim (and it is sometimes chance which says which a person will turn out to be). For example, the Wolfgang study showed that 64 percent of the offenders and 47 percent of the victims had prior arrests. More important, the majority of these arrests were not for crimes against property (the predominant kind of non-alcohol use crime) but for crimes against person.

There is no study of other types of crime which compares with that of Wolfgang for careful and detailed analysis of persons and settings. Shupe (1954) examined blood and urine for alcohol in a group of 882 Columbus, Ohio, felons arrested either during or immediately after the offense. Presuming guilt, he found that alcohol was present more often in crimes of violence (e.g., 92 percent of the "cuttings" and concealed weapon arrests) and less often during more skilled offenses against property; e.g., 60 percent in forgery. The curious thing is that the 60 percent forgery figure is the lowest one. Two questions immediately arise. One is, given the criterion for inclusion in the study of immediate arrest during or after the offense, is it only inebriates who get caught right away? Perhaps "yes" since the majority of the alcohol blood levels of the arrested offenders were over 0.20. The second question is, what is the prevalence of alcohol in the blood for nonarrested persons in the same setting or with similar characteristics to the offenders? Quite possibly the arrests occurred among populations most of whom were accustomed to having some liquor inside them.

Sexual Offenses in relationship to alcohol have been the subject of surveys by Cruz (1943) and by Selling (1940). In England, Cruz found that among 86 sexual delinquents nearly half were "constant" drinkers and nearly one-fifth were drunk at the time of the offense. Selling examined 100 cases of male sex offenders and concluded that 8 percent were chronic alcoholics, and 35 percent were drinking at the time of the offense—an action which offenders said was a prerequisite for their offense. One would like to know how many persons of like social status and age as those in Selling's sample would also be chronic drinkers or to have been drinking during the same period of time as the offenses occurred. Without such controls one can make little out of such statistics. It would be well to know also to what extent the recollection of being drunk provides a rationalization for the criminal act, a self-excusing "it wasn't me it was liquor" kind of alibi.

Plaut (1965, unpublished) has reviewed other work on alcohol involvement by types of crime. He proposes that alcohol is directly responsible for some crimes when inhibitions are removed leading the person to act in ways he would not ordinarily do. The experimental evidence for inhibition removal, as for example sexual and aggressive impulses, supports that thesis. Criminal behavior may also occur as part of an effort to obtain beverages, as in liquor store theft or other property crime to gain money to purchase liquor. Chronic drinking can produce an alcoholic unable to hold a job or maintain his social position; such a man may begin to associate, as on skid row, with more delinquent oriented persons and may become involved in the criminality of parts of that subculture. Haughey and Neiberg (1962) along with Blane (1965) also distinguish between alcohol as a primary factor in crime—as in assault and homicide where violence is unleashed—and its being a secondary factor in the sense that a chronic alcoholic acts in criminal ways. They describe cases of alcoholics writing bad checks to get money because they have no jobs and need funds. The "addictive pattern" of the chronic alcoholic involves loss of self-esteem, separation from the positive influences of one's family, departure from the values of conventional groups, etc. So it is that as associates and values and self-concepts change (in addition to reduced judgment and control when actually drinking), petty theft, assault, neglect, desertion, non-support, disturbing the peace and the like can take place. A third association between alcohol and crime is a negative one. Haughey and Neiberg, along with Plaut and others, affirm that criminality requiring either physical or social performance skill and reliability over time are incompatible with either problem drinking or excess acute drinking prior to the offense. Neither an administrator of an organized racket nor a safecracker can afford to be drunk or to drink heavily prior to going to work. One must also call attention to the likelihood that both criminality and alcohol problems can be end results or symptoms of the same underlying events: for example, exposure to disordered social environments and/or the presence of psychopathology including aggressive antisocial components.

Alcoholic Histories of Felons

A number of studies have been surveys of one kind or another directed to populations of apprehended or

409-074 O - 70 - 4

incarcerated offenders, as for example the inmates of a prison. Typically the inmate is asked about his past use of alcohol. When he is classified according to the offense for which he is arrested, or if he is asked about his criminal history, it is possible to construct a crude index of alcohol use by type of offender. Such surveys suffer from arbitrary classifications when offenders have committed a variety of crimes and they also suffer from a certain "bias" if the offender does not care to speak with perfect truth about either his alcohol use or past criminality. One of the most instructive inmate surveys was that of new (male) arrivals in California prisons. Replies to a questionnaire indicated that 98 percent of the 2,325 men used alcoholic beverages, 88 percent of those reported intoxication at least once; age 16.6 was the average age for first intoxication. Twenty-nine percent (of total sample) claimed that alcohol use had been a major problem in their lives; 6.4 percent had been medically treated for a drinking problem. More of the problem drinkers had prior convictions (23 percent) than did nonproblem drinkers (14 percent). Twenty-eight percent of the men claimed they were intoxicated at the time they committed the commitment offense; (50 percent committed for auto theft, over one-third of those sent up for manslaughter, assault, sex offenses, forgery and bad checks, and (curiously) ten percent convicted on narcotics counts.

Other inmate surveys include 1,000 consecutive jail admissions in Massachusetts (Ullman, Demone, et al., 1957) which showed 31 percent for drunkenness. These offenders were older and better educated than the other inmates. Compared to the adult Massachusetts population, the drunkenness offenders were less well educated and less often foreign born. Comparing their histories of other offenses, the inebriate group (two or more drunkenness offenses) showed fewer past property crimes than the noninebriates. Other surveys are those of Bardonnel (1951), Guze et al. (1962), and Whalen (1962). All purport to show a higher than expected proportion of alcohol problems among convicted offenders than would be expected according to normal population rates. Some surveys have concentrated on youthful offenders. Demone, Blacker, and Freeman (1964–65) found that 63 percent of 500 male delinquents, average age 15, were drinkers; excessive drinking is said to occur two to three times more often among these boys than among comparable high school populations. MacKay et al. (1963) in a Massachusetts survey reported about one-sixth of the boys aged 8 to 17 were problem drinkers. Cramer and Blacker (1963) examining female inmates report the majority of their small sample had alcohol problems.

Criminal Histories of Alcoholics

Special attention is often given to chronic alcoholics, either sampled from skid row or clinics, or from prison, to learn about their criminality. For example, Clark, Hannigan, and Hart (1964) in a sample of 100 alcoholic felons report a preponderance of crimes of violence; only one planned skilled offense was committed by an alcoholic felon. Most men had extensive histories of past arrest on minor counts. As parolees alcoholics were said to have higher rates of recidivism. Blacker (1959) surveyed a Massachusetts alcoholic inmate sample and reported that the per man median number of past arrests was 58.5. One-third had only been arrested for alcohol use offenses, one-third for other minor crimes, and one-third for serious offenses, of these only one-third showing a recent felony arrest, a fact leading Blacker to conclude that one-sixth of these men were "potentially dangerous." Arai and Iijima examined Japanese offenders under the influence of alcohol at the time of their crime, the majority of whom proved to be alcoholics. Half of the sample had been involved in violent crimes, 30 percent in property offenses. The authors attribute at least one-quarter of the offenses to the specific presence of alcohol, that leading to emotional explosions and violence. Other offenses were said to be facilitated by the presence of alcohol.

Pittman and Gordon (in Pittman and Snyder, 1962) (see also Pittman and Gordon, 1958) have done the most careful and detailed study of chronic offenders, in their case a sample of 187 chronic drunkenness offenders whose criminal careers were examined. All were imprisoned recidivists in New York State. The average frequency of arrest was 16.5 with the number of arrests increasingly progressing with age. Nearly one-quarter of all past arrests had been for other than drunkenness; these other crimes had not increased with age. The authors point out that inebriates who have as youths and young men been involved in theft, burglary, etc., change their conduct and show more intoxication offenses as they get older, age 35 to 40 being the critical period. The past histories of the inebriates showed gambling and homicide to be the least frequent but present other type of crimes; with increasing percentages of men involved in burglary (12 percent), larceny (23 percent), disorderly conduct (22 percent), and vagrancy (35 percent). One-third of the sample had been arrested only for alcohol use offenses. Thirty-seven percent had serious arrest records; many of their crimes being committed under the influence of alcohol. Pittman and Gordon remind us that many of their fellow inebriates had not committed such crimes. They suggest a "career" pattern, that many men who become drunkenness offenders started out with purer criminal interests but that they failed as criminals and drifted into alcoholism as an adjustment to criminal career failure. The authors find that the criminal career of the drunkenness offender is divided into two phases; under age 40 it is filled with many arrests unrelated to alcohol; afterwards their offenses are for alcohol use. (The authors are aware that arrest records are but a dim reflection of actual offenses.) Categorizing their men into three groups, approximately one-third with no crimes other than alcohol use, one-third with minor crimes, and one-third with serious crimes, they compared them on background characteristics and found no differences. Their proposal that criminal failures become alcoholics, gravitating to skid row, is limited to the special subgroup of one-third who started their offending career with property acquisition ambitions rather than alcohol interests per se.

COMMENT

It is difficult to do good work in any field and, when good work in social inquiry or science is done, it must lead to further questions and, necessarily, awareness of what we have not learned from what has been done before. The field of studies of alcohol involvement in crime is no different. The poor studies, of which there are many, at least focus our attention on events of interest and remind us of the need for care in designing research. The good studies, of which one would cite Wolfgang on homicide and Pittman and Snyder on inebriate offenders, tantalize with further questions. As a general statement most studies are simply descriptive and too easily conclude or imply that alcohol plays a critical role in the production of the crime reported. Blane (1965) has done a fine job of setting forth the limitations of much of the work done. He notes that research methods have been grossly inadequate all too often, that there has been no base of reason or theory to provide a framework for either inquiry or understanding, and that any criminal act is an outcome of many forces acting over time and in the situation. The presence of alcohol is only one such factor, and how alcohol affects conduct is conditional on what the user is like and what else is happening. At the very least a criminal outcome is the consequence of alcohol (dosage over time, concurrent physiological state, etc.) plus personality plus group or subcultural membership plus opportunity plus drinking circumstances plus other events. Even this additive scheme is insufficient, for the likelihood is one of interplay or interaction with differing outcomes each time one element in the drama of conduct is altered.

The weight of argument on alcohol leading to crime rarely considers alcohol as an inhibitor of crime, yet alcohol does suppress function as well as release inhibition. As a sedative or tranquilizer ("perhaps the best tranquilizer," said Leake and Silverman, 1966) it must account for the reduction of action too, some of that action criminal. The difficulty here is the same one faced in the examination of other drugs; one samples among identified cases of trouble; suicide, accidents, criminals, drug dependents, and what-have-you and becomes aware of the presence of a drug in the person. In some cases one can also prove that the drug was a necessary element, either as an acute component or part of a chronic use pattern. What one does not get are the cases of users of that same drug who not only did not get in the kind of trouble one is measuring, but who were perhaps "saved" from that bit of trouble by their drug use (and its correlates). Logically one can argue that the overwhelming presence of, say alcoholics, among offenders or death drivers is sufficient evidence of alcohol as a potentially dangerous substance. That is so, providing one qualifies it by saying "for that subgroup of persons with such-and-such characteristics whom one has identified as being in trouble compared to others in trouble and in proportion to expected population rates." To go beyond that, to generalize to all persons, to say that the use of drug x or drug y increases the risk of trouble one must sample from the population at large to learn how all of those who have used the drug have fared and to compare them, controlling for all other conduct-influencing variables, with nonusers of drug x or drug y. That is impossible since no social drug use occurs at random and apart from other conduct-influencing factors such as childhood experience, social group membership, personality, health, and what-have-you. The use of the well-known and available mind-altering drugs, alcohol included, is a part of the fabric of lives. Ideal knowledge can never be obtained; in its absence we rely on inference and our inferences must be carefully drawn. A careful inference is one that has not only ruled out other logical possibilities, but one based on tests to eliminate alternatives. For the most part, in the study of alcohol and crime—and in other work on drugs and dangerous behavior—we have not yet reached the stage where we can be sure of our inferences. In particular we must restrict our generalizations, presume multiple causes for events, and presume subgroups of people who respond differently to the same drug.

On the basis of available information it is plausible to assume that alcohol does play an important and damaging role in the lives of offenders, particularly chronic inebriates and in the production of crime. Yet one cannot be sure on the basis of the work done to date that the alcohol use of offenders exceeds that of nonoffenders with similiar social and personal characteristics (if any such match is possible). One cannot be sure that the alcohol use of offenders is any greater at the moments of their offense than during their ordinary noncriminal moments. One cannot be sure that the alcohol-using offenders would not have committed some offense had they not been drinking. One is not sure that the alcohol use of offenders differs from that of the other persons possibly present in the same or like situations which inspired or provoked the criminality of one and not the other. Finally, and this is an important point in view of the fact that all studies have been done on apprehended offenders, one does not know that the relationship now shown between alcohol use and crime is not in fact a relationship between being caught and being a drinker rather than in being a criminal and being a drinker. Given the foregoing questions and given the likelihood that people who do use alcohol to excess—and who explode into violence or sneak into thievery in the process—also have other characteristics which mark them as ones who disregard the welfare of their fellow men (and are equally unable to secure their own well-being), a prudent student of conduct will not hasten to label alcohol a cause and crime a result when it is equally likely that both alcohol excesses and crimes are "results."

The foregoing cautions may seem too stringent. Yet we deem it worse to take action on the basis of falseness which is believed to be fact than it is to act, and one must always act in spite of the state of knowledge, on the grounds of acknowledged uncertainty tempered by reckonings of probability.

ALCOHOL AND CRIME: SUMMARY

Arrests for alcohol use account for more than half of all reported offenses in the United States. Surveys of of-

fenders reveal that the offender has more often been drinking prior to the commission of certain types of crimes than other types. For example in big city homicides either or both victim and killer have been drinking in the majority of cases. Alcohol is also implicated in other crimes of violence, and in unskilled property crimes. Some offenders do report they were drinking before the crime; some offenders committed for crimes other than alcohol use are found to have alcohol problems. Studies of delinquent youths suggest a strong likelihood of heavy and illicit drinking as part of their pattern of asocial or antisocial conduct.

Future work will probably confirm the existence of various groups whose alcohol use patterns over time are linked to crime in different ways. In some of these groups—e.g., delinquent youths—alcoholic excesses will be part of, but not central to, general maladapted and antisocial behavior. In others one expects alcohol use to facilitate misbehavior and, in some cases—e.g., homicide—to be a critical unleashing element which is necessary for criminal outcome. In yet other groups alcohol use will be a chronic later life problem after other kinds of criminality have terminated; for still other groups alcohol addiction will accompany or precede a kind of misfit adjustment which will include petty criminality or, in some, will be limited to skid row life and only to crimes of alcohol per se. Rare to the point of uniqueness will be the case of the nondrinker turned criminal by a single exposure to alcohol or the case of the normal moderate or heavy (nonproblem) drinker who, with no history of personal or social troubles, commits a criminal act when drinking.

RECOMMENDATIONS: PRELIMINARY DISCUSSION

Most Americans drink without adverse effects. As the prohibition experiment showed, they are not about to stop. Most offenders drink as well but with them drinking may have adverse effects, influencing their choice of crimes and perhaps being a necessary element for some offenses. Recidivism rates show that many offenders are not about to stop being offenders even after arrest and/or imprisonment. One presumes they are equally impervious to changes in their drinking habits. All chronic alcoholics drink and the effects are nearly always adverse. Statistics about treatment or jail effects do not suggest that this group will stop their drinking either, at least not for long. Obviously any recommendation which proposes, after carefully noting the high probability that alcohol does contribute to suicide, accidents, and crime, that people reduce their drinking is doomed not only to failure but to a hostile and ridiculing reception as well. When drug use is gratifying, well established, and generally approved, one may as well abandon the notion of stamping it out. The popularity of cancer-generating cigarettes is a case in point.

It isn't only futile to try to persuade people to stop drinking, it is unnecessary, for there is no reason for the normal drinker to stop. His drinking is controlled, need not become a progressive disease, gives more pleasure than pain, and ordinarily does not lead to trouble. The drinking troubles the normal person has are ones that he and his society are fully prepared to accept as the price of being able to continue to drink. What one might be able to persuade the normal man to do is to control how he drinks and where, and to give him the information a rational man needs so that he himself—with his peers—may act to reduce risks.

The people whose drinking requires greater control are the problem drinkers: potential, chronic, and acute, These are the ones who are at risk of disease and early death, of suicide, of accidents, of interpersonal disturbances and social failure, and of crime either as offenders or victims. As chronic inebriates they will also offend the public taste not only by being down and out, but by being drunk as well. These problem groups are not likely to listen to reason in any event, nor even to respond to the urgings of kindness or brutality. Poorly educated and out of touch, they do not read. Often hostile to authority and convention, they may not want such models. Lacking in self control perhaps they cannot stop in any event, at least not without some remarkable intervention in their lives. Some diseased are beyond any but medical care, and some well beyond that. And many, without anything else but alcohol as a focus of life or source of pleasure or tranquilization, may well ask us what we have that is better than their spiritous familiar.

RECOMMENDATIONS

One may conceive of our task as fourfold. Our first task is to accept our own present inability to make any dramatic immediate changes in the drinking habits of Americans at large or problem drinkers in particular.[4] The second task is to control the risks to the present generation of drinkers and those around them as much as we can. The third task is to streamline our handling of alcohol use offenders as such (chronic drunkenness and related charges). The fourth task is to embark on a long-term program aimed at preventing future excess drinking in the coming generations.

As a general statement we would propose under step two, control of risks in the present generation, that one separate the target populations in which one is interested and tailor programs of education, case identification, and legislative action for each. For example, suicide risks seem concentrated among problem drinkers already identified as such. Furthermore they are concentrated among non-skid-row residents who have warned of their suicidal intentions. Programs for suicide prevention of the sort being developed by the Suicide Prevention Center in Los Angeles, and expanded programs to be supported by the National Institutes of Health can be expected to include these cases in their work. The task here is to insure liaison between workers knowledgeable about suicide prevention and workers knowledgeable about alcoholics. With regard to accidents, especially traffic accidents, it is evident that the explosive growth of urban traffic and of accom-

[4] When Prohibition began, drinking was reduced; before it was repealed, drinking had returned to pre-Prohibition levels (Leake and Silverman, 1966).

panying accidents requires a national endeavor which is many-faceted. Control of drunk driving is only one feature of such a program, although an important one. Other efforts must concentrate on highway safety engineering, auto safety engineering, expanded driver training, more stringent and more frequent auto license examinations including medical approval for vehicle operation, and the provision of more personnel to highway traffic police and the modernization of local police department traffic procedures (see reports of other task forces to this Commission) and the rapid expansion of adequate rapid transit to reduce traffic volume. Control of drunk driving itself is a controversial matter, but if the public and their elected representatives really want to reduce the horrendous rate of traffic injuries and fatalities, they must be prepared to enact legislative controls. These include, for instance, mandatory license suspensions for drunk driving along with mandatory referral to alcohol treatment centers, rigid blood level or urine standards as proof of intoxication including possible widespread blood level spot checks for suspects by the police at roadblocks, in and around bars, etc.—perhaps on the model of the Scandinavian countries or Switzerland and direct prohibition of any driving for persons diagnosed as problem drinkers. Other control procedures have been discussed and debated; the arguments are beyond the scope of this report.

In regard to crimes, it seems unlikely that any special solutions will be found which are not part of wider crime prevention efforts, as for example mental health efforts, antipoverty programs, antidelinquency endeavors in the slums and, of course, improvement of police procedures on a national scale. One feature does recommend itself. Given the apparently higher than expected incidence of drinking among delinquents and the possible association between later criminality and early alcohol excesses, one can view the first arrest for an alcohol related offense or the report of juvenile intoxication as a warning signal that further offenses involving both crime and alcohol will be upcoming. The first such offense by adolescents should be an alarm. Juvenile officers, probation workers, juvenile judges should be alerted to the possibility of further alcohol offenses in conjunction with other criminality. Perhaps the most modern methods of juvenile police work and of juvenile corrections may bear fruit if applied in these early stages. Other task forces of the Commission will be recommending optimal juvenile correctional procedures. We deem it unlikely that the prevention-correction problem with the young person using alcohol illicitly and to excess is qualitatively different than the treatment of other forms of delinquency or potential drug abuse in populations having similar social or psychological characteristics.

With reference to step three, streamlining present procedures for handling public drunkenness and associated misdemeanors, we recognize an area of controversy among legislators, medical people, alcohologists, and law enforcement workers. Our own work with legislators (Blum and Funkhouser, 1965) indicates that California State legislators are open-minded and willing to eliminate public drunkenness from the criminal codes providing that the alternatives will be economical and effective. Certainly a tremendous burden would be lifted from courts and jails if drunks were handled by civil procedures. The question is whether those civil procedures—as for example public health authority jurisdiction—are any more effective than the present methods. Not only must considerations of cost and kindness be borne in mind, but civil rights as well (under hospital "institutionalization"). One might add that the effectiveness of treatment as measured by cures ideally would also be a standard, but at this stage we suspect that neither jails nor hospitals nor clinics would wish to compete for the honors on the basis of their records of past success. (We should note in this regard that the treatment of alcoholics can be moderately successful and that voluntary participation is not essential (see Blum and Blum, 1967). It may well be that some cooperative effort such as police apprehension followed by voluntary commitments to public health facilities or trial commitments to correctional ones will be in order. Such a procedure parallels the developments for two routes (voluntary versus court conviction) for handling narcotic offenders; a very similar problem in its social, psychological, and medical aspects—but not in terms of legal status or public opinion.

With reference to step four, programs for preventing future alcohol excesses in association with dangerous behavior, the recommendations must be the same as those required for other crime and drug abuse prevention efforts. Social, economic, educational, medical, and mental health improvements must be made in metropolitan slum areas and in other places where people live lives of deprivation, disorder, and delinquency. For persons in risk of becoming alcohol abusers and dangerous to others who are not members of easily identified high-risk groups, one needs more knowledge of the psychophysiology of drug dependency, improved techniques for early case finding and case referral, and improved treatment methods, the latter dependent upon further research. The role of the police must not be minimized; their critical abilities as trouble spotters, their capabilities for putting in motion informal (family, neighborhood, community agencies, etc.) controls over deviant behavior, their presence as respected symbols of safety and protection; all must be enhanced. Yet even if we make great steps on all the foregoing programs, one must not be overly optimistic; given the present rate of change in our society and the unknown outcomes of those changes, neither drug dependency nor alcohol-associated criminality will disappear.

Beyond the elimination of the conditions which breed misery and anger, and the provision of civilizing environmental settings which channel and control destructive or selfish human impulses, a long-term program of prevention will do well to capitalize on present trends toward moderate use of alcoholic beverages. If Jellinek was correct in saying that Americans are drinking more and abusing liquor less (see also Leake and Silverman, 1966), we are already moving in the proper direction. At present scientific leaders in the field believe that culturally integrated drinking allows for heavy consumption without heavy trouble following in its wake. "Integrated" drink-

ing is that which occurs as part of other important activities (meals, festivals, religious rites, etc.) and where—as we discussed earlier—other people including authorities (parents, elders, etc.) are present. To get this kind of approved and self-controlling drinking pattern established in groups without that pattern (the extreme groups described by Cisin and Cahalan, potential alcoholics in other groups—as for example delinquent youth or problem-drinker college students) the presumption is that one should teach people how to drink. That means that either beginning in childhood in the family setting—which means a cohesive family must exist—or later in life as an adult, people must be taught such things as drinking just before or during meals, to prefer the blood level low-peak slow-acting beverages, to place drinking in a context where other skilled activities (ranging from good conversation to dancing) are expected and valued, and so forth. We shall not go into further detail here.

We are fortunate that several groups have been addressing themselves to the alcoholism prevention problem and that their recommendations are now or will shortly be available. The Wine Advisory Board of the State of California has, through its scientific staff and consultants, produced a number of "teaching" books and pamphlets, some directed toward the medical profession, others toward the public at large, some to journalists and others toward housewives in particular. Their work is an excellent example of teaching moderation in the framework of other activities; medical care, eating, parties, etc. The other group is the Cooperative Commission on the Study of Alcoholism. Established by funds from the National Institute of Mental Health, the Cooperative Commission will be bringing out in 1967 a report ("Alcohol Problems: A Report to the Nation," Oxford University Press) including much on prevention. Unfortunately, the Commission failed to address itself to the problems which concern us here; there is no study of or recommendations made for the control of alcohol-related dangerous behavior—suicide, accidents, or crime as such. They do recommend eliminating public drunkenness as an offense. Many of the suggestions to be offered are directly relevant.

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ST. LOUIS PROPOSAL FOR FUNDS TO ESTABLISH A DETOXIFICATION CENTER [1]

PROJECT PLAN

This proposal aims to establish a 30-bed detoxification center at St. Mary's Infirmary in St. Louis, Mo. This proposal builds on the 1963 St. Louis police directive that all individuals arrested, suspected of public intoxication, be medically examined at a city hospital. The center will treat individuals in St. Louis detained by the police on charges of public intoxication. The center, ready for immediate operation, will employ a medical doctor; nurses, social workers, sociologists, attendants and volunteers, utilizing a multidisciplinary team approach.

The Sisters of Mary, with extensive experience in the inpatient hospital management of alcoholics, will participate in the center. Referral of patients to other community resources will be under the direction of the social work consultant, Laura E. Root. The evaluation of the project will be done under the direction of Michael Laski, St. Louis Police Department, planning and research division, and the Social Science Institute of Washington University, which will also conduct a follow up of a random sample of patients treated in the first 6 months.

I. GOALS

1. *Nature of the Problem.* For many decades, the chronic inebriate has been arrested in communities throughout the United States for public intoxication on the streets. St. Louis has experienced a great burden on police service, court time, and jail expense because of numerous arrests on this charge. For example, in the years 1963, 1964, and 1965, 7,847, 3,761, and 2,445 persons, respectively, were arrested for drunkenness.[2] Every such arrestee was conveyed to a city hospital for a medical examination prior to detention by the police. Currently, the time expended by a police officer in processing an inebriate from arrest to detention ranges from 92 to 375 minutes; the average time is 190 minutes. Thus, it is evident that the chronic alcoholic is criminally processed and reprocessed at a significant cost to the police department without any deterrent or rehabilitative effect.

Within the past year, a new legal view of the chronic alcoholic offender has been handed down in the case of *Driver* v. *Hinnant* by the U.S. Court of Appeals for the Fourth Circuit and *Easter* v. *District of Columbia* by the U.S. Court of Appeals for the District of Columbia. In the former, on January 22, 1966, it was held that:

> The upshot of our decision is that the State cannot stamp an unpretending chronic alcoholic as a criminal if his drunken public display is involuntary as a result of disease. However, nothing we have said precludes appropriate detention of him for treatment and rehabilitation so long as he is not marked a criminal.

In the latter, on March 31, 1966, the unanmious court stated that, "Chronic alcoholism is a defense to the charge of public intoxication and therefore is not a crime."

In view of the above decisions, it can be expected that treatment facilities will have to be provided for the chronic police case inebriate in other jurisdictions, including St. Louis. Consequently, municipalities should prepare to meet this eventuality.

2. *Need To Be Met.* It has been clearly shown that repeated jailing does not act as a deterrent to the public police case inebriate. This was emphasized by Attorney General Nicholas deB. Katzenbach, while testifying before the ad hoc subcommittee of the Senate Judiciary Committee on the Law Enforcement Assistance Act of 1965, when he said that:

> We presently burden our entire law enforcement system with activities which quite possibly should be handled in other ways. For example, of the approximately 6 million arrests in the United States in 1964, fully one-third were for drunkenness. The resulting crowding in courts and prisons affects the efficiency of the entire criminal process. Better ways to handle drunks than tossing them in jail should be considered. Some foreign countries now use "sobering-up stations" instead of jails to handle drunks. Related social agencies might be used to keep them separate from the criminal process.

It is evident that there is a need to provide medical treatment and rehabilitative services for the chronic public intoxicant and thereby remove him from the "revolving door" of arrest, detention, and incarceration. If this

[1] This proposal, published in part, was submitted to the Office of Law Enforcement Assistance, Department of Justice. Funds were provided, and the center was in operation by November 1966.

[2] In 1963, the St. Louis Metropolitan Police Department instituted a forward-looking policy requiring that physical examinations be given to all arrested intoxicants. Concurrently the department intensified its efforts to take into custody all public intoxicants in St. Louis in order to protect them against physical injury or violence and reduce crimes against the person. An increased number of training sessions on alcoholism also was instituted in the police academy.

need is met, it will relieve the burden upon the St. Louis Metropolitan Police Department and all other local police agencies confronted with similar problems.

3. *Target Groups or Organizations Affected.* Operation of the detoxification center has as its primary goal the treatment of individuals arrested by the police for being "drunk-on-street." By removing the public intoxicant from the street and forwarding him to the center, the police can protect the individual from physical harm and prevent a possible crime against his person. Thus, the center will not only assist the police department by preventing crime, but also help to restore the human dignity of the public inebriate.

After the public intoxicant is detoxified at the center, it is proposed that the following agencies assist with the rehabilitation of the patient:

(*a*) Greater St. Louis Council on Alcoholism.
(*b*) Alcoholics Anonymous.
(*c*) Al-Anon.
(*d*) Missouri Division of Employment Security.
(*e*) Missouri Division of Vocational Rehabilitation Service.
(*f*) Missouri Division of Welfare.
(*g*) Malcolm Bliss Mental Center (Alcoholism Treatment and Research Center).
(*h*) St. Louis Human Development Corporation.

It is anticipated that other private and public agencies and facilities will become involved, e.g., the Metropolitan Federation of Churches.

4. *Hypothesis.* The St. Louis Metropolitan Police Department believes that the chronic police case inebriate is salvageable. To demonstrate this, it proposes to establish a sobering-up station for rehabilitation of some of these offenders. * * * The Alcoholism Treatment and Research Center, (ATRC), located at the Malcolm Bliss Mental Health Center (a State-operated hospital) has demonstrated that the chronic police case inebriate and the indigent alcoholic can be helped.

In view of the experience at ATRC, the St. Louis Police Department plans to utilize the detoxification center in order that chronic inebriates may be detoxified, built up physically, and exposed to an alcoholism treatment milieu at the center. Furthermore, they will receive counseling concerning their employment potential, with a referral to the appropriate community agency as well as a follow up. Those individuals who may need retraining will be counseled and referred appropriately for the necessary rehabilitation. It is believed that this exposure to the multidisciplinary team and the milieu at the center will have an effect upon each patient. He will be accepted by the entire team as a sick human being. This technique should have an impact upon his chronicity, and serve as an impediment to the "revolving door" process of arrest, jail, release, intoxication, rearrest, and jail again.

5. *Project Demonstration or Achievement.* It is planned to remove the chronic police case inebriate from the streets, courts, and jails through a process of detoxification and residence at the center for approximately 7 days.[3] Prior to discharge, each patient will be referred to an appropriate community agency. It is hoped that this approach will have an impact upon the revolving door process in terms of the recidivist and the community, by reducing the burden of this problem.

II. METHODS

1. *What Will Be Done.* In summary, the detoxification center will attempt to achieve the following goals:

(*a*) to remove chronic inebriates to a sociomedical locus of responsibility which will markedly reduce police processing,
(*b*) remove chronic inebriates from the city courts and jail,
(*c*) provide sociomedical treatment for them,
(*d*) begin their rehabilitation, and
(*e*) refer them to an agency for further rehabilitation, with the goal that they will return to society as a productive person.

To accomplish the above goals, the center will be established at St. Mary's Infirmary, 1536 Papin Street, St. Louis, Mo., located within 1 mile of the central business district and near police headquarters. City hospital No. 1 is within 5 minutes from the infirmary. The center, with a 30-bed capacity, will operate around the clock.

The involvement of the St. Louis Metropolitan Police Department and the legal basis for picking up a public intoxicant and transporting him to the center for sobering up have been approved by the city counselor of St. Louis. When the center is at bed capacity, any public intoxicants picked up by the police department will be processed under present procedure, i.e., taken to one of the two city hospitals for a medical examination and then transferred to the holdover at police headquarters. There they will be booked as "Protective Custody" and released within 20 hours or booked as "Drunk-on-Street" for forwarding to the city court.

The detoxification center is designed to serve the entire population of the city of St. Louis. In the past, approximately 50 percent of the arrests of public intoxicants have occurred in the fourth police district, which is contiguous to the downtown business and industrial districts. As the center will accept patients on a first-come, first-served basis, it is not known how broad the representation of the population of the public intoxicant offender will be from the remaining police districts of the city.

The alcoholic offender will be processed as follows:

(*a*) A police officer will take the intoxicated person to the reception room of the center, where center personnel will complete identification forms and safeguard the patient's personal property.

(*b*) Center personnel will begin the necessary routines for the detoxification procedure If the patient is only in the acute stage of intoxication, he will be retained at the center. Should the patient be medically ill, i.e., with pneumonia, or should he be psychiatrically ill and display bizarre behavior, he will be conveyed by the police to either city hospital No. 1 or Malcolm Bliss Mental Health Center.

[3] Up to a seven-day period is necessary in order that the inebriate will have the alcohol out of his system as well as to reduce the impact of the acute brain syndrome.

(*c*) An intoxicant will be showered and, if necessary, deloused. Then, he will be clothed and assigned a bed. (See Attachments 1 and 2 for care of acute stages of alcoholism.)

(*d*) The patient will remain on bed care until ambulatory; the general rule is from 1 to 2 days. Drug regimen will consist of tranquilizers, vitamins, forced fluids, and a high protein diet.

(*e*) The patient will be urged to participate in physical therapy as soon as he is ambulatory.

(*f*) For the remainder of the stay, the patient will participate in the ongoing inpatient program, as follows: Attend orientation, didactic lecture, participate in group therapies, and sociodrama. Furthermore, as part of his treatment, he will be assigned a work task to aid in his rehabilitation. During his stay at the center, he will be counseled by staff members of the team as well as an employment counselor from a community agency. Discharge plans will be made by the multidisciplinary team with the appropriate followup and after care.

2. *How the Work Will Be Organized.* Operation of the detoxification center is necessarily dependent upon a "team approach" concept for insuring attainment of the project goals. Dr. Joseph B. Kendis, the half-time project medical codirector, will be responsible for supervising the medical staff who will be on duty from each noon until the following morning. Medical coverage for this period will be provided on a contractual basis with St. Louis University medical residents.

Dr. Kendis also will be responsible for establishing a medical treatment regimen to detoxify the patients. He will designate treatment routines and procedures with the necessary prescribed medication, depending upon the degree of intoxication of the patient. (See attachments 1 and 2 for care of acute stages of alcoholism.) He will also be responsible for all further medical evaluations of intoxicants admitted to the center. He will determine when the patient's condition is improved enough to warrant discharge, and will be prepared to render all medical opinions to the city court judges concerning any patient who leaves against medical advice.

Dr. Kendis will be responsible for didactic lectures and for group therapy. The entire center staff will be trained in the techniques of alcoholism group therapy by Laura E. Root, consultant in alcoholism, Social Science Institute of Washington University, St. Louis.

The administrator of St. Mary's Infirmary will share with the project codirectors the operation of the center in terms of staffing and patient care. She will be responsible, under the direction of Dr. Kendis, for supervision of all center personnel.

The staffing will provide coverage of all shifts with a minimum of three or four personnel, including a licensed practical nurse. All center personnel will serve as members of the treatment team (multidisciplinary for the modified therapeutic milieu) which will demonstrate the open-door philosophy of the treatment of the alcoholic. The detoxification center will be run under this treatment plan, which will include the usual social therapies, such as recreational group work, and sociodrama. In terms of this procedure, a large group of all ambulatory patients will meet daily for unstructured alcoholism group therapy sessions.

The social worker, as a team member, will participate in the therapeutic milieu, and a major portion of his time will be devoted to making appropriate patient referrals to community agencies, as well as work with families and employees of the patient.

III. RESULTS

1. *Evaluation.* The evaluation of the detoxification center and its impact on police and community procedures for handling the drunkenness offender will be undertaken by the Social Science Institute of Washington University, St. Louis, under the direction of David J. Pittman, Ph. D., and Laura E. Root, M.S.W., in addition to Mr. Michael Laski, research assistant of the planning and research division of the St. Louis Metropolitan Police Department. The Social Science Institute has had extensive experience in the creation, operation, and evaluation of the Alcoholism Treatment and Research Center of the Malcolm Bliss Mental Health Center in St. Louis and its current director, David J. Pittman, Ph. D., is an international authority on alcoholism.

Evaluation falls basically into two categories; the impact of the detoxification center on police, court, and correctional processes; the impact of center on the public drunkenness offender.

The measures of impact of the detoxification center on the police department, the city courts, and the city workhouse will be:

(*a*) Operation of the center will reduce the time required for a police officer to process a public intoxication offender from the location of arrest to the center, rather than to a city hospital and prisoner processing division, which is located in headquarters building at 1200 Clark Avenue. A time study will compare the processing time of the above two procedures and demonstrate the expected reduction of police involvement.

(*b*) The operation of the center will reduce the number of drunkenness cases in the city courts. A comparison will be made, by month, of the drunkenness cases on the docket for the periods of September 1, 1965, to August 31, 1966, and September 1, 1966, to August 31, 1967.

(*c*) There will be a reduction in the number of individuals arrested for public intoxication who are sentenced to the city workhouse. A comparison will be made, by month, of the number of public intoxication offenders sentenced to the workhouse for the periods of September 1, 1965, to August 31, 1966, and September 1, 1966, to August 31, 1967.

Measures of the impact of the detoxification center on the public drunkenness offender will be:

(*a*) An admission form for each patient entering the center will be prepared. It will contain basic information

for before and after measures of the effectiveness of intervention by the center on the course of alcoholism.

(*b*) Analyses:

(*i*) Demographic profile of the patient population.

(*ii*) Differentiation as to type of offenders, e.g., youthful, skid row, middle income, aged, etc.

(*iii*) Referral profiles (name of public or private agency).

(*iv*) Recidivism (based on police record check).

(*c*) Follow-up study of detoxification center patients:

(*i*) It is hypothesized that the intervention in a patient's alcoholism by the center will effect changes in the following life areas:

(A) Fewer arrests.

(B) Greater employment.

(C) Longer periods of sobriety.

(D) More residential stability.

(E) Acceptance for treatment by another agency (referral).

(F) Alcoholics Anonymous membership.

(*ii*) The cost of follow-up field interviews with all patients is too expensive. Therefore, a random sample of admissions (200) for the first 6 months will be followed up and interviewed 6 months after their discharge from the center. Measures to be systematically investigated are listed above.

2. *Significance.* The St. Louis Metropolitan Police Department expects to demonstrate, through the detoxification center, a new and more humane approach to removing the chronic police case inebriate and the indigent alcoholic from the streets. The center will employ modern treatment techniques specifically designed for the care and rehabilitation of the alcoholic. It will develop a model which any police department in communities throughout the United States or abroad could duplicate.

One important aspect of this center's role will be an initiation by the St. Louis Metropolitan Police Department of a community approach to alcoholism in conjunction with St. Mary's Infirmary, the Social Science Institute, and other public and private agencies working together to provide treatment and rehabilitation for the chronic police case inebriate.

* * * * *

3. *Continuation.* It is anticipated that the results obtained during the period of the grant will justify application for OLEA funds to finance a second year of demonstration. At the present time, the State of Missouri has an alcoholism program in the planning stages and it is hoped that subsequent funding for the center will be assumed by the city of St. Louis or the State of Missouri, or jointly.

4. *Dissemination.* A comprehensive report on the project will be prepared for dissemination to police departments and public agencies throughout the country which demonstrate an interest in the project. The report will describe in detail the method used in operating the detoxification center and the problems incurred, and will evaluate the success of the center's operation. More specifically, it will describe the effects of the center upon police processing time, the city court docket, and the city workhouse. Also, it will describe the effect of the treatment dynamics on the patients, and include the results of the follow up study which is to be made on 200 patients.

[Attachment 1 to St. Louis Proposal]

GUIDE FOR TREATMENT OF ACUTE ALCOHOLISM

1. History, physical, and neurological examination. Look for injuries and complications (as heart failure, pneumonia, tuberculosis, unconscious patients, head injury, etc.). These patients should be admitted to City Hospital.
2. Stop all alcohol. NEVER GIVE PARALDEHYDE. (Ease of paraldehyde addiction, toxicity of paraldehyde, and synergism with alcohol.)
3. Close observation to avoid accidental injury or suicide.
4. Bed rest, up to 24 hours to avoid falls and subsequent injury.
5. Vitamin B complex or Berrocca C with added 100 mg. thiamine daily i.m. for 3 days.
6. Multivitamin capsules one t.i.d. plus oral thiamine 100 mgs. t.i.d.
7. 100 mg. Librium i.m. on entry unless vital signs are depressed or other contraindications (head injury, etc.).
8. Librium 25 mg. q.i.d. orally as early as 4 hours after original i.m. injection. If patient is elderly, is debilitated, or is a small person, give Librium i.m. in 50 mg. dosage instead of 100 and orally in 10 mg. dosage instead of 25. If extreme drowsiness or ataxia develops, stop Librium until symptoms subside. Later, Thorazine 25 mgs. q.i.d. orally or this dose may be increased if necessary.
9. If there is a seizure history or course is stormy, give Dilantin sodium 100 mgm. t.i.d.
10. One capsule of Noludar, 300 mg. at bedtime and repeat one cap once during night if needed, (prn order). Withdrawal after 1 week.
11. General diet. Bedtime snack (sandwich, etc.).
12. Orange juice with 15 gm (1 tablespoonful) dextrimaltose to 300 cc. glass urged at frequent intervals. (Mainly to help replenish glycogen store in the liver and because of its vitamin C, sodium chloride, and potassium content.)
13. On admission or as soon as possible, nurse will check urine for sugar and acetone (clinitest and acetest) and notify house officer if either is present.
14. Omit any glucose from IV's until sure the patient is not diabetic (urine check).
15. Antacids 30 cc. q 2–4 if needed for gastritis (heartburn, nausea, vomiting).

16. Never give any medications containing alcohol (including cascara, elixirs, cough mixtures, paregoric, etc.).
17. In all patients with delirium tremens or hallucinosis, see form, "Treatment of Delirium Tremens."

[Attachment 2 to St. Louis Proposal]

TREATMENT OF DELIRIUM TREMENS

SYNDROME: Restlessness and insomnia, hallucinations (auditory and visual), illusions, disorientation, tremor, fear.

EXAMINATON: Physical and neurological examination. Check vital signs and level of consciousness. Note head injury, fractures, pneumonia, tuberculosis. Ask for consultation if the patient has any complication. Unless a closed ward is mandatory, patients with possible head injuries are admitted to Surgery, those in coma or with pneumonia to Medicine, and those with convulsions to Neurology. Admit to the hospital for care.

ORDERS TO BE WRITTEN:

1. Stop alcohol.
2. Constant supervision to avoid accidental injury or suicide.
3. *Bed rest* for 24 to 48 hours to give the patient rest, to avoid orthostatic hypotension while patient receives tranquilizers, and to avoid falling during a convulsion with the possibility of sustaining a head injury and the development of a subdural hematoma.
4. *Regular diet.*
5. *Force fluids.* Give fluids by mouth if possible. Orange juice with ½ oz. dextrimaltose to 10 oz. glass urged at frequent intervals. (Mainly to replenish glycogen stored in the liver and because of its vitamin C, sodium chloride, and potassium content). If fluids cannot be retained by mouth, give 1,000 cc. of 5 percent glucose/saline I.V. with 4 cc. Berocca-C 500.
6. *Vitamins.* Multivitamin capsules 1 p.o. t.i.d. and thiamine chloride 100 mg. p.o. t.i.d. Each time the patient refuses oral medication, give parenterally Berocca-C 2 cc. i.m.
7. Librium 100 mg. i.m. stat. Then 25 to 50 mg. orally every 4 hours to control agitation..
8. *Sedation.* Chloral hydrate 1.0 gm. h.s. (or nonbarbiturate hypnotic) p.r.n. for insomnia. May be repeated once. *Do not use Paraldehyde* (addiction, toxicity, synergism with alcohol).
9. *Antibiotics.* As indicated for infection.
10. *Antiacids.* For gastritis 30 cc. Amphogel every 2–4 hours.
11. *Barbiturates.* Use only to control convulsions: Phenobarbital .03 gm every 6–8 hours. If patient goes into status epilepticus, call the neurology consultant. Intravenous sodium luminal (phenobarbital) in large amounts (0.3–0.6 grams) is the drug of choice.
12. *Dilantin-sodium.* 100 mg. t.i.d. may be given prophylactically if there is a seizure history or if the course is stormy.
13. Keep *full light on* in room at night to avoid shadows and allay delirium. A reassuring nurse or attendant is helpful in allaying apprehension. Restraints are *not* to be used as they only tend to make the patient more agitated. The patient must be under constant supervision so that he does not injure himself in response to his hallucinations.
14. *Urinalysis.* Rule out diabetes mellitus with acetest and clinitest on admission.

[Attachment 3 to St. Louis Proposal]

TREATMENT PROGRAM—"A NEW APPROACH": DETOXIFICATION CENTER FOR THE ST. LOUIS METROPOLITAN POLICE DEPARTMENT

The chronic court and police case inebriate have a potential for rehabilitation. In most courts, judges have the problem of handling this individual whom we have termed the "revolving door alcoholic." Most judges attempt to use every means at their disposal to avoid the inebriate's incarceration while waiting for treatment services to be established. Unfortunately, in the United States, most communities do not offer many services to this marginal man.

Research studies have shown that repeated jailing does not act as a deterrent to the revolving door alcoholic. Up to the present, most communities use incarceration as the method of treatment which, from the point of view of rehabilitation, is a failure. Custodial care is the traditional approach used in handling the inebriate as opposed to offering any systematic regimen for these individuals. The only positive aspect of custodial care during incarceration is the meeting of the man's basic needs for shelter and food and the enforcement of sobriety. Generally the physical resources are repaired during incarceration, but they are soon debilitated following release and the onset of another drinking episode. Nonpunitive treatment for his excessive drinking will be given the public alcoholic when he is picked up DOS (drunk on the streets) and brought to the detoxification center rather than being sent to the jail or workhouse, or released back to skid row. The detoxification center will provide care for these alcoholics—a sobering up process for a 7-day period.

Treatment will be based on the belief that these individuals are salvageable and that they can be helped to live a life without alcohol through reeducation and treatment. Ultimately some can learn to break their dependency needs and learn to be self-supporting as well.

For those who are mentally or physically ill and need care, they will be transferred for appropriate treatment. It can be anticipated, however, that some will need custodial care, either in a chronic hospital or a mental institution.

We suggest this type of program, which is basically a sobering up center, because it has been found in some of the European countries that this kind of treatment can help the public alcoholic. An attempt must be made to begin effective intervention for this type of offender, especially in view of the recent court rulings on public intoxication which is expected to be appealed to the Supreme Court for a decision.

In St. Louis, at the Malcolm Bliss Mental Health Center, an Alcoholism Treatment and Research Center (ATRC) opened in February 1962. Part of this was a grassroots community effort in which citizens raised $47,500 which then was matched by Hill-Burton funds, to create this first public treatment facility in the State of Missouri. The ATRC is the site of a 5-year (1961–66) mental health demonstration project, with a total funding of $250,000 sponsored by the U.S. Public Health Service (Grant No. MH 657) with David J. Pittman, Ph. D., as the principal investigator.

The location of the demonstration project in a municipal hospital made it possible to work with a lower socioeconomic population, which to date has received little or no systematic study. It is upon the basis of the clinical results which were obtained that this treatment is proposed for the public alcoholics.

The detoxification center will make use of the following treatment techniques: (1) Counseling and evaluation (vocational/employment); (2) physical therapy; (3) group therapy; (4) work therapy; (5) self-government; (6) didactic lectures and films; and (7) sociodrama. The purpose of this design is to help the public alcoholic to be rehabilitated and ultimately self-supporting.

A study will be made of each patient in order to evaluate his personal resources for meeting the demands of life. It will be an assessment of positives rather than negatives. It has been found through clinical experience at ATRC that when the staff emphasizes an individual's potentials rather than his negative traits, this creates an atmosphere of acceptance for the alcoholic right from the start. Therefore, any assessment or evaluation of the public alcoholic must be positive from the outset.

During the evaluation period, patients will be expected to participate in the ongoing program. Once the evaluation is completed, there will be a conference held by the staff to establish tentative goals for the clients' aftercare program in the community. The patients must be involved in this planning.

The physical part of the program will be held each morning and every participant who is physically able shall be expected to work out in the yard, otherwise it will be held within the facility. This is one of the best methods of assisting the physically debilitated alcoholic to get back into shape.

Group therapy will be conducted by the various staff members with the participants. It will be held on a daily basis with patients who are ambulatory as well as many staff members who are on duty participating. Unstructured group therapy sessions will be held for not more than 1 hour. If the discussion is such that the patients would like to continue, they may break up into smaller groups of six to eight with an aid acting as the therapist.

Research and clinical experience in the field of alcoholism throughout the world has made group therapy the treatment of choice for most alcoholics. When the term "unstructured group therapy" is used, it does not mean the same as group psychotherapy. The alcoholism therapist is more direct and didactic, inasmuch as it is within this technique of treatment that many of the alcoholics dependency needs are met and handled.

Work therapy is an integral part of the rehabilitation of the public alcoholic once he enters the center. Clinical experience has shown that the alcoholic needs to relearn acceptance of responsibility as part of his treatment. Therefore, each patient will be expected to volunteer for a work task under the guidance of the housekeeper and the chairman of the self-government. He will be expected to assume responsibility for this task for the duration of his stay and will be expected to take pride in his work.

It can be anticipated that at first he will be somewhat reluctant to involve himself in work therapy. However, if he gets support from the staff and the fellow patients, he will soon find it acceptable.

The patients at the center will have a self-government structure which would give these individuals an opportunity to assume further responsibility. Elections would be held on a weekly basis and the first group of patients would be encouraged to establish the pattern and set up a constitution with their own rules and regulations which would be appropriate to the detoxification center program.

Didactic lectures and films will be held frequently and will provide current basis information about the disease of alcoholism, together with all its ramifications which occur as a result of this disease. Staff members will assume responsibility for the lectures and selection of film.

Lectures will be confined to 25 or 30 minutes in length, followed by discussion period. Lectures will include information on the physical, socioculture, psychological, and socioeconomic aspects of alcoholism.

Sociodrama will be conducted two times a week, and will consist of role playing and acting out sessions, such as an interview with a future employer. It is expected that given the proper training some of the aides could be trained to utilize this technique.

The above program is geared to handle the treatment and rehabilitation of the public alcoholic while he is in the detoxification center. It will be necessary to discuss aftercare in the next section.

AFTERCARE

It is presumptuous to assume that the public alcoholic will be able to change his type of life pattern which he has had for many years, after 7 days in the detoxification center. A strong aftercare program must be made available to reinforce his new life patterns. In designing an aftercare program, it would be impossible to have avail-

able all methods of aftercare treatment which are needed. Therefore, it is necessary to make use of existing community resources. Understandably, many of the agencies will have to be assisted in learning to give service to the public alcoholic. It can be anticipated that some community action will be necessary if these agencies are to assume their responsibilities in the totality of aftercare.

An integral part of the comprehensive treatment plan of the indigent alcoholic and alcoholic offender, will be the use of the Lee House which is a boarding home for men and women alcoholics. It is anticipated that aftercare for some of the patients would be the use of this facility. For some men who would not be ready for community living, an appropriate discharge plan would be a stay at Lee House where he would receive a modified live-in experience with supervision and support of his new life patterns.

Conceivably, after a period at a halfway house, the indigent alcoholic could move back into his own living situation, with attendance at AA as well as return visits to the detoxification center. Here he could be comfortable in having a facility and staff which would understand and reinforce his objective of sobriety and the ability to be self-supporting.

Other community agencies which could be anticipated as participating in this aftercare program of the detoxification center would be health and welfare agencies, mental health services, and hospital facilities. The agencies would have to understand the relationship between the public alcoholic and poverty. Because of his drinking problem, he has had limited social and economic resources, which places him at the bottom strata of society. Any help must include continuing therapies to support his sobriety as well as retraining to provide basic economic skills, which are necessary in any urban society. These agencies can assist an alcoholic to establish himself in the community. An example of this could be the involvement of the Missouri Division of Employment Security and the Division of Vocational Rehabilitation. It is anticipated that counselors from these agencies will be assigned to the detoxification center which would meet a needed service. They, together with the staff social worker who had evaluated the patient, could make appropriate job referrals and/or recommendations for retraining where appropriate.

Other welfare agencies which could be expected to be involved in aftercare would be Salvation Army Men's Social Service Center and Goodwill Industries. Both of these agencies have worked very well in assisting some of the alcoholics who were in the ATRC program at Malcolm Bliss Mental Health Center.

Currently, there are no outpatient clinics for alcoholics in St. Louis. It would be hoped that in the future ATRC would establish an outpatient clinic which could give service to the detoxification center participant who is out in the community.

Mental health services, such as outpatient psychiatric clinics at the various hospitals will be available to the alcoholics in their rehabilitation program should they have any additional psychiatric problems other than the alcoholism.

Hospital facilities, as we indicated earlier, will be available both for physical, chronic, and psychiatric care. It would be expected that these facilities would be utilized by the detoxification center participant when needed.

An appropriate aftercare program for the public alcoholic is one of the most important factors to be considered in the total treatment program. Continued support, while he is striving to obtain his goal of a new life pattern is imperative for the public alcoholic.

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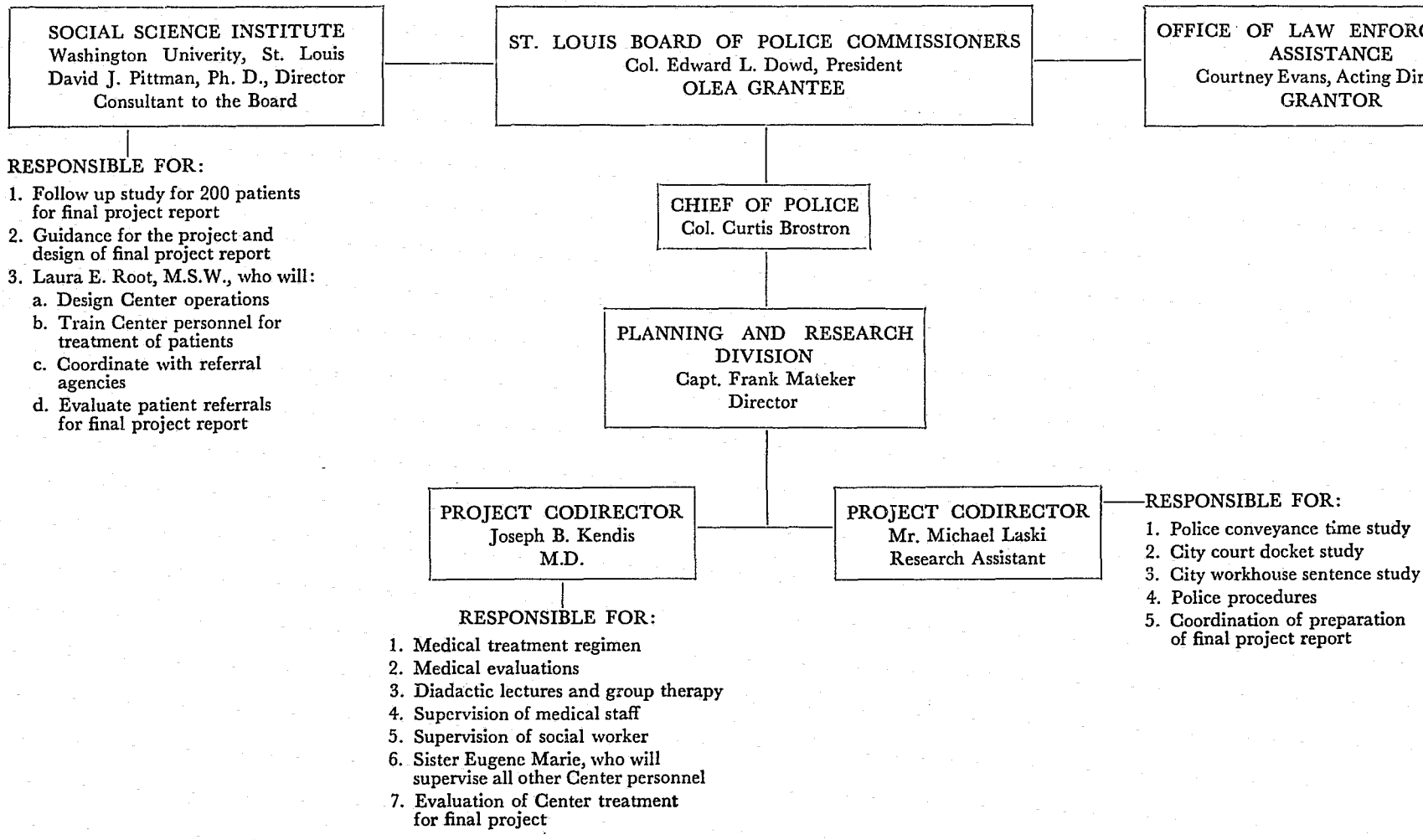
[Attachment 4 to St. Louis Proposal]

ORGANIZATION CHART—ST. LOUIS DETOXIFICATION CENTER, LOCATED AT ST. MARY'S INFIRMARY, THIRD FLOOR, 1536 PAPIN STREET, ST. LOUIS, MO. 63103



PROPOSAL FOR THE MANHATTAN BOWERY PROJECT

I. SUMMARY OF THE PROPOSAL

A. In May 1966, at a meeting of New York City judicial and law enforcement officials, Mayor Lindsay requested the Vera Institute of Justice to develop a humane and effective program for assisting homeless alcoholics.[1] Since that time Vera staff members have consulted with and made trips to the Center for Alcohol Studies in New Brunswick, N.J., as well as to alcoholism programs in Boston, Rochester, St. Louis, San Mateo, Seattle, and the District of Columbia. The staff have also compiled an inventory of services in and around New York City which assist alcoholics and skid row men. They have observed the actual operations of many of these programs and discussed their procedures in detail with both their staff and clients.

On the basis of staff research, the Vera Institute has concluded that:

1. there is an urgent need for emergency street rescue, sobering-up, and drying-out services for homeless alcoholics;
2. such emergency services must be effectively tied into existing long-term rehabilitative programs for this group; and
3. all efforts and services on behalf of these men should operate on a voluntary basis without the use of either arrest or involuntary commitment.

A preliminary proposal for the establishment in lower Manhattan of a street assistance program and a drying-out infirmary was submitted to Mayor Lindsay on November 1, 1966. This proposal was tentatively approved by the Mayor and submitted to the New York State Department of Mental Hygiene in December 1966. The Department of Mental Hygiene while endorsing the plan generally suggested that more extensive medical supervision and hospital backup would be required for its effective operation. The Vera Institute then entered into discussions with St. Vincent's Hospital concerning the possibility of their participating in this project. St. Vincent's, after careful review of the original proposal, agreed to take on medical supervision of the proposed project and to provide necessary hospital backup.

B. The Vera Institute, therefore, in cooperation with the New York City Departments of Welfare, Police, Correction, Health, and Hospitals, and with St. Vincent's Hospital, now proposes to develop and coordinate a 1-year demonstration program, the Manhattan Bowery Project, which would substitute for the present revolving door policy of police, court, and jails, a medically oriented noncoercive assistance approach toward the homeless derelict of the Bowery.

Primary administrative responsibility for the project would be vested with the Vera Institute of Justice. State, Federal, or private funds in support of this project would be channeled to Vera directly or to the New York City Community Mental Health Board (or some other appropriate city agency) which would allocate the necessary funds to Vera. Vera would in turn subcontract with St. Vincent's Hospital and members of its staff to provide medical supervision and hospital backup for the project. Vera would also enter into agreements with the city of New York by which the city would provide the project with the space and services of the Men's Shelter and with necessary services from the Departments of Correction, Police, and Welfare. The project would begin May 1, 1967. If successful, administration of the project would ultimately be taken over on a permanent basis by an appropriate municipal agency. This proposed administrative arrangement is, of course, subject to such modification as the city of New York, St. Vincent's, and the funding agency would deem appropriate for the effective funding and operation of the project.

In addition to the city agencies and to St. Vincent's Hospital the following private organizations have agreed to cooperate with the program: the Salvation Army; Volunteers of America; Holy Name Center; Bowery Mission; Herald Counselling Center; and the Fellowship Center, Inc.

This description of the proposed Manhattan Bowery Project is part of a grant application by Vera Institute of Justice to the State of New York for funding for the project.

[1] For the purposes of this proposal the term "homeless alcoholic" refers to destitute men in public physical distress on or near the Bowery. Most, but not all, of these men are under the influence of alcohol at the time of their distress.

1. The Manhattan Bowery Project would operate in the following way:

a. A street rescue patrol under the administrative supervision of the Vera Institute would secure on a voluntary basis, transportation, shelter, and medical assistance for those men who are so obviously intoxicated or debilitated that they are unable to take care of themselves on the street.

b. A pilot, 50-bed detoxication ("sobering up") and alcoholic withdrawal ("drying out") infirmary would be established at New York City's Men's Shelter. The infirmary would be under the medical supervision of St. Vincent's Hospital; patients requiring hospital care would, in most instances, be transferred to St. Vincent's.

c. A diagnostic and screening service for infirmary patients and a patient referral service to rehabilitation programs, mental, chronic disease, or TB hospitals, custodial and nursing institutions, vocational training centers, etc. would be developed. The referral services would emphasize effective followup by physically escorting discharged patients to referral agencies and conducting negotiations on their behalf for continued help by such agencies.

d. Full utilization and coordination of existing services and the development of improved or additional services for homeless alcoholics would be encouraged.

2. If successful, the project would accomplish the following individual and community benefits:

a. *More effective help for homeless alcoholics.*

(1) The patient would be sobered up in a protected atmosphere without the risk of physical assault, accident, or exposure on the street.

(2) He would be withdrawn from alcohol under adequate medical supervision. Symptoms of alcohol withdrawal such as nausea, shakes, hallucinations, and anxiety would be diagnosed and appropriate treatment administered. Patients with serious medical complications to their alcoholic condition such as diabetic coma, cardiac, or lung involvement would be diagnosed and promptly hospitalized.

(3) The chronic alcoholic would end the heavy phase of his drinking bout sooner and with less serious consequences to his health.

(4) He would be encouraged and actively assisted in entering rehabilitation programs suited to his age, background, and capacity.

b. *Relief of distressing conditions in the Bowery neighborhoods.*

(1) Fewer men would appear on the street drunk, incoherent, and in a state of deterioration and filth.

(2) The street atmosphere should be more conducive to family life and business; property values in the neighborhood might even be affected.

(3) A reduction in the numbers of intoxicated men who stagger across the Bowery would facilitate the flow of traffic.

c. *Reduction of the burden on the police and the criminal system.*

(1) The number of homeless alcoholics and other Bowery men who would otherwise be shunted through the criminal process should be substantially reduced. Police, courts, and correction would thus be able to concentrate their efforts on detection of more serious offenders and on improving the quality of justice and the rehabilitation of offenders.

d. *Benefits to community health facilities.*

(1) The program would help to maintain a tolerable health level among homeless alcoholics; fewer men would require emergency admission to hospitals and those men admitted would enter in better condition and require shorter periods of treatment.

(2) The street rescue system would obviate the necessity for ambulance calls for homeless alcoholics who are merely intoxicated or debilitated.

(3) The infirmary program would provide prescreening of potential hospital patients. Some men who might otherwise seek attention at a hospital emergency ward or outpatient clinic would be treated by the project or referred to a less intensive source of treatment. The preliminary delousing and bathing service of the infirmary would make any subsequent hospital treatment of these men far less onerous for hospital personnel than it would be if these men came directly to a hospital from the street.

(4) The delousing and tuberculosis detection services of the infirmary would reduce the risk of public contagion.

II. THE PROBLEM AS IT EXISTS TODAY

Alcoholism afflicts an estimated 1 out of 15 Americans. The great majority of alcoholics remain relatively nonvisible to the general public. But this is not so on the Bowery or on skid rows in other cities. There the alcoholic is distressingly, embarrassingly visible. By no means are all the men living on the Bowery alcoholics, although the incidence of alcoholism is higher among this segment of the population than among the population as a whole. A recent study by Columbia University's Bureau of Ap-

plied Social Research indicates that approximately 20 percent of the Bowery's 6,000 homeless men are alcoholics, that is, men who get drunk almost every day, work sporadically or not at all, and probably cannot stop drinking without going into alcoholic withdrawal. Another 20 percent of Bowery men go on periodic binges. Such men work regularly at spot jobs and seasonal occupations, but punctuate working periods with heavy drinking bouts, at the end of which they are physically spent. The remaining 60 percent of the Bowery population are working men and pensioners who constitute little problem to society.

In September 1966, a series of street censuses made by the Vera staff found that at any one time, the total number of prone or staggering public drunks on or within two blocks of the Bowery did not exceed 20 persons.

The high visibility of homeless alcoholics is attributable to their lack of family or social ties: When the homeless alcoholic falls in the street, there is no one to put him to bed. No taxi driver or doorman sees that he gets home. The intoxicated Bowery man lies where he falls or is put in a paddy wagon and escorted to court where he generally receives a suspended sentence and is turned loose. The acute psychotic wards of municipal hospitals theoretically provide medical care to assist a destitute alcoholic in getting through the period of shakes, tremors, impending DT's, and other physical symptoms which accompany alcoholic withdrawal. Indeed, many destitute alcoholics come to hospital emergency wards and plead for admission. But in fact overcrowded hospitals, particularly in lower Manhattan, are able to admit only those alcoholics who have active delirium tremens or dangerous medical complications over and above their alcoholic condition. While the administrators of many of these hospitals would like to provide medical care for these men, other more desperately ill patients claim first priority on hospital beds. In consequence, men in a state of filth and deterioration stagger along the Bowery. Many collapse on the sidewalk where they are an eyesore and a nuisance, or worse, become a target for hoodlums whose specialty it is to prey upon homeless men.

The practice of arresting and jailing derelicts has come under increasing attack by medical and legal authorities. For one thing, the arrest process, particularly when it relies upon daily roundups, frequently sweeps into court men who are neither drunk nor alcoholic, but simply impoverished inhabitants of skid row areas. In 1964 alone, 68,000 skid row arrests were processed through the New York City criminal courts—a figure representing 34 percent of all citywide arrests that year. In almost every case the arrested person without the benefit of counsel pleaded guilty. In January 1966, however, with the introduction of Legal Aid attorneys to the New York City Men's Social Court, the conviction rate of homeless men arrested on alcohol-related charges—generally the lounging and loitering section of a disorderly conduct charge—fell from 98 percent to 2 percent. As a result the police stopped the practice of daily roundups of the derelicts in the area. This in turn was followed by a demand by Bowery merchants and civic organizations that police resume "cleaning up" the streets. Police have recently begun picking up homeless men again, but now on charges of soliciting alms, wiping windshields, assorted park violations, etc.

The revolving door process of arrest and jail accelerates the deterioration of the Bowery derelict by reinforcing his feelings of hopelessness and shame. The recidivism rate of homeless alcoholics who go through the criminal process each year is shamefully high. The annual cost of such processing to New York City is in millions of dollars; yet it achieves little more than cleaning the streets for short periods of time.

The police and court process is sometimes jutsified on the grounds that homeless alcoholics are taken off the streets long enough to restore them to health. Yet the facts do not sustain this justification: in police roundups many of the worst cases are left lying on the street; most of those arrested receive suspended sentences and are back on the street in a matter of hours.

Recent Federal court decisions indicate that the criminal process may soon be unavailable as a means by which the streets can be cleared of homeless alcoholics. In both *Driver* v. *Hinnant* and *Easter* v. *District of Columbia,* Federal appellate courts held that it is unconstitutional to convict chronic alcoholics of public intoxication or other alcoholism-related offenses.

Defendant Driver had a record of over 200 arrests for public intoxication in the North Carolina State courts. Defendant Easter had a record of over 70 arrests in the District of Columbia on charges of public intoxication and related offenses. The U.S. Court of Appeals for the Fourth Circuit held that since Driver's intoxication was a medical symptom of an uncontrollable disease, a criminal conviction for public intoxication would be unconstitutional as a cruel and unusual punishment. In the *Easter* case, the Circuit Court of Appeals for the District of Columbia held that chronic alcoholism is a defense to a charge of public intoxication.

The issue of the constitutionality of convicting chronic alcoholics for public intoxication has not yet reached the Supreme Court. Over a dissent by Justices Douglas and Fortas, the Court recently refused, probably for procedural reasons, to review a California case involving this issue. The Court's refusal to review the case at this time can in no way, however, be interpreted as an indication of its disagreement with the holdings of either *Driver* or *Easter.*

III. DESCRIPTION OF THE PROPOSED MANHATTAN BOWERY PROJECT [2]

The Manhattan Bowery project would undertake to perform four basic services and, in addition, to evaluate the impact of these services on homeless alcoholics, the Bowery neighborhood, and public agencies.

The aspects of the proposed project are summarized below:

A. *Street Rescue*

Seven days a week, the Bowery and its immediate vicinity would be patrolled by a three-men team com-

[2] In the United States at this time there is no existing formal program which provides both street rescue and voluntary detoxication for homeless alcoholics. The Vera Institute, in an attempt to forecast some of the practical problems that might arise in connection with operation of such a program, and with the cooperation of the Departments of Welfare, Police, and Correction conducted on Oct. 13–14, 1966, a prepilot rescue and detoxication service for a 24-hour period in the Welfare Department's Shelter for Men at 8 East 3d Street. A three-man street rescue team approached 16 Bowery men who were either prone on the street or seemed about to go down. These 16 men represented a majority of all such men on the Bowery between noon and 5 p.m. on October 13 (a warm and sunny day). Thirteen of the 16 agreed to come to the Men's Shelter where they were washed, deloused, and put to bed. Twelve of these men remained at the shelter for the night; the 13th stayed for a meal and counseling from the director of a Bowery alcoholism program and then left. The men were examined by a physician and kept under round-the-clock nursing supervision. No one developed serious medical complications while in the infirmary. There were no problems of order or discipline. The next day 10 of the 12 men agreed to enter an alcoholism rehabilitation program sponsored by the Bowery Mission; 1 man was sent to Camp LaGuardia; and 1 man returned to his lodging house. Despite short notice the Department of Welfare provided a refrigerator, stove, and television set. In addition the Men's Shelter staff assigned social work personnel to the experiment. Presence of adequate medical personnel to provide medication and precautionary examinations was considered a key to the relatively trouble-free operation of the 2-day project.

posed of a lodging house clerk, a rehabilitated alcoholic, and a plainclothes policeman. The New York Police Department has tentatively agreed to make available the necessary police coverage. Rehabilitated alcoholics would be recruited from graduates of programs operated by the Salvation Army, Bowery Mission, Volunteers of America, and Fellowship Center. The lodging house clerks would be paid out of the project's budget.

The street team would seek out and offer assistance to homeless alcoholics who are either prone, intoxicated, or in a state of physical deterioration. If the offer of help is accepted, the man would ordinarily be transported to the infirmary facility described below. Should the man refuse transportation to the infirmary, alternative forms of assistance would be offered; for example, the man could be driven to a lodging house or to a facility maintained by the Salvation Army or the Bowery Mission.

The street patrol would send men who seemed dangerously ill to a hospital immediately rather than transporting them to the infirmary first. The patrol would summon an ambulance for any man who was unconscious, unable to walk, incoherent, or in some acute medical emergency. The ambulance would transport such a man to a nearby hospital.

The function of the policeman would be to protect both the civilian team members and the derelicts from assault or infringement of their rights. The policeman would also act as driver of one of two unmarked station wagons which would be supplied to the project by the Police Department. In appropriate cases, the police officer would summon an ambulance on the car's radio.

B. *The Detoxication and Withdrawal Infirmary*

The New York City Welfare Department has tentatively agreed to make available an upper floor of the Men's Shelter as an infirmary for the pilot project. Architects from the city's Department of Hospitals inspected the building and concluded that this floor has adequate room for wards, offices, treatment and recreation areas and is equipped with good shower and toilet facilities. Members of St. Vincent's staff with extensive experience in hospital administration also inspected the shelter and found it eminently suitable for use as an infirmary facility.

The basement of the shelter has a fully operative kitchen which feeds as many as 3,000 men at a sitting. The feeding of infirmary patients could be absorbed into the shelter's meal program. The shelter is also equipped with a Department of Health tuberculosis examining station where clients are regularly screened. The caseload of the infirmary could be included into the examination program of the health station.

The medical treatment services and the hospital backup for the proposed infirmary would be under the supervision of St. Vincent's Hospital. The Vera Institute of Justice would have ultimate administrative responsibility for the operation of the infirmary and would take direct charge of nonmedical administrative matters, including supervision of office personnel, bookkeeping, ordering of nonmedical supplies, and similar matters.

During the first month of operation, the infirmary would limit its capacity to 25 beds, but once the staff has been trained the capacity could be expanded to 50 beds. At full capacity, and assuming an average of a 3-day stay per patient, the daily intake would be about 17 patients; thus, the annual capacity of the station would be approximately 6,000 patients. On the basis of discussions with physicians experienced in treating homeless alcoholics, we estimate that the required staff and treatment would be as follows:

1. Staffing

The staff of the infirmary (including the street rescue team) would include:

Position	Total number of persons required to provide 7-day week operation
Medical director, devoting one-third of his time to the project	1
Consulting psychiatrist, devoting 2 days per week to the project	1
Physician coverage:	
Daytime (8 a.m. to 8 p.m.) 6 hours on ward duty; on call service at other times	4
Nighttime (8 p.m. to 8 a.m.) physician will sleep at infirmary and will provide services as required	3
Nursing coverage:	
Registered nurse: 24 hours a day	4
Practical nurse: 24 hours a day	4
4 medical case aides: 24 hours a day	18
Project coordinator	1
Assistant project coordinator	2
Social case work coverage:	
1 case supervisor	1
1 case worker	1
Social case aides	8
Correction officer:	
24 hours daily coverage (to act primarily as ward clerk but also to maintain order if necessary)	5
Secretaries	2
Street patrol:	
Police officer, 16 hours daily	4
Lodging house clerks, 16 hours daily	4
Rehabilitated alcoholic, 16 hours daily	4
Janitorial coverage: Provided as needed by Men's Shelter staff	
Total	67

The infirmary's medical director would be Dr. Robert Morgan, a physician on the staff of St. Vincent's Hospital who has had extensive experience in the treatment of alcoholics.[3] In so far as possible the project's staff physicians and nurses would be recruited from the St. Vincent's Hospital staff and would retain their official status as St. Vincent's employees. The medical case aides, like the civilian members of the street rescue teams, would be recruited either from alcoholic rehabilitation programs or from the clerical staffs of Bowery lodging houses. Medical aides would be paid by the cooperating agency.

2. Treatment

The medical operations of the infirmary would, of course, be subject to continuing revision and evaluation by the medical director and staff physicians. At this time we believe the treatment can be expected to be along the following lines:

A man brought to the project's infirmary would be examined by the physician on duty to determine the degree of physical disability. If no medical emergency existed, the patient would be showered, deloused, and put to bed. He would be medicated as needed until sober. On awakening he would be fed, and then re-

[3] Robert R. Morgan, M.D.: B.S. St. John's University, 1952; M.D. Cornell Medical School, 1956; internship and residency St. Vincent's Hospital, 1956–60; Gastrointestinal Fellow Brooklyn's V.A. and Kings County Hospitals; Diplomate, American Board of Internal Medicine; Fellow, American College of Gastroenterology; Associate, American College of Physicians; member: American Society of Internal Medicine, American Federation for Clinical Research, New York City Medical Society on Alcoholism.

examined and a more detailed medical history taken by a staff physician. Each patient would have a chest X-ray, urine analysis, complete blood count, serology, and transaminase blood tests. Other tests would be made as indicated.

If any grave medical condition developed after admission to the treatment facility (such as heart attack or stroke), the patient would ordinarily by transferred by ambulance to St. Vincent's Hospital. In some circumstances it might prove impossible to admit the patient to St. Vincent's: The patient might be suffering from a condition which St. Vincent's is unequipped to treat (tuberculosis, for example); in certain extraordinary situations bed space might be unavailable. In such situations the patient would be transferred to another city or voluntary hospital. St. Vincent's would, of course, undertake primary responsibility for providing hospital care to infirmary patients.

If specialized consultation, diagnostic tests, or treatment were needed, such as setting a fracture, extensive suturing, or special X-rays, the patient would be transported by ambulance or one of the project's vehicles to the St. Vincent's Hospital emergency room or outpatient department for these services. When treatment is completed, the patient would be returned to the infirmary.

If no emergency requiring hospital admission developed, the patient would remain at the infirmary under medication until alcohol withdrawal symptons had passed. It is anticipated that, depending on the extent of drinking and physical deterioration prior to admission, and on available referral resources, a patient would remain in the infirmary for a period of 2 to 5 days.

Extended care would not be provided. A patient requiring such long-term care would be referred either to a hospital, nursing home, mental hospital, or a semicustodial institution such as Camp La Guardia.

While at the infirmary, a psychiatrist would be utilized to aid in diagnosing underlying mental illness, and to supervise group psychotherapy twice a week. AA meetings would be held, and staff members would discuss problems with the men. Social work screening and referral would be done. Recreation facilities including television, reading material, and cards would be available.

Subsequent to discharge, if the patient remained in need of medication, he could return daily to the infirmary to receive it. In appropriate cases antabuse medication would be encouraged. Also, in selected cases, where anxiety was great, the patient could be given tranquilizers. Discharged patients would be encouraged to return and participate in group meetings.

A patient's stay at the infirmary would be voluntary. At the time of his admission he would be informed of this fact, and he would be so informed again as soon as he was sober. A patient would be told, however, that the doctors recommend that he remain in the infirmary until he is sufficiently withdrawn from alcohol so that he would be in no danger of serious medical complications.

C. *Screening and Referral Service*

A tentative arrangement has been worked out with the Department of Welfare to screen patients by the combined staffs of the Manhattan Bowery Project and the Men's Shelter. The Vera Institute would have administrative responsibility for the screening and referral service. Each patient would be interviewed by social case aides who would be recruited from the Urban Corps and who would work under the supervision of a Department of Welfare caseworker. A wide range of referrals is available, and methods and standards for facilitating referrals, and actively assisting the men in following up on such referrals would be developed by the combined staffs. For example, caseworkers might recommend that some patients enter a rehabilitation program sponsored by the Salvation Army or the Bowery Mission, that those patients in need of prolonged semi-institutional care might enter Camp LaGuardia and that others be referred to a supervised lodging house which might serve as a halfway house. Many patients would, of course, be referred to Operation Bowery for psychiatric and social counseling.

There would be no limit to the times a patient could use the services of the infirmary and no penalty attached to repeated use. If anything, repeated use would be encouraged so that a man could learn to put an early stop to a drinking binge. It is anticipated that a certain number of alcoholics would appear repeatedly at the infirmary in a steadily deteriorating condition. The staff would try to persuade such a man to seek institutional care.

D. *Program for Utilization and Further Development of Services for Bowery Alcoholics*

Services currently available to Bowery men are surprisingly numerous. At present, however, many homeless alcoholics either do not know of their existence or are put off by complicated referral procedures. There is, moreover, considerable duplication of services by private and public agencies. An important function of the project would be to encourage better utilization of existing services and to develop communication and cooperation among private and public agencies concerned with homeless alcoholics. The staff would develop referral techniques which require minimum waiting time on the part of the Bowery alcoholic. For example, the project would try to arrange that a patient wishing to enter Camp LaGuardia or a private rehabilitation program would be transported to the facility directly from the infirmary instead of waiting several days at a lodging house. The staff would also work with the Department of Welfare to see that patients qualify for Medicaid and Medicare assistance, social security, union disability, and other benefits to which they are entitled.

Another way in which the project could be useful is by encouraging the development of more effective law enforcement in the Bowery area. At the present time,

Bowery men are routinely mugged by hoodlums who descend on the Bowery on "check days," those days when it is known the men received social security, veterans', and other disability benefits. The Vera staff is presently assisting the police in working out plans for increased police protection.

Increased law enforcement is also needed with respect to the control of bars and liquor stores in the Bowery area which sell alcohol in violation of the Alcoholic Beverage Control rules. The project staff could work with the police, the Alcoholic Beverage Control Board, and the liquor industry to cut down on these illegal sales.

E. *Evaluation of the Project by a Team of Sociologists Under the Supervision of the Vera Institute Would Be Conducted Along the Following Lines:*

1. Impact of the program on street conditions in or near the Bowery; decrease in the numbers of publicly distressed men.

2. Practical problems involved in operating the project; percentages of the men approached by the street rescue team who agree to enter the program voluntarily; alternatives for those men who refuse help; numbers admitted to the project; length of stay; physical condition of the men at admittance and on discharge; relative effectiveness of various kinds of treatments, screening, and referrals.

3. Impact of the program on arrest policies and the administration of justice; decreases in the number and kind of alcohol-related arrests after the inception of the project; decrease in the numbers processed through the courts or admitted to correction facilities.

4. Impact on health facilities in the area; decrease in ambulance calls; effect upon hospital admissions in the area and length of stay of alcoholic patients in hospitals; decrease in reported accidents involving alcoholics.

5. Problems involved in transferring administrative control of the project from a private to a municipal agency; evaluation of the effectiveness of the transfer.

Careful statistics and records would be kept by the project from its inception. Medical and social records of all patients would be compiled, and an assessment of the program in each case would be attempted.

IV. ESTIMATED OPERATIONAL BUDGET

The total estimated cost for 1 year of operation of the Manhattan Bowery Project will be $618,515. Public and private agencies in New York City have tentatively agreed to underwrite a substantial part of this cost. Additional funding of only $353,890 is still required.

A. *Elements of the Project for Which Financing has Already Been Secured*

1. Contributions by the city of New York:	
a. Department of Welfare:	
(1) Meals and snacks for 50 patients a day, 365 days a year at $1.20/day/patient	$22,000
(2) Heat, electricity, janitorial, and maintenance for 5th floor of Men's Shelter	18,000
(3) Linen service to supply 50 patients/day with sheets, night clothes, towels, bedding, robes at $0.30/patient	5,500
(4) Housekeeping supplies—soaps, disinfectants, paper goods, mops, pails, etc	1,000
(5) New clothing for estimated 10 patients/day at $4/patient	14,600
(6) Equipment: 15 motel-type beds and mattresses at $70/unit	1,050
Office and storage equipment: 7 desks at $100, 5 file cabinets at $100, 15 chairs at $20, 5 steel storage cabinets at $50	1,750
Pantry equipment: sink, stove, refrigerator, storage cabinets	300
Recreation and dining furniture:	
40 straight-back chairs at $15	600
5 dining tables at $50	250
10 lounge-type chairs at $30	300
(7) Personnel: 2 welfare caseworkers at $7,000 annual salary	14,000
Total Welfare contribution	79,350
b. Department of Correction:	
5 correction officers (full time): estimated annual salary including pension, health and life insurance, and other fringe benefits, $10,000	50,000
c. Police Department:	
4 police officers (full time): estimated annual salary including pension, health and life insurance, uniform allowance, and other fringe benefits, $10,000	40,000
2 police department vehicles (depreciation and operating costs including insurance, maintenance, gasolene)	2,560
Total Police Department contribution	42,560
Total New York City contributions	171,910
2. Contributions by the Vera Institute of Justice:	
a. Personnel:	
Project coordinator	12,000
2 assistant project coordinators at $7,000	14,000
Total personnel	26,000
b. Research and evaluation: Research and evaluation is budgeted on the basis of 2 years of salary for personnel since it is estimated that in addition to work done during the course of the project, 6 months of preproject planning and 6 months of postproject research and evaluation will be required to complete a report on the project.	
Research director, 24 months at $10,000/year	20,000
Clerical help, 24 months at $4,000/year	8,000
IBM processing and tabulation	3,000
Supplies, printing, and reproduction costs, travel	10,000
Total research and evaluation	41,000
c. Preproject planning costs: Since May 16, 1966, the Vera Institute has devoted substantial time and resources to the planning and development of the Manhattan Bowery Project. Assuming this contribution will continue at the same rate until June 30, 1967, the total value of the preplanning costs will be as follows:	
Personnel:	
Staff attorney	10,125
Secretary	6,435
FICA and other benefits	1,000
Operating expenses: (travel, telephone, postage, Xerox, data processing, etc.)	4,900
Total preproject planning costs	22,460
Total contributions by Vera Institute of Justice	89,460
3. Contribution by Spotless Dry Cleaning, Inc.:	
Drycleaning for salvageable clothes of infirmary patients, estimated cost of $8.92/day	3,255
Total amount for which funding has been secured	[1] 264,625

[1] Private agencies will in addition provide transportation, room, board, and maintenance to alcohol rehabilitants serving as medical case aids.

B. *Elements of the Project Which Require Funding*

Listed below are the items for which no financial commitment has yet been made. A total grant of $322,790 will be required in order to complete the financing of the project for 1 year.

1. Personnel (full time unless otherwise indicated):	
a. Medical staff:	
Medical director (one-third time)	$12,000
Staff physicians, part time to provide: 6 hours daytime ward duty at $15/hour; 12 hours nighttime duty at $45/night; and estimated 1 hour daily on-call service at $15/hour (total daily cost, $150)	54,750
Consulting psychiatrist, 2 days a week	10,000
Nursing supervisor	9,000
4 registered nurses at $8,000	32,000
4 practical nurses at $6,000	24,000
Weekend, part-time, and emergency nursing coverage at $360/week	18,720
Total medical staff	160,470
b. Civilian street patrol members at $2.50/hour, 12 hours coverage daily	10,950
c. Office staff:	
2 secretaries at $5,200	10,400
Receptionist	5,200
Bookkeeper (2½ days/week at $75/week)	3,900
Total office staff	19,500
d. FICA employer's tax and disability insurance	7,000
e. Employees welfare, bookkeeping costs to St. Vincent's	7,000
Total personnel	204,920
2. Consumable supplies:	
a. Office supplies: stationery, pens, pencils, etc	1,200
b. Postage	600
c. Nursing supplies: cotton, tongue depressors, bandages, gauze, antiseptics, scrub brushes, paper goods, etc	1,500
d. Medications and other drug items: tranquillizers, antibiotics, antabuse, vitamins, etc	20,000
Total consumable supplies	23,300
3. Permanent equipment:	
a. Medical and nursing equipment:	
2 physician's examining tables at $100 (second hand)	200
2-wheeled litters at $450	900
4 examining lights at $50	200
Resuscitator	1,500
3 high-backed wheelchairs at $200 (second hand)	600
Water sterilizer at $100	100
Miscellaneous medical and nursing equipment, hemostats, stethoscopes, infusion equipment, suction pump, scissors, syringes, needles, sutures, forceps, storage jar, foot basins, kidney basins, bedpans, rubber sheets, trashcans, etc	6,000
Total medical and nursing equipment	9,500
3. Permanent equipment—Continued	
b. Dormitory equipment:	
20 hospital beds with rails, high-low adjustment at $300 (second hand)	6,000
20 mattresses at $100	2,000
Total dormitory equipment	8,000
Total permanent equipment	17,500
4. Travel and subsistence:	
Local travel and subsistence	900
Intercity travel and per diem at $16/day	2,000
Total travel and subsistence	2,900
5. Laundry: Laundry for patient's washable clothing	400
6. Emergency and outpatient services at St. Vincent's:[2] This amount includes:	
a. Intensive laboratory tests for sobering up station patients, e.g.: gastro-intestinal workup, liver battery, urinary tract workup, cardiac workup: estimated 3 patients/day at $75/patient.	
b. Emergency room treatment including: X-ray and treatment of simple fractures, intensive emergency care for up to 3 hours (patients requiring care in excess of this amount will be admitted as hospital inpatients); minor surgery and medical treatment not provided at the sobering-up station; estimated 3 patients/week at average cost of $30/patient, average daily cost $13.	
Total estimated daily cost of outpatient and emergency department services at $238/day	$86,870
7. Miscellaneous expenses:	
a. Liability and theft insurance including malpractice	13,000
b. Emergency patient fund—taxis, subway fares, recreational items such as books, records, movies, Christmas decorations, etc	2,500
c. Telephone	2,500
Total miscellaneous expenses	18,000
Total amount for which commitments are still required	353,890
Total operating costs for 1 year	618,815

[2] Medicaid reimbursements:

The cost of the emergency and outpatient services set forth above may be subject to reimbursement under the provisions of the New York State medicaid statute. At this point in time it is unclear, however, whether and to what extent the above services would, in fact, be eligible for such reimbursement. St. Vincent's would attempt to obtain medicaid reimbursement for all project patients receiving emergency and outpatient services and to the extent it is so reimbursed, it would refund the funding agency in the amounts it receives from the medicaid program on account of the above services.

It is also possible that part of or all of the cost of the project's street rescue, infirmary, and casework services would be eligible for medicaid reimbursement. The possibility of such reimbursement (particularly for the nonmedical aspects of the project) is even less certain than is the prospect for reimbursement for medical services administered in St. Vincent's outpatient and emergency department. During the course of the project strenuous efforts will be made to obtain medicaid reimbursement for services administered by the project. To the extent money received from medicaid is attributable to services previously financed by a particular funding agency, such money would, of course, be turned over to that agency.

The costs of the above services are based on the results of the 24-hour sobering-up experiment sponsored by Vera and on the experiences of the St. Vincent's Hospital Emergency Department in handling skid row patients. The figure is at best, however, somewhat speculative; therefore, the amount budgeted above for emergency and outpatient services would be subject to review and renegotiation after the project had been in operation 3 months.

ARRESTS FOR PUBLIC INTOXICATION*
by John M. Murtagh

I. Arrests in New York City

For more than a century, New York's Bowery has been a kind of magnet for the inadequate person, for men and women seeking a dark place of escape.[1] Stretching from Chatham Square, in Chinatown, to Cooper Square, near East 8th Street, the Bowery is perhaps the most miserable mile in the United States. This dingy, tawdry, hopeless street is dotted with scores of mouldering flophouses, some dating back a hundred years.[2] Its name has become a symbol for drabness and despair. On its lonely beat live thousands [3] of grimy unfortunates in almost every stage of decay.

Scores of arrested Bowery derelicts have until recently been arraigned in part 10 of the criminal court during the day, and part 11 (night court) during the evening.[4] The arraignments took place in a modern Criminal Courts Building in lower Manhattan, a little to the south and west of the Bowery and within a stone's throw of the historic Five Points area, in imposing, mahogany walled, air-conditioned courtrooms.

One cannot reflect on night court without thinking of a platoon of derelicts from the Bowery, some 20 in number, making their appearance. The procession was slow and solemn and sad. The court officer read the complaint: "* * * and that the said defendants did annoy and disturb pedestrians." He recited in detail the words that accused the defendants of disorderly conduct.[5] The tragic figures lined up before the bench. They were unshaven, dirty, and down-and-out. Most of them were still drunk. Notwithstanding the impressive judicial setting, one was aware only of a compound of smell, noise, dirt, drunkenness, and sweating people packed into a large but crowded courtroom.

"You have a right to an adjournment to secure counsel or witnesses." The court officer slowly recited the usual formula. "How do you plead, guilty or not guilty?"

They all pleaded guilty, one after another, and were sent out to be fingerprinted. An hour later they returned to the courtroom. Several received suspended sentences. The others, who had a number of previous convictions, received a short workhouse sentence and went on their way to jail like a shadow parade of the hulks of sunken ships. Sunken men. Gone, their collective smell still fouled the air.

Night court was a dumping ground for derelicts. It could have served as the inspiration for another "Erewhon," [6] the satirical narrative of an imaginary land in which sick people are sentenced to jail terms, and criminals receive sympathy and medical treatment.

New York City's penal approach to the problem began in the 1800's.[7] A law proscribing public intoxication was enacted in 1833.[8] At that time, when Cooper Square marked the outskirts of town and Times Square was a wilderness, members of the City Watch (New York City did not yet have a police department) spent much of their time rounding up derelicts in the Five Points area of the old Sixth Ward.[9]

John M. Murtagh

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[1] Berger, "The Bowery Blinks in the Sunlight," N.Y. Times, May 20, 1956, § 6 (magazine), p. 14.

[2] Ibid.

[3] The number is usually estimated to be between 12,000 and 20,000. Bendiner, "Immovable Obstacle in the Way of a New Bowery," N.Y. Times, Jan. 21, 1962, § 6 (magazine), p. 22.

[4] N.Y.C. Crim. Ct. Rule I. This rule became effective Sept. 1, 1962.

[5] "Any person who with intent to provoke a breach of the peace, or whereby a breach of the peace may be occasioned, commits any of the following acts shall be deemed to have committed the offense of disorderly conduct * * * 2. Acts in such a manner as to annoy, disturb, interfere with, obstruct, or be offensive to others * * *." N.Y. Pen. Law, § 722.

[6] "Erewhon" is an approximate reversal of the letters in the word "nowhere." In this book, English author Samuel Butler satirized the cruelty of punishing the sick. One victim of the practice was convicted of "pulmonary consumption" and sentenced to "imprisonment, with hard labor, for the rest of your miserable existence." The judge reproached him: " 'It is intolerable that an example of such terrible enormity should be allowed to go at large unpunished. Your presence in the society of respectable people would lead the less ablebodied to think more lightly of all forms of illness; neither can it be permitted that you should have the chance of corrupting unborn beings who might hereafter pester you. * * * But I will enlarge no further upon things that are themselves so obvious. You may say that it is not your fault. * * * I answer that whether your being in a consumption is your fault or no, it is a fault in you, and it is my duty to see that against such faults as this the commonwealth shall be protected. You may say that it is your misfortune to be criminal; I answer that it is your crime to be unfortunate.' " Butler, "Erewhon," 96–98 (1872).

[7] Costello. "Our Police Protectors," 78–79 (1884).

[8] "Any person who shall be intoxicated, under such circumstances, as shall, in the opinion of any such magistrate, amount to a violation of public decency, may be convicted of such offense by any such magistrate, upon competent testimony, and fined for such offense, any sum not exceeding $5; and in default of payment of such fine, may be committed to prison by such magistrate, until the same be paid; but such imprisonment shall not exceed 5 days." N.Y. Sess. Laws 1833, ch. 11, § 4.

[9] Costello, op. cit. supra note 14, at 77–79.

In 1845 a police department was created,[10] in good measure to deal with Bowery derelicts.[11] Originally an amusement center, the Bowery had declined and by this time was well on its way to becoming the city's skid row.[12] In the first 10 years of the department, the number of drunk arrests totaled almost 150,000.[13] By 1874 the number exceeded 40,000 a year; [14] one out of every three of the derelicts arrested was a woman; [15] children as young as 11 years of age were arrested; [16] the maximum penalty was $10 or 10 days in jail.[17]

In his memorable vice crusade of the early 1890's, the fabulous reformer, Rev. Dr. Charles H. Parkhurst, called upon the police to make even more drunk arrests. He was shocked by the widespread inebriety that prevailed on the Bowery. One evening in 1892 he gained admittance to a flophouse and beheld dozens of drunks asleep on bare canvas cots, breathing heavily in the foul air. He put his handkerchief to his nose and exclaimed: "My God! To think that people with souls live like this!" [18]

In November 1935, a 32-year-old derelict, Louis Schleicher, was arraigned in the old magistrates' court in the Bronx.[19] The charge was public intoxication.[20] The defendant was still drunk. He was a defeated man; he had no desire to fight constituted authority, and was ready to plead guilty in the traditional fashion.

Magistrate Frank Oliver, a foe of social injustice, scrutinized the defendant. Schleicher was long unshaven, dirty beyond belief, and clad literally in rags. He had a faraway look in his eyes. Judge Oliver read the charge: "* * * and that the said defendant did then and there commit the offense of public intoxication in that he was lying on the sidewalk while under the influence of liquor."

The judge then made and granted a motion on behalf of the defendant to dismiss the complaint as being insufficient on its face.[21] In an oral opinion, he ruled that the police must allege and prove not only that the defendant was drunk in public, but that he was disorderly and that his conduct tended to cause a breach of the peace. Schleicher left the courthouse, a bit bewildered.[22]

Some 5 years later, Chief Magistrate Henry H. Curran attempted to effect general compliance with Judge Oliver's ruling. He directed the court clerks to discontinue the use of forms dealing with public intoxication, and to return all unused forms to judicial headquarters where they were destroyed.[23] He sought thereby to limit drunk arrests to instances in which the derelict could properly be charged with disorderly conduct. As a result, no one has ever since been charged with public intoxication in New York City.[24]

The police did not welcome the new judicial attitude. To a degree, they even proceeded to evade it. In the years that followed, they frequently made arrests on a charge of disorderly conduct when drunks were not in fact disorderly; and the derelicts seldom had the initiative to plead other than guilty. But even with a limited police program of arrests, New York City over the years acquired a reputation for relative tolerance of drunken derelicts. The late Police Chief William H. Parker of Los Angeles was referring to this reputation when, in arguing against a proposed reduction in the annual budget of his department for the year 1959, he suggested wryly that perhaps Los Angeles should abandon its policy of harassing drunks in favor of the "New York system, where drunks are left to lie in the gutter." [25]

New York City, with a population of almost 8 million, has averaged only 30,000 drunk arrests annually in recent years,[26] in marked contrast with Los Angeles, with a population of 2,500,000, where each year there are nearly 100,000 arrests.[27] Similarly, the arrest rate for public drunkenness in New York City is decidedly lower than in just about every other city throughout the United States.[28]

And in the past several months, even this limited program has been terminated in New York City. Under a State law effective on January 1, 1966,[29] New York courts are required to make available free counsel to the indigent in all but traffic cases. As a result, legal aid counsel began to be assigned to derelicts who requested counsel, and the attorneys proceeded to enter pleas of not guilty. After trial, the charge of disorderly conduct was almost invariably dismissed.

A bulletin was then sent to the judges [30] urging them not merely to offer counsel in such cases but actually to assign counsel in every case where the derelict was indigent. When in over 3,000 cases it developed that after trial only a small fraction of 1 percent of such cases resulted in conviction, an order was sent to the court clerks under date of May 13, 1966.[31] The order pointed out that derelicts who stood trial for disorderly conduct were almost never convicted and directed the court clerks to comply with rule 4 of the rules of the New York City Criminal Court in all such cases. Rule 4 provides that whenever the facts stated for inclusion in a complaint appear to be insufficient to make out the offense charged, the clerk is to note the facts on form 343 and send the parties interested before the judge presiding in the part. The judge causes the officer to be sworn, hears his testimony and any other relevant testimony or evidence, and determines whether a complaint should issue.

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[10] N.Y. Sess. Laws 1844, ch. 315.

[11] Costello, op. cit. supra note 14, at 116.

[12] Berger, supra note 8.

[13] 22 N.Y.C. Bd. of Aldermen, Doc. No. 14, pp. 6–7 (1855).

[14] 1874 N.Y.C. Bd. of Police Justices Ann. Rep. 16. The city then had some 1 million residents as compared to 8 million, the approximate present population.

[15] Ibid. These mass arrests of women for public intoxication appear to reflect the vigorous use of the statute to deal with the human inadequacy among hoardes of immigrants who were fleeing from a society that was not capable of sustaining them to a society that was not capable of receiving them.

[16] The docket books of the New York City police justice courts for the decade of the 1870's reflect the arrests of such children.

[17] N.Y. Sess. Laws 1859, ch. 491, § 5.

[18] Crusade, "That Was New York," The New Yorker, Nov. 19, 1955, pp. 201, 207–08.

[19] Bronx Arrest Ct. No. 22811, N.Y.C. Magistrates' Ct., Nov. 7, 1935.

[20] For the procedure in the magistrates' court, see N.Y.C. Crim. Ct. Act § 120, N.Y. Sess. Laws 1910, ch. 659, as amended. This section was repealed by N.Y. Sess. Laws 1962, ch. 697.

[21] Bronx Arrest Ct. No. 22811, N.Y.C. Magistrates' Ct., Nov. 7, 1935.

[22] This incident was but an interlude in a typical skid row life. Schleicher's first arrest was in 1933 and he was sentenced to 30 days on a charge of disorderly conduct, Seventh Dist. Ct., Manhattan, No. 7800, N.Y.C. Magistrates' Ct., Sept. 9, 1933. When on Aug. 13, 1950, his body was received at the City Morgue, Bellevue Hospital, Box No. 248, he had amassed over 50 arrests under a half dozen aliases—all for drunkenness or disorderly conduct. His death certificate, No. 156-50-117626, was filled out under the alias of Jack Kelly. Nothing further was known about him.

[23] Order of Chief Magistrate, No. 77, N.Y.C. Magistrates' Ct., November 1940.

[24] See, e.g., 1940–42 N.Y.C. Magistrates' Ct. Ann. Reps. When, in 1962, the New York City Criminal Court Act was revised, the section dealing with public intoxication was deleted. N.Y. Sess. Laws 1962, ch. 697.

[25] N.Y. Times, May 3, 1959, p. 46, col. 3.

[26] No statistics differentiate between arraignments for types of disorderly conduct in New York City. In 1964 there were 80,299 disorderly conduct arraignments, 1964 N.Y.C. Crim. Ct. Ann. Rep., and there were 75,977 such arrests in 1965. 1965 N.Y.C. Crim. Ct. Ann. Rep. A reliable estimate is that some 30,000 of these in each year involved drunken derelicts.

[27] E.g., Analysis Section, Planning and Research Division, Los Angeles Police Dep't, Annual Statistical Digest (1965).

[28] In 1963 the total of city arrests for drunkenness was 1,419,533. This figure is computed on the basis of 2,914 cities with a combined population of 94,085,000. Federal Bureau of Investigation, Uniform Annual Crime Reports 104–05 (1963). The total of city drunkenness arrests for the year 1964 was 1,360,290 computed on the basis of 3,012 cities with a combined population of 99,326,000. Federal Bureau of Investigation, Uniform Annual Crime Reports 106–07 (1964).

The estimated New York City rate would be 375 per 100,000. Note 34 supra. The overall city rate, however, would be 1,508.8 per 100,000 in 1963, Federal Bureau of Investigation, Uniform Annual Crime Reports 104–05 (1963), and 1,369.5 per 100,000 in 1964.

[29] N.Y. County Law, art. 18B, N.Y. Sess. Laws, 1965, ch. 878, art. 18B.

[30] 1966 Bulletin of the Administrative Judge No. 1, N.Y.C. Crim. Ct., Apr. 25, 1966.

[31] See 1966 Bulletin of the Administrative Judge No. 2, N.Y.C. Crim. Ct., May 13, 1966.

When the clerks proceeded to comply with the rule in all such cases, the judges almost invariably dismissed the case, refusing to order complaints. The police department followed with a commendable display of cooperation. Chief Inspector Sanford D. Garelik, at the instance of Police Commissioner Howard R. Leary, issued an order [32] calling attention to the opinion of the judges and directing that an officer shall only make an arrest of a derelict for disorderly conduct when the facts and evidence are sufficient to sustain the charge.

As a result, the indiscriminate arrests of drunken derelicts in New York City have at long last ceased.[33] Night court is no longer the inspiration for another "Erewhon"; it now resembles a court of justice. Part 10, which is exclusively for the arraignment and trial of derelicts, will soon be discontinued.

[32] Order re: Arrest of Vagrants Charged With N.Y. Pen. Law § 722(2) from Sanford D. Garelik, Chief Inspector, N.Y.C. Police Dep't, to all commands, June 10, 1966 (T.O.P. No. 206).

[33] Since the issuance of the order by Chief Garelik, there have been no drunk arrests in New York City. This has been most evident in the absence of such arraignments in parts 10 and 11 of the N.Y.C. Criminal Court where virtually all such arraignments were held.

THE DRUNKENNESS OFFENDER

Chapter 7, Section 1, Report of the President's Commission on Crime In the District of Columbia (1966)

Contents

In fiscal 1965 there were 44,218 arrests for violations of the public intoxication law in the District of Columbia—50 percent of all nontraffic arrests.[1] These arrests reflect the essential inability of the police, courts and prisons to deal effectively with what is basically a major health problem in the District and throughout the United States—chronic alcoholism.[2] The need for non-criminal alternatives for dealing with alcoholics is practically urgent in light of the March 1966 decision of the United States Court of Appeals in *Easter* v. *District of Columbia*,[3] where the court ruled that chronic alcoholism is a legal defense to the charge of public intoxication. The few changes in District practices since the *Easter* decision, however, have served only to accelerate the "revolving door" of chronic alcoholism and underline the gross inadequacy of the city's treatment resources. In this section the Commission examines the methods used in handling drunkenness offenders before and after the *Easter* case, and recommends new procedures designed to serve the needs of the public inebriate and the community.

PROCEDURES AND FACILITIES BEFORE EASTER

THE LAW ENFORCEMENT APPROACH

Prior to the *Easter* decision, the public inebriate in the District of Columbia was traditionally handled within the criminal process. Drunkenness offenders were apprehended by the police and detained until sober. Unless they could post 10 dollars collateral, they were prosecuted by the Corporation Counsel in the District of Columbia Branch of the Court of General Sessions. There was a perfunctory trial, after which the defendants might be placed on probation or fined, but were usually sentenced to the D.C. Workhouse for an average term of 32 days.[4] The ultimate dispositions of the 44,218 drunkenness arrests in fiscal 1965 were approximately as follows: Forfeiture of collateral, 20,000; dismissal by the prosecutor, 670; incarceration, 15,500; fine and/or suspended sentence, 7,240; probation, 800.[5]

Arrest and Detention

Before *Easter*, individuals arrested for intoxication in the streets or in public places were most frequently charged with violation of the District of Columbia Code provision forbidding any person to "be drunk or intoxicated in any street, alley, park, * * * or in any place to which the public is invited * * *," with a maximum penalty of 90 days imprisonment or $100 fine, or both.[6] Related statutes were sometimes utilized in dealing with the drunkenness offender, principally the statutes barring disorderly conduct or driving under the influence of alcohol.[7] More than one-third of all disorderly conduct arrests were accompanied by an intoxication charge which appeared to be the primary reason for the arrest.[8]

In deciding whether to make an arrest under the intoxication statute the police officer exercised considerable discretion. The officer was instructed to consider such factors as the person's general appearance (clothes in disarray), odor of alcohol on breath, physical appearance (flushed face, manner of walk and speech), response to

[1] Metropolitan Police Department, Washington, D.C. [hereinafter cited as MPD], Ann. Rep., 43 (1965).

[2] See, e.g., Proceedings, Secretary's Conference on The Court and the Chronic Inebriate (U.S. Dept. of Health, Education, and Welfare [hereinafter cited as HEW], 1965); Proceedings, Conference on The Alcoholic and the Court (Oregon Mental Health Division, 1963); Proceedings, Workshop on The Chronic Alcoholic Jail Offender (State of South Carolina, 1964); D. J. Pittman and C. Gordon, Revolving Door: A Study of the Chronic Police Case Inebriate (College and University Press, 1958). The 89th Congress reflected a sudden upsurge of interest in alcoholism control at the Federal level. See, e.g., H.R. 781, S. 2657, S. 2834, S. 3089. On March 1, 1966 President Johnson, in his Message on Domestic Health and Education, recommended a significant Federal effort in the alcoholism field. HEW recently announced its plans for implementing the new program. HEW news release, Oct. 20, 1966.

[3] 361 F. 2d 50 (D.C. Cir., Mar. 31, 1966) (en banc).

[4] Letter from M. C. Pfalzgraf, Superintendent, D.C. Workhouse, Nov. 9, 1966.

[5] The Clerk of the Court of General Sessions reports that 23,584 cases of public intoxication were filed in fiscal 1965. Of the remaining 20,634 arrests, charges were not prosecuted in approximately 670 cases. MPD Ann. Rep., 49 (1965). There were, therefore, approximately 20,000 forfeitures of collateral. Of the cases that did go before the court, 16,343 were committed to a penal institution. Dept. of Corrections Record Office for the D.C. Jail, Annual Report, 1 (1965). Therefore, approximately 7,240 (23,584 minus 16,343) persons were fined or received a suspended sentence. About 800 were placed on probation after a few days of commitment for "drying out" purposes. D.C. Court of General Sessions Probation Dept., Annual Report (1965). Around 15,500 (16,343 minus 800) received prison sentences.

[6] 25 D.C. Code § 128 (1961). Under 22 D.C. Code § 104 (1961) the punishment may be increased by 50% for second offenders. The intoxication statute also prohibits any person to "drink any alcoholic beverage in any street, alley, or park * * *" Violation of this provision of the statute results in a separate charge of "Drinking in Public." In 1965 there were 2,014 arrests made for this offense. Letter from the MPD, April 1, 1966 [hereinafter cited as MPD letter]. According to the Department, it would be a "rare occasion" when a person was charged with both "Drinking in Public" and "Drunk." Ibid.

[7] 40 D.C. Code § 609 (1961); 22 D.C. Code § 1121 (1961). See also 25 D.C. Code § 127 (1961).

[8] There were 14,885 arrests for disorderly conduct in 1965. MPD Ann. Rep., 43 (1965). The MPD estimates that in 1965 some 5,500 disorderly conduct charges were accompanied by an intoxication charge. MPD letter.

questions, apparent ability to take care of himself, and behavior toward other citizens.[9] Members of the Department were encouraged not to make an arrest if the inebriated person was accompanied by someone who could take care of him, if he was close to his home and could get there safely, or if he would take a taxicab and go home.[10] The Department recently reaffirmed a 1958 statement of policy which declared:

> District Inspectors shall direct Commanding Officers to instruct members of their commands, whereever reasonable and proper, to permit a person under the influence of alcoholic beverage to go home instead of arresting him. Provided, the person's condition is such that he is not likely to injure himself or others and is not likely to be a source of public complaint or a subject of a police report.[11]

Intoxication charges under these general criteria each year from 1955 through 1965 have ranged from 39,506 to 47,950 (Table 1). The arrests in 1965 involved about 27,000 persons, many of whom were arrested in high-crime precincts.[12] As shown in Table 2, Precincts 2, 9, 10 and 13 accounted for 49 percent of the total arrests, with another 25 percent of the arrests occurring in the downtown area of the First Precinct. More arrests occurred on Friday and Saturday than on other nights.[13]

Table 1.—Intoxication charges compared to all nontraffic charges

[Fiscal years 1955–1965]

Fiscal year	All nontraffic charges	Intoxication charges	
	Number	Number	Percent of all nontraffic charges
1955	94,393	39,824	42
1956	92,666	39,506	43
1957	99,400	43,829	44
1958	97,085	41,124	42
1959	101,163	42,898	42
1960	95,383	40,400	42
1961	92,871	40,861	44
1962	95,182	46,097	48
1963	99,353	47,950	48
1964	96,234	44,206	46
1965	100,309	44,792	45

SOURCE: MPD Annual Reports (1955–65). Charges (not arrests) are tabulated as the MPD did not begin tabulating arrests until fiscal 1964.

Police officers were also instructed that persons

> found on any public space or on any private property in a semiconscious or unconscious condition, even though the person may be known to be of notoriously intemperate habits and has a strong odor of alcohol on his breath, shall be immediately removed to a hospital for examination in an effort to determine if such person is suffering from any serious illness or injury.[14]

Despite this regulation, 16 persons arrested for intoxication died while in police custody in 1964–1965.[15] Police and medical authorities agree that public inebriates frequently require immediate medical attention and that persons arrested for intoxication may in fact be suffering from a serious illness.[16] In 1965, however, only 1,922 of the over 44,000 arrested inebriates were taken by the police to D.C. General Hospital and admitted for medical attention.[17] In St. Louis, by contrast, every such offender receives an immediate medical examination at a hospital and 10 percent are retained for further treatment.[18] Failure to institute similar procedures in Washington has cost lives, delayed the initiation of treatment for the alcoholic, and required the police to undertake a medical responsibility for which they were not equipped.

Table 2.—Distribution of charges for intoxication, by precinct

[Fiscal years 1956 and 1965]

Precinct	Fiscal 1956		Fiscal 1965	
	Number	Percent	Number	Percent
1	9,854	24.9	11,209	25.0
2	9,465	24.0	7,851	17.5
3	1,831	4.6	1,199	2.7
4	1,835	4.6	332	.7
5	2,268	5.7	2,759	6.2
6	682	1.7	1,021	2.3
7	618	1.6	596	1.3
8	189	.5	298	.7
9	3,473	8.8	6,455	14.4
10	2,960	7.5	4,714	10.5
11	680	1.7	1,961	4.4
12	690	1.7	765	1.7
13	3,540	9.0	3,279	7.3
14	907	2.3	1,589	3.5
Other	514	1.3	764	1.7
Total	39,506	99.9	44,792	99.9

SOURCE: MPD Annual Reports (1956 and 1965). Charges (not arrests) are tabulated as the MPD did not begin tabulating arrests until fiscal 1964.

After being arrested, an intoxicated male was taken to the precinct station; females were taken directly to the Women's Bureau. On weekend evenings, three inebriates were often crowded into small, filthy cells designed for a single person. No objective test was used either before or after arrest to determine the individual's blood alcohol level or its effect on his physical or mental condition. After a 4-hour sobering-up period, the inebriate was released if he, or someone on his behalf, posted 10 dollars collateral.[19] In 1965 approximately 20,000 (about 45 percent) of the individuals arrested for drunkenness posted and forfeited collateral at the stationhouse. Under the existing practice of the Court of General Sessions, forfeiture usually terminated any criminal proceedings.[20] If collateral was not posted, offenders were detained until the following morning—in the case of Saturday night arrests, until Monday morning—when they were brought into court.

Prosecution

Public intoxication cases were prosecuted by the Corporation Counsel in the District of Columbia Branch of the Court of General Sessions. Approximately 23,500

[9] MPD letter.
[10] Ibid. This procedure requires, of course, that the intoxicated person actually have a home, know where he lives, have money to pay the fare, and be receptive to the suggestion.
[11] MPD letter.
[12] Staff computation based on data provided by MPD.
[13] MPD Ann. Rep., 43 (1965).
[14] General Order No. 6, Series 1962. See also General Order No. 8, Series 1965, which covers the handling of persons in custody who are taken to a hospital for treatment.
[15] Letter from MPD, Nov. 29, 1965. The MPD letter of April 1, 1966, however, stated that from 1963 through 1965 10 prisoners died while in police custody and 4 more died after hospital treatment.
[16] See Alcohol and Alcoholism: A Police Handbook, prepared by the Correctional Association of New York and the International Association of Chiefs of Police (Undated).
[17] Letter from Dr. V. S. Chupkovich, Acting Chief Medical Officer in Charge of Admitting and Emergency, D.C. General Hospital, June 2, 1966.
[18] Letter from St. Louis, Mo., Chief of Police Curtis Brostron to Dr. D. J. Pittman, Director and Professor of Sociology, The Social Science Institute, Washington University, St. Louis, Mo., April 10, 1966, enclosed with a letter to the Commission from Dr. Pittman, April 25, 1966.
[19] 11 D.C. Code § 748(a) (1961). There is no limit to the number of times collateral can be forfeited.
[20] 16 D.C. Code § 704 (Supp. V, 1966); Order of the Municipal Court of the District of Columbia, Nov. 2, 1959.

drunkenness charges were processed in the Court of General Sessions in 1965.[21] On an ordinary Monday morning prior to *Easter*, there were about 200 cases involving drunkenness or disorderly conduct before the court.

The disheveled prisoners were brought from the precincts to the "bullpen" in the basement of the courthouse and then herded en masse into the courtroom. They were perfunctorily informed of their right to counsel, which was rarely exercised; nearly all pleaded guilty. If a guilty plea was entered, the proceedings took less than a minute; they took only slightly longer if the defendant pleaded not guilty. Since there was no objective evidence on the issue of whether the defendant was actually drunk, the arresting officer's view of the facts was almost always accepted.

Upon a finding of guilty, the sentencing judge decided whether to impose a fine, suspend sentence, place the defendant on probation, or commit him to the Workhouse. In 1965 approximately 800 persons were placed on probation,[22] and about 15,500 persons were sentenced to imprisonment usually ranging from 10 to 90 days—for an average term of 32 days.[23] The remaining 31 percent of the court cases, 7,240 out of 23,584, resulted in fines, suspended sentences or occasional verdicts of not guilty.

Prior to *Easter* the court rarely invoked the 1947 Act entitled "Rehabilitation of Alcoholics," which recognized the alcoholic's need for treatment in these terms:

> The purpose of this chapter is to establish a program for the rehabilitation of alcoholics, promote temperance, and provide for the medical, psychiatric, and other scientific treatment of chronic alcoholics; to minimize the deleterious effects of excessive drinking on those who pass through the courts of the District of Columbia; to reduce the financial burden imposed upon the people of the District of Columbia by the abusive use of alcoholic beverages, as is reflected in mounting accident rates, decreased personal efficiency, growing absenteeism, and a general increase in the amount and seriousness of crime in the District of Columbia, and to substitute for jail sentences for drunkenness, medical and other scientific methods of treatment which will benefit the individual involved and more fully protect the public. In order to accomplish this purpose and alleviate the problem of chronic alcoholism the courts of the District of Columbia are hereby authorized to take judicial notice of the fact that a chronic alcoholic is a sick person and in need of proper medical, institutional, advisory, and rehabilitative treatment, and the court is authorized to direct that he receive appropriate medical, psychiatric or other treatment as provided under the terms of this chapter.[24]

Although the statute directed the Board of Commissioners to establish a residential treatment center and a subsidiary diagnostic center, the single facility provided was the Department of Public Health's Alcoholic Rehabilitation Clinic, which offers only outpatient services.[25]

The statute offers a treatment alternative for chronic alcoholics who are arrested and thereby enter the criminal process. The court may suspend the proceedings in *any* criminal case and hold a hearing to determine if the defendant is a chronic alcoholic.[26] The defendant is entitled to counsel, appointed if necessary, and he may request a hearing before a jury. If the court or jury concludes after the hearing that the defendant is a chronic alcoholic, the court "may" order him "committed to the clinic for diagnosis, classification and treatment as his condition may require" for no more than 90 days. Every person committed to the clinic must first go to a classification and diagnostic center, upon the basis of which the clinic director may recommend that the court: (1) permit the person "to remain at liberty conditionally and under supervision"; (2) place him in an appropriate institution for treatment; or (3) try him on the original criminal charge. After the first 90-day period has expired, the clinic director may recommend recommittal for an additional 90-day term if the person "is in need of additional treatment in an appropriate hospital or institution." If so, a second hearing identical to the first must be held.

The court was reluctant to use the commitment statute prior to *Easter* because of its cumbersome procedures and the lack of adequate treatment programs and facilities. The outpatient Alcoholic Rehabilitation Clinic, however, was used as a probation resource for 1,300 convicted inebriates between 1950 and 1963, when its use was discontinued by the Probation Department of the court.[27]

Probation

A special probation program for drunkenness offenders was initiated in 1946 by the Probation Department of the Court of General Sessions. It is operated by a supervisor and four probation officers who work exclusively with persons charged with public intoxication or offenses related to the use of alcohol.[28]

Before the *Easter* decision, defendants were selected for the program by a standardized screening process. Those with previous felony records were automatically excluded. Defendants with lengthy intoxication records and those with only one or two prior intoxication arrests were also excluded. The former were rejected because they were considered too debilitated for successful rehabilitation, and the latter because they were thought to be insufficiently aware of their drinking difficulties. Defendants with three to five prior intoxication arrests were most likely to pass this preliminary screening.

The drunkenness offenders provisionally accepted for the special probation program were sent to the District of Columbia Jail for 3 to 4 days to "dry out." During that time the background information supplied to the probation officer was verified. The Probation Department also interceded with employers in an effort to avoid loss of jobs as a result of arrest and temporary confinement.

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[22] D.C. Court of General Sessions Probation Dept., Annual Report (1965).

[21] Supra note 5.

[23] Supra note 5. See also D.C. Dept. of Corrections, Selected Criminological Data, Table 4.6 (1965). Sentences over 135 days may be imposed when there is a conviction on more than one charge. Id., Table 6.6.

[24] D.C. Code § 501 (1961). See Hearings on H.R. 496 Before the Subcommittee on Health, Education, and Recreation of the House Committee on the District of Columbia, 80th Cong., 1st Sess. (1947).

[25] The statute directs the Commissioners "to establish and equip a clinic in connection either with some existing hospital or with some correctional institution or other facility for the diagnosis, classification, hospitalization, confinement, treatment, and study of persons who are found to be chronic alcoholics, as defined herein. * * *" 24 D.C. Code § 503 (1961). The Alcoholic Rehabilitation Clinic is partially financed by section 14 of the original act, now a part of the tax laws, which provided for a 10% (now 6%) levy on licenses for the manufacture or sale of alcoholic beverages for the support of the "clinic" envisioned by the statute. The funds have amounted to about $70,000 yearly. D.C. Dept. of Public Health, Comprehensive Mental Health Services in the District of Columbia, 86 (1965).

[26] 24 D.C. Code § 504 (1961).

[27] Letter from Dr. Murray Grant, Director, D.C. Dept. of Public Health, May 2, 1966 [hereinafter cited as DPH letter].

[28] App. (ACA), 700.

Final acceptance in the program depended on the outcome of another interview with one of the probation officers. According to the Director of Probation, if the defendants "admitted" that they were alcoholics and expressed a desire to stop drinking, they were generally recommended for probation.[29]

If unemployed, individuals chosen for the probation program were obliged to get a job, assisted in some cases by the job placement program of the Probation Department. They were required to attend meetings twice weekly during their first month on probation and once a week thereafter. The meetings, frequently attended by as many as 200 persons, used some of the techniques of Alcoholics Anonymous and usually featured two speakers who would tell of their past experience with alcohol and their redemption through A.A. Other than these meetings, there was very little supervision of the individual probationers, who had no regular personal contact with the probation officer. The average caseload in the Alcoholic Rehabilitation Unit exceeded 100 offenders for each officer.[30]

When it was established in 1946, the Alcoholic Rehabilitation Unit of the Probation Department was virtually unique.[31] Since that time other municipal courts have developed special programs designed to reduce the number of drunkenness offenders brought into the court.[32] The 1957 Report of the District of Columbia Commissioner's Committee on Prisons, Probation and Parole (Karrick Report) concluded that the Probation Department's program had made "a renewed and determined effort to salvage many of the chronic alcoholics who are brought before the court." [33] In recent years, however, the program has suffered from numerous deficiencies. The 1966 report of the American Correctional Association prepared for this Commission concludes that "what started out in 1946 as an increased service for the offender, now offers him less than the regular probationer.[34]

The screening criteria developed by the Probation Department were arbitrary and poorly designed. The emphasis on prior drunkenness arrests automatically excluded first offenders and violators with lengthy records, some of whom could benefit from a well-designed probation program. Those included in the program were accepted without a presentence investigation. They were required to express concern about their drinking by virtually acknowledging that they were alcoholics and to display an interest in trying an Alcoholics Anonymous approach. Failure to meet these standards usually resulted in a jail sentence.[35]

Program content was also poor. It consisted primarily of attendance at large group meetings; there was no individual supervision or attention unless the probationer sought out his probation officer. Probationers were required to sever any connections with the Alcoholic Rehabilitation Clinic of the Department of Public Health, since the Director of Probation believed that the clinic's drug and psychiatric approach was incompatible with his A.A.-oriented program and was not an effective rehabilitative method.[36] Clinic personnel, on the other hand, believed that the probation officers did not have the necessary medical expertise to make adequate diagnoses of alcoholics, and that the court program did not meet the health needs of the alcoholics admitted to probation.[37]

Comprehensive evaluation of the Probation Department program is handicapped by lack of adequate statistics. In fiscal 1965, 838 drunkenness offenders out of 5,416 screened by the Alcoholic Rehabilitation Unit were placed on probation.[38] There are no meaningful data, however, on what happened to these people. For example, the Department reported that about 75 percent of the individuals placed on probation "completed" the program; it did not report whether the probationer stopped drinking or whether he was arrested for drunkenness while on probation. Yet it is known that in 1965 there were 553 rearrests of individuals on probation for drunkenness (not necessarily 553 different individuals), but only 131 revocations of probation.[39] The American Correctional Association reports that in 20 years of operation the Probation Department has never undertaken an adequate evaluation of its program.[40]

The D.C. Workhouse

Persons sentenced to jail for public intoxication went to the D.C. Workhouse, which is a short-term, minimum-security installation at Occoquan, Virginia, about 24 miles from Washington. The average daily population at the Workhouse in fiscal 1965 was 1,540. As indicated by Table 3, more than 80 percent of the inmates admitted to the Workhouse prior to *Easter* were drunkenness offenders. The average age for these offenders was 47 years, and approximately 55 percent of them were Negro.[41] Workhouse officials report that drunkenness offenders were confined for an average of 32 days in 1965.[42]

Like other institutions of its kind across the country, the Workhouse was the "end stage in America's revolving door policy toward the chronic drunkenness offender." [43] As discussed in chapter 6, it offered little in the way of rehabilitation for the public inebriate. Chronic alcoholics generally present a most difficult challenge even to the best correctional program, because of their poor physical and mental condition, general sense of dependence and poor motivation.[44]

The short sentences given by the court and the lack of treatment resources made it nearly impossible to provide more than custodial care at the Workhouse. Notwithstanding the variety of physical ailments often associated with chronic alcoholism, no medical examinations were given on admission. Drunkenness offenders were rarely assigned to social education classes or therapy groups because of their short term of confinement. Rehabilitative efforts were limited to providing nourishing food and farming or prison maintenance work for those who were physically able. Upon release from the Workhouse, the

[29] Letter from R. J. Conner, Director of Probation, D.C. Court of General Sessions, Nov. 17, 1965.
[30] The unit's 4 probation officers annually handle over 800 persons sentenced to 6 months probation. App. (ACA), 700, 701, 702.
[31] For a discussion of the views of the founder of the program, see R. J. Conner, The Answer to an Alcoholic's Problem (1965).
[32] See, e.g., Burnett and Harrison, "Two Court Programs for the Chronic Offender," in The Court and the Chronic Inebriate (HEW, 1965).
[33] Report of the District of Columbia Commissioner's Committee on Prisons, Probation and Parole [hereinafter cited as Karrick Report], 128 (1957).
[34] App. (ACA), 700.
[35] Ibid.
[36] See Conner, supra note 31, at 2.
[37] Interview with Dr. George C. Gallagher, Acting Chief, Alcoholic Rehabilitation Clinic, Aug. 19, 1965.
[38] D.C. Court of General Sessions Probation Dept., Annual Report (1965).
[39] Ibid.
[40] App. (ACA), 701.
[41] D.C. Dept. of Corrections, Selected Criminological Data, Table 4.3 (1965).
[42] Supra note 4.
[43] D. J. Pittman, "The Chronic Drunkenness Offenders: An Overview," in The Court and The Chronic Inebriate, 13 (HEW, 1965).
[44] See, e.g., A. H. MacCormick, "Correctional Views on Alcohol, Alcoholism and Crime," in Proceedings, Conference on Alcohol, Alcoholism and Crime, 61 (State of Mass., 1962).

Table 3.—Commitments to the Workhouse and Women's Reformatory

[Fiscal years 1961–1966]

	1961	1962	1963	1964	1965	1966
WORKHOUSE						
Average daily population	1,543	1,376	1,389	1,557	1,540	1,397
Received:						
Intoxication	10,110	14,074	16,367	14,942	12,875	11,857
Other misdemeanants	2,625	1,876	3,242	3,360	3,024	3,062
Total	12,735	15,950	19,609	18,302	15,899	14,919
WOMEN'S REFORMATORY						
Average daily population	205	171	169	170	169	104
Received:						
Felonies	23	32	44	54	41	22
Intoxication	774	864	800	885	654	393
Other misdemeanants	234	235	477	276	388	259
Total	1,031	1,131	1,321	1,215	1,083	674

SOURCE: D.C. Department of Corrections.

drunkenness offender was without supervision or meaningful assistance. He was typically transported to downtown Washington and discharged on a street corner with little money and no real alternative but to return to skid-row life. Strikingly high recidivism rates attested to the basic inadequacy of the Workhouse's correctional program.[45]

Several years ago the Department of Corrections and the Department of Public Health collaborated in an experimental effort to modify the typical institutional pattern. Special treatment was given to a group of 100 inmates who were convicted of public intoxication and committed to the Workhouse for 90 days.[46] The treatment consisted of short-term individual therapy, group therapy, occupational and recreational therapy, and social casework relating to post-release plans. Follow-up after release was provided by the outpatient services of the Alcoholic Rehabilitation Clinic. When the results were evaluated after 2½ years, it was concluded that "a sizeable group of chronic drunkenness offenders can be helped through enforced psychiatric treatment." [47] This type of help, however, is not presently available for drunkenness offenders dealt with through the law enforcement process.

MEDICAL AND TREATMENT FACILITIES

Prior to *Easter* the District of Columbia had very limited treatment services for alcoholics who were not processed through the courts as drunkenness offenders. For the most part, these facilities served only alcoholics who were seriously ill or who voluntarily sought assistance.

The District of Columbia General Hospital provides intensive inpatient medical care in its Alcoholism and Drug Addiction Unit. The Unit has a capacity of 42 beds and a staff of 27. It has been used almost exclusively as a drying out facility for severely debilitated alcoholics after a prolonged drinking spree. In fiscal 1965 it treated 985 patients, 85 percent of whom were alcoholics who stayed an average of 7 days.[48] Many of the patients suffered from delirium tremens and acute brain syndrome and responded to short-term therapy; some suffered from chronic brain syndrome, a relatively permanent impairment which requires long-term treatment.[49]

Saint Elizabeths Hospital also has facilities for alcoholic patients. Most of its alcoholic patients are committed by court order under the District of Columbia Hospitalization of the Mentally Ill Act.[50] To be eligible for admission an alcoholic must also have some physiological impairment, such as a chronic brain syndrome, or be psychotic. The hospital also admits voluntary patients and a few skid-row alcoholics who are either incompetent to stand trial or who are found not guilty by reason of insanity. Approximately 300 "seriously disturbed alcoholics" are in Saint Elizabeths Hospital.[51] Their average stay is 3.9 months.[52]

The Alcoholic Rehabilitation Clinic of the Department of Public Health carries the main burden of supplying outpatient services to alcoholics in the District of Columbia. With a staff of 18, the clinic aided about 950 patients in fiscal 1965.[53] Some additional outpatients are served through the facilities of the new Area C Mental Health Center.[54] The clinic typically has had about 400 active cases each month, about 750 people on its rolls, and about 70 new cases a month. People seeking help are assisted immediately, even though the staff is undermanned so that it cannot operate evenings or weekends. Prior to *Easter*, most of the clinic's patients were self-referrals, often pressured to come in by family or employer.

Upon arrival at the clinic a voluntary patient was interviewed by a public health nurse. Individuals in an acutely alcoholic state were sent to D.C. General Hospital. Based on a testing and orientation period, the clinic staff decided on a course of treatment. Most patients were placed in one of several weekly group therapy units, depending on their educational and occupational backgrounds. The clinic staff referred some alcoholics to A.A. when they thought the individual could respond to its self-disciplinary demands. In addition to group therapy, the clinic used mild tranquilizers in the early phases of treatment and other drugs, where appropriate, to restrict drinking.

Although many patients dropped out after the first two visits, including most of the derelict alcoholics, the clinic claims a respectable improvement rate among those who remained. A study of 150 patients who had received over 25 sessions of therapy indicates quite a high improvement rate; complete sobriety for prolonged periods of time was found in 24 percent of the cases, an additional

[45] Over 99% of the intoxication offenders incarcerated in the Workhouse as of July 30, 1965, had prior convictions for an offense, usually public intoxication. D.C. Dept. of Corrections, Patterns of Recidivism Among Offenders Committed to the Department of Corrections, Table IV.1 (July 30, 1965).

[46] Mindlin, "Evaluation of Therapy for Alcoholics in a Workhouse Setting," 21 Quar. J. of Studies in Alcohol, 90–112 (1960).

[47] Id. at 112. Of 100 cases 32 showed improvement, 45 showed no change, and the outcome could not be ascertained in 23 cases. Predictive indices developed during the study suggested that only 12% of unselected chronic drunkenness offenders would benefit from this type of brief therapy in confinement. Ibid.

[48] D.C. Government, Report of the Chronic Drunkenness Offender Task Force [hereinafter cited as Task Force Rep.], 22 (1966). The operating cost of the unit was $480,935 in fiscal 1965. Ibid. The Chief of Psychiatric Services at D.C. General Hospital reports that there were 86 police referrals of intoxicated persons to Psychiatric Services in fiscal year 1965, including 43 prisoners. In addition, there were 83 court referrals, 586 unreferred voluntary admissions and 221 referred voluntary admissions. Unreferred admissions ordinarily come through the emergency room of the hospital. Letter from Dr. J. A. Ryan, Chief, Psychiatric Services, D.C. General Hospital, May 17, 1966. The Dept. of Public Health reports that as presently operated the unit can accommodate approximately 1,000 alcoholics and 210 addicts per year. DPH letter.

[49] A 1963 study of admissions to the unit disclosed that about 85% were diagnosed as having acute brain syndromes.

[50] 21 D.C. Code ch. 3 (Supp. V, 1966).

[51] DPH letter. Saint Elizabeths Hospital reports that on June 30, 1964, there were 278 resident patients, most over age 50, whose diagnoses involved alcohol—acute brain syndrome, 13; chronic brain syndrome, 251; alcoholism, 14. Of these, 155 were admitted during 1964.

[52] Task Force Rep., 23–24. The cost of operation is estimated at $188,332 per year. Ibid.

[53] Id. at 22. The estimated personnel costs of the clinic were $147,791 per year. Ibid.

[54] The Dept. of Public Health reports that the clinic and the Area C Mental Health Center together treat approximately 1,250 outpatients per year. DPH letter. The center has 20 beds and a staff of 15, with an estimated yearly capacity of 360 inpatients and 300 outpatients. Task Force Rep., 22.

61.5 percent were improved, and only 14.5 percent showed no improvement in their drinking pattern.[55] The clinic reports that parolees obliged to participate in the program react just as favorably as do self-referrals. The staff estimates, however, that 90 percent of its patients need more intensive treatment than can be provided at the clinic.

CONCLUSION

In 1957 the Karrick Report concluded that the procedures and facilities in the District of Columbia for handling drunkenness offenders were grossly inadequate.[56] Nine years later the same deficiencies exist.

The practice of dealing with destitute public inebriates as criminals has proved to be expensive, burdensome and futile. The cost of incarceration alone was estimated to be $2 million annually; the costs of police processing, adjudication and available treatment services increased the total cost to over $3 million.[57] In 1965 drunkenness offenders accounted for half of all non-traffic arrests, about one-third of the non-traffic cases in the Court of General Sessions, and 80 percent of the population of the Workhouse.[58] In view of the dimensions of serious crime in the District of Columbia, this expenditure of law enforcement resources on the public inebriate was clearly excessive.

Table 4.—Prior arrests for intoxication

[Calendar year 1965]

Prior intoxication arrests recorded [1]	Distribution of prior arrests for intoxication		
	Sample	Male	Female
Total	372	345	27
	percent	percent	percent
1	23.4	22.9	29.7
2 through 4	20.2	19.8	25.9
5 through 9	14.5	14.8	11.1
10 through 14	6.9	6.4	14.8
15 through 19	5.4	5.6	----
20 through 24	5.9	5.6	7.4
25 through 49	11.3	11.6	7.4
50 through 99	8.9	9.3	3.7
100 through 149	2.2	2.3	----
150 through 199	1.1	1.2	----
200 through 299	.1	.3	----
300 through 399	[2]	[2]	----

[1] Includes all prior arrests for intoxication in the District of Columbia, including those of fiscal year 1965.
[2] Less than 0.1 percent.

SOURCE: 1965 sample of arrests for intoxication provided by the Metropolitan Police Department, District of Columbia.

Moreover, criminal procedures did not serve as a deterrent. The number of public intoxication charges in the District has increased over the last 10 years (Table 1). Repeaters accounted for a large proportion of arrests. In 1965 approximately 27,000 persons were arrested for public intoxication—8,000 two or more times, 4,000 three or more times, and 2,400 four or more times.[59] Most intoxication arrests involve persons with an extensive record of public drunkenness (Table 4). Fifty-six percent of those arrested for intoxication in 1965 had been arrested 5 times or more during their lifetime; 29 percent had been arrested 20 times or more; and 12 percent had been arrested 50 times or more. Only 23 percent were drunkenness offenders for the first time, compared to 32 percent in 1956.[60]

Substantial resources have been devoted to apprehending, convicting and punishing the estimated 6,000 skid-row chronic alcoholics in the District.[61] The resort to criminal sanctions has completely failed. Periodic commitments to a penal institution were a misguided solution, failing to meet either the alcoholic's immediate health needs or the more basic problems underlying his illness.[62] Reliance on short-term criminal remedies allowed health authorities in the District of Columbia to neglect their responsibilities to deal effectively with the problem of chronic alcoholism. To this extent, therefore, the use of the criminal law to punish alcoholics was responsible for helping to perpetuate the chronic drunkenness offender problem in the District.

DEVELOPMENTS SINCE THE EASTER CASE

On March 31, 1966, the United States Court of Appeals for the District of Columbia, in the case of *Easter* v. *District of Columbia,* unanimously held that chronic alcoholism is a valid defense to a charge of public intoxication.[63] The court stated that "the public intoxication of a chronic alcoholic lacks the essential element of criminality; and to convict such a person of that crime would also offend the Eighth Amendment." [64] The court cited congressional findings in the 1947 statute that a chronic alcoholic is suffering from a sickness and has lost the power of self-control in the use of intoxicating beverages.[65] It indicated that it would have reached the same conclusion even in the absence of congressional guidance, relying in part on the recent decision of the United States Court of Appeals for the Fourth Circuit in the similar case of *Driver* v. *Hinnant.*[66]

The *Easter* decision plainly required complete revision of the traditional punitive approach to the chronic alcoholic. The District of Columbia Government, however, was not prepared for the decision, and its response has been totally inadequate. Needed treatment facilities, originally called for in 1947, have not yet been obtained. The law enforcement approach remains substantially unaltered; public inebriates continue to be arrested, detained in precinct stations, and prosecuted by the

[55] D.C. Dept. of Public Health, Alcoholism Clinic, Facts and Figures, 6 (1964).
[56] Karrick Rep., 83–131.
[57] The cost estimate included these items: police processing, $360,000; court salaries, $76,000; incarceration, $1,204,000; Alcoholic Rehabilitation Program, $75,000; and Psychiatric Services of D.C. General Hospital, $80,000. In its grant proposal to the Dept. of Justice for the financing of an emergency care clinic, the D.C. Dept. of Public Health calculated that in 1964 the 18,202 persons committed to the D.C. Dept. of Corrections for intoxication stayed for an average of 21 days at a cost of $5 per day—for a total of $1,911,210. Other jurisdictions have developed similar cost estimates. In Toronto, Canada, the cost of each arrest and trial is estimated at $50 and the cost of incarceration at $5 per day. These are net cost figures, the total paid in fines having been deducted. Province of Ontario, Alcoholism and Drug Addiction Research Foundation, Interim Report: Study of the Chronic Drunkenness Offender (Feb. 1963).
[58] Supra notes 1, 5. The MPD estimates that 5% of total police time is spent handling drunkenness offenders. MPD letter.
[59] Staff computation based on data provided by the MPD.
[60] Karrick Rep., 94.
[61] D.C. Dept. of Public Health, Facts and Figures, 1 (Feb. 1962).
[62] Past practices may have prevented some crimes involving alcoholics, who are frequently the robbery or assault victims of their fellow alcoholics or of other persons who take advantage of the alcoholic's intoxicated state. MPD letter. The Karrick Report found that 50% of persons arrested for intoxication had at some time previously been charged with a felony. Karrick Rep., 97–99. The Commission study of 1965 intoxication arrestees indicates that 71% had been previously arrested for a felony. Without more study, however, it is impossible to judge the relationship, if any, between the arrestee's drinking habits and his prior criminal record. For a general discussion of the relationship between alcoholism and crime, see S. D. Bacon, "Alcohol, Alcoholism, and Crime: An Overview," in Proceedings, Conference on Alcohol, Alcoholism and Crime (State of Mass., 1962).
[63] *Easter* v. *District of Columbia,* 361 F. 2d 50 (D.C. Cir. 1966) (en banc).
[64] Id. at 55.
[65] Id. at 51–53. The court rejected as irrelevant the fact that the facilities contemplated by 24 D.C. Code §§ 503, 505 (1961) had never been provided, stating that "one who has committed no crime cannot be validly sentenced as a criminal because of lack of rehabilitative and caretaking facilities." 361 F. 2d at 53.
[66] 356 F. 2d 761 (4th Cir. 1966).

Corporation Counsel.[67] No longer subject to sentencing or incarceration as criminals, however, chronic alcoholics are released without any meaningful assistance. Already severely debilitated, their health has been further jeopardized by the accelerated rate at which they have been processed through the courts.[68]

CONFUSION IN COURT PROCEDURES

The initial burden of implementing the *Easter* decision fell on the District of Columbia Branch of the Court of General Sessions. Hampered by the lack of diagnostic and treatment services, different judges proceeded in various ways. The net effect was considerable confusion concerning the manner in which the defense of chronic alcoholism should be raised and the procedures which should be followed in the event that the defense was sustained.

The first judge to deal with drunkenness offenders after *Easter* required that the defendant raise the defense of chronic alcoholism in any case of drunkenness that came before him. However, if the defendant raised the issue, the judge committed him to D.C. General Hospital for diagnosis for a maximum of 30 days.[69] A subsequent judge took the view that the court should itself raise the defense where the defendant's history showed chronic alcoholism to be a real probability. He used a procedure under which each person charged with public intoxication was examined by a Health Department doctor in the court cell block. If the doctor diagnosed the defendant as a chronic alcoholic, the judge then utilized the provisions of the 1947 Rehabilitation of Alcoholics statute to commit the defendant for further diagnosis and treatment.[70] In recent months most judges have adopted the view that "the Court has the obligation to inject this issue on its own motion when it appears likely from the evidence that the defense may be available." [71]

When the defense was raised for an alcoholic, confusion still persisted regarding procedures to be followed by the court in compliance with the *Easter* decision. After preliminary diagnosis of the defendant, some judges used the procedures of the 1947 statute. They held the hearings required by the statute and entered orders committing defendants to various facilities. Other judges entered verdicts of not guilty pursuant to *Easter* and released the defendants to the street. During the summer months, adjudicated alcoholics were convicted and sent to jail despite the prior adjudication,[72] released on the street,[73] or committed under the 1947 statute to the Workhouse, the Alcoholic Rehabilitation Clinic, D.C. General Hospital, or Glenn Dale Hospital.[74] Alcoholics sent to the latter two facilities simply walked away on occasion due to lack of supervision.[75] Alcoholics sent to the Workhouse under the 1947 statute were locked in separate dormitories, although regular prisoners were allowed freedom of the grounds.[76] Some alcoholics were sent to facilities which were unable to accommodate them because judges continued to make commitments even though the facility was operating beyond capacity.[77]

The court's difficult burden was not eased by the Corporation Counsel. Municipal prosecutors continued to prosecute intoxication defendants as they did before *Easter*. They assumed no responsibility for exercising prosecutive discretion in those cases where the defendant's criminal record or prior adjudication as a chronic alcoholic indicated a clear and provable defense to the intoxication charge. Neither did they establish any pretrial procedures to assist the court in screening cases in which the defense should be raised. We believe that the corporation Counsel had at the very least an obligation to call the court's attention to facts such as prior record or adjudication which suggested chronic alcoholism.[78] In view of the confusion that has developed in the wake of the *Easter* case, it is essential for the Corporation Counsel to exercise his descretion intelligently and helpfully.[79]

These circumstances projected a distorted image of the administration of justice in the Court of General Sessions.[80] Although the judges were not responsible for lack of treatment facilities and were in most cases performing their clear duty under the law, the disparate manner in which drunkenness offenders were treated engendered much confusion and little confidence. The police and court have collaborated to process the chronic alcoholic through the system at an increasing rate of arrest, release and rearrest. The number of drunkenness offenders at the Workhouse declined from 1,027 on June 30, 1965, to 211 on June 30, 1966.[81] Many alcoholics who formerly would have been in custody are now on the streets and subject to arrest. Their constant rearrest resulted in a dramatic increase in the number of public inebriates processed by the courts. The typical Monday morning docket grew from 200 to 300 intoxication cases, and additional judges have occasionally been pressed into service.[82] This additional burden has aggravated the already overcrowded conditions at the Court of General Sessions, at great cost to all misdemeanants appearing before the court.

FAILURE TO PROVIDE FACILITIES

Confusion in court procedures reflected a basic lack of planning by the city government. Responsibility for the gross inadequacy of treatment services for alcoholics rests with the Board of Commissioners and the Department of Public Health. Although the unanimous holding in

[67] Since the *Easter* case, arrests for public intoxication are approximately 10% below the level of the preceding year. Letter from MPD, Sept. 13, 1966. Yet, more drunkenness offenders are being processed by the courts and fewer are at the Workhouse. This anomaly suggests that the decrease in arrests has occurred among persons able to post collateral. The Chief of Police has recently "reminded District police that it is their duty to arrest drunks and the court's duty to decide whether those arrested are chronic alcoholics * * *." The Evening Star (Washington), Nov. 3, 1966, p. B1.

[68] The Washington Post, June 4, 1966, p. A3; June 5, 1966, p. B3; Aug. 23, 1966, p. A1; Report of the Ad Hoc Committee on Alcoholism of the D.C. Public Health Advisory Council, 8-10, 23 (June 24, 1966); Letter from Sidney S. Sachs, President, D.C. Bar Association to Walter N. Tobriner, President, D.C. Board of Commissioners, Oct. 7, 1966.

[69] The Evening Star (Washington), April 1, 1966, p. B1.

[70] The Washington Post, May 3, 1966, p. B1.

[71] *District of Columbia* v. *Walters*, et al., Crim. No. D.C. 18150, D.C. Ct. of Gen. Sess., p. 2 (Greene, J., Aug. 16, 1966, reprinted in 112 Cong. Rec. 22716 (Sept. 22, 1966). This view would appear to be compelled by recent decisions of the Court of Appeals in the analogous field of mental illness. See *Lynch* v. *Overholser*, 228 F. 2d 388 (D.C. Cir. 1961), reversed in part, 369 U.S. 705 (1962). The court held that "insanity is not strictly an affirmative defense and can be raised by either the court or the prosecution" and that the cases "establish almost a positive duty on the part of the trial judge not to impose a criminal sentence on a mentally ill person." Id. at 392, 393. See also *Whalem* v. *United States*, 346 F. 2d 812 (D.C. Cir. 1965), where an en banc court held that although a defendant may refuse to raise the issue of insanity himself, he may not, in a proper case, prevent the court from injecting it; and *Pate* v. *Robinson*, 383 U.S. 375 (1966).

[72] The Washington Post, July 6, 1966, p. B1.

[73] The Evening Star (Washington), June 22, 1966, p. C16.

[74] The Washington Post, June 21, 1966, p. A1.

[75] The Washington Post, June 20, 1966, p. A1; June 20, 1966, p. B1.

[76] *District of Columbia* v. *Walters*, et al., supra note 71, at 6.

[77] The Washington Post, May 27, 1966, p. B1.

[78] Canon 5 of the Canons of Professional Ethics of the Bar Association of the District of Columbia and of the American Bar Association provides that "The primary duty of a lawyer engaged in public prosecution is not to convict, but to see that justice is done." See also *Berger* v. *United States*, 295 U.S. 78, 88 (1935).

[79] Report of the Ad Hoc Committee on Alcoholism of the D.C. Public Health Advisory Council, 19, June 24, 1966.

[80] The Washington Post, Aug. 10, 1966, p. A24.

[81] Letter from M. C. Pfalzgraf, Superintendent, D.C. Workhouse, Nov. 9, 1966.

[82] The Washington Post, Aug. 23, 1966, p. A1.

Easter was widely anticipated throughout the community, no effective steps were taken to prepare for it. In the 8 months after the *Easter* decision no suitable diagnostic and treatment facilities were provided.[83] During this period approximately 3,400 persons were adjudged chronic alcoholics.[84]

After the *Easter* case, the Department of Public Health failed to provide the court regularly with needed medical personnel.[85] Drunkenness defendants were obliged to wait in the D.C. Jail for several days after their initial court appearance pending the appearance of a Health Department physician and the court was forced to reschedule its cases. In recent months the Department has provided personnel to screen intoxication defendants on a daily basis. There are obvious difficulties in making a diagnosis in a cell block; yet this service merits continuation so that the court can deal in a rational manner with the many derelicts who are now coming before it.

The Department was also totally unable to provide the more extensive diagnostic facilities contemplated by the 1947 statute, which requires that the court, after making a preliminary determination that the defendant is a chronic alcoholic, commit him to a "classification and diagnostic center for observation, examination and classification." [86] No such facility existed. As a substitute the Board of Commissioners assigned two dormitories of the Workhouse to the Department of Public Health for the purpose.[87] No meaningful effort, however, was made to transform these prison buildings into a diagnostic center.[88] Medical attention was minimal; prison uniforms were simply exchanged for hospital smocks. Indeed, normal conditions at the Workhouse for regular prisoners appeared superior to those for alcoholic "patients." The prisoners had opportunities for work and recreation and grounds privileges while the alcoholics were restricted to their dormitory and spent their days in idleness. In short, the District's "diagnostic center" was completely unsuitable for the treatment of chronic alcoholics. According to one Court of General Sessions judge, "in all but name, it is hardly more than a penal institution." [89]

Moreover, the "patients" were being retained at the Workhouse dormitory for longer periods than were necessary for any diagnosis of their condition. Although the Department of Public Health advised the court, at various times, that the duration of commitment would be 5 days, 7 to 10 days, or 2 weeks, nearly half the alcoholics were confined for over 2 weeks in early August 1966.[90] Ultimately, the court had to explicitly limit Workhouse diagnostic commitments to 1 week.[91]

The District was similarly unable to supply the treatment facilities envisioned as a necessary component of the 1947 act's procedures. The act specifies that upon receipt of the diagnostic report the court must commit the defendant to an appropriate treatment facility or release him. A total of about 100 beds available in various local hospitals and institutions and the exclusively outpatient facilities of the Alcoholic Rehabilitation Clinic were plainly insufficient to serve the 3,400 persons who were adjudged chronic alcoholics in the first 8 months following *Easter*.[92] Nor were the treatment programs adequate in those facilities. As a result, only the seriously ill could be given inpatient treatment, and the Department of Public Health had to recommend outpatient treatment at the clinic for the vast majority of court-adjudged alcoholics.[93] This practice proved grossly inadequate, since very few chronic alcoholics can be expected to benefit from the type of outpatient treatment available at the clinic. Patients committed to the clinic did not appear for subsequent treatment and were rearrested with great frequency.[94] Court referrals so far outstripped the clinic's limited capacity that it could no longer accept any voluntary patients even though their prognosis was far more favorable.

In 8 months since the *Easter* opinion there has been no major improvement in treatment facilities for alcoholics in the District of Columbia. Although funds were received from the U.S. Department of Justice in April 1966 for a 50-bed emergency care unit (detoxification facility), the Department of Public Health has indicated that the facility will not be open until the spring of 1967.[95] There is an acute need for an inpatient treatment center so that the city's derelict alcoholics will not be forced to face an uncertain fate on the streets of Washington this winter. Congress recently approved $300,000 of the District's $600,000 request to establish a "Rehabilitation Center for Alcoholics" at the Women's Reformatory at Occoquan, Virginia.[96] The Reformatory is to be transferred to the Department of Public Health and will provide accommodations for 300 to 500 patients. The center recently began operations and is expected to be fully available in the spring of 1967.[97]

PROPOSALS FOR CHANGE

The bankruptcy of the law enforcement approach to public intoxication is clear. Twice in the past 20 years, in the Rehabilitation of Alcoholics statute of 1947 and in the Karrick Report of 1957, public officials have recognized the need to revamp the existing system of dealing with the public inebriate. Recognition of the problem, unfortunately, has not been followed by effective action.

The *Easter* decision, however, compels a more honest response by the community. If the law is not to become a mere facade, the District must establish a meaningful treatment program as an alternative to incarceration for alcoholics. Although the opinion of the Court of Appeals recognized chronic alcoholism as a defense to a criminal charge of drunkenness, the decision has resulted in neither the removal of the chronic alcoholic from the criminal process nor provision for his treatment. For the most part the judges in the District of Columbia have tried to utilize the 1947 act, but inadequate facilities have frustrated their good intentions. Since *Easter* there has been, in fact, a marked deterioration in the health of the city's derelict alcoholics—a condition which goes unheeded only by a callous disregard for human life.[98]

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[83] During this period two judges have subpoenaed District officials in an effort to ascertain the state of facilities and planning. See, e.g., The Evening Star (Washington, D.C.), June 22, 1966, p. C16.

[84] It is estimated that 3,850 persons had been adjudged chronic alcoholics by Nov. 26, 1966, and that 450 of this total represented duplications. Letter from F. B. Beane, Jr., Chief Deputy Clerk, Criminal Division, D.C. Court of General Sessions, Dec. 1, 1966.

[85] *District of Columbia* v. *Walters*, et al., supra note 71, at 3-4.

[86] 24 D.C. Code § 505 (1961).

[87] Order No. 66—744, May 26, 1966.

[88] *District of Columbia* v. *Walters*, et al., supra note 71, at 5-7.

[89] Id. at 6.

[90] Id. at 7.

[91] Id. at 7-8.

[92] See letter from W. J. Tobriner, President, D.C. Board of Commissioners, to Judge C. W. Halleck, D.C. Court of General Sessions, June 6, 1966.

[93] *District of Columbia* v. *Walters*, et al., supra note 71, at 8.

[94] Id. at 11.

[95] The Washington Post, Oct. 22, 1966, p. B1.

[96] Memorandum from Dr. Murray Grant, Director of Public Health, to Commissioner J. B. Duncan, Sept. 30, 1966; The Evening Star (Washington, D.C.), Oct. 13, 1966, p. B1.

[97] Interview with R. J. Tatham, Chief, Office of Alcoholism and Drug Addiction Program Development, Dept. of Public Health, Oct. 25, 1966.

[98] Letter from Dr. S. L. Billet, Chief, Alcoholic Rehabilitation Clinic, to the Washington Daily News, Sept. 20, 1966, p. 24.

Essential to any long-term solution is the realization that chronic alcoholism is a serious public health problem that has been almost completely neglected. A meaningful community effort to combat this disease requires a wide range of costly treatment facilities. It also requires a statutory framework in which treatment goals are given priority and a reevaluation of present police, court and correctional practices.

TREATMENT FACILITIES AND PROGRAMS

Comprehensive plans for the treatment of alcoholics in Ontario, Canada, and St. Louis, Mo., suggests the following basic ingredients of an intelligent municipal program: [99]

(1) *Immediacy of Service.* Geographically decentralized facilities for the emergency care of intoxicated persons must be available at all times. Diagnosis and treatment should be initiated immediately upon the inebriate's arrival.

(2) *Comprehensiveness and Flexibility.* The range of services offered must cover the complete physiological and psychological needs of both non-alcoholic inebriates and patients in various stages of alcoholism. In addition to emergency care, this means that a comprehensive plan for alcoholics must provide diagnostic and classification services, short-term residential facilities and half-way houses, facilities for out-patient care and full range of out-patient services, including psychological and vocacational counselling, for those alcoholics who can be treated in the community.

(3) *Continuity and Coordinated Administration.* The patient should be guided to that treatment program which is appropriate to his state of recovery. This requires, at the very least, centralized administration of the entire program which permits reevaluation of the alcoholic's needs and reduction or transferral of supervision at proper stages in his treatment.

(4) *Prevention and Education.* The plan should include education directed at increasing public awareness of the dangers of alcoholism, as well as efforts to encourage the early identification of persons who are incipient alcoholics. The "recovered" alcoholic should be provided with facilities about which he can structure his life to help prevent a relapse, especially in the case of "skid-row" alcoholics.

(5) *Research and Evaluation.* Considering the acknowledged medical difficulties in dealing with alcoholism, any comprehensive plan must provide for continued research into the causes of the disease and the treatment needs of its victims. Evaluation of experimental programs would enable the responsible authorities to select those programs best designed to treat special types of alcoholics.

A comprehensive program along these lines has been outlined by District of Columbia officials. The plan describes a full range of facilities, including several emergency care units, a 100-bed hostel for alcoholic patients, halfway houses for men and women, a short-term intensive care unit to supplement the 42 beds at D.C. General Hospital, facilities for the extended residential care of alcoholics, and vastly enlarged outpatient services.[100] Over the long term, the program was focused on a 200-bed comprehensive alcoholism treatment center located in the heart of the District of Columbia, which would combine in one facility emergency care, diagnosis, intensive care, and outpatient units, and around which the emergency care clinics and aftercare facilities could function as satellites. The plan also suggested an extensive program of vocational training and rehabilitation services for patients referred from the Departments of Health, Corrections, Probation, Vocational Rehabilitation, Public Welfare, and the Board of Parole.[101]

On the basis of information now available, the plan appears to outline an adequate spectrum of facilities for the treatment of alcoholics. Its implementation, however, poses serious problems. Based on the responses of District officials to the *Easter* ruling, the Commission has substantial doubts that they have the requisite determination or expertise to execute a comprehensive treatment program for alcoholics.

Although the new rehabilitation center at the Women's Reformatory is perhaps essential as a temporary measure to meet the pressing needs of the city's alcoholics, it is grossly deficient as a permanent solution. The center's scheduled capacity of 500 patients may be too limited in view of the fact that approximately 1,000 intoxication offenders were incarcerated in the Workhouse prior to *Easter* and that about 3,400 persons have already been adjudged chronic alcoholics. The new center is intended to provide a full range of rehabilitative services, including group psychotherapy, individual counseling, academic remediation, vocational assistance and medical care, but Congress appropriated only half of the funds requested by the District Government for this purpose. Although the center will begin to accept patients in December 1966 it will not be prepared to offer a full treatment program until the spring of 1967 because of the difficulty in obtaining skilled professional staff.

Under these circumstances the Commission is concerned about the proposed use of the new center by the Department of Public Health. If the new center is too small or services limited, the problem will not be solved by simply committing alcoholics to it for an abbreviated period of time. Inpatient care is a suitable approach only when community-oriented residential treatment is available upon release. Since Washington has no hostels, halfway houses or other intermediate aftercare treatment steps, the treatment potential of the new center cannot be maximized. While the line between penal and treatment care is far from clear, the community's experience

[99] St. Louis Human Development Corp., Comprehensive Alcoholism Treatment Program for St. Louis City and County: A Proposal to Provide Treatment for the Low Income Alcoholic and Chronic Alcoholic Offender (1965); Alcohol and Drug Addiction Research Foundation, Future Management of Alcoholism in Ontario (1965). Currently in preparation are the results of a 5-year study on alcoholism for the Cooperative Commission on the Study of Alcoholism by the Institute for the Study of Human Problems of Stanford University, being financed by the National Institute of Mental Health. Letter from Sidney Cohen, Research Associate, Institute for the Study of Human Problems, Stanford University, March 14, 1966. See also Hoff, "Comprehensive Rehabilitation Program for Alcoholics," 7 Archives of Environmental Health 460 (1963).

[100] Task Force Rep., 6–11.

[101] Id. at 11.

over the last several months makes it incumbent upon the Board of Commissioners and the Court of General Sessions not to authorize the involuntary commitment of chronic alcoholics to the new center if its program is only custodial and unaccompanied by the necessary aftercare program and facilities. Until the new center at Occoquan is fully operational and fully integrated into a comprehensive treatment program, alcoholics should be taken there only on a voluntary basis so that they will not have to face the rigors of a winter on the streets.

The shortcomings of the Occoquan center emphasize the need for a treatment center within the District of Columbia. As originally proposed by the District Government, the Occoquan center was to be a temporary facility which would be replaced by a hostel and diagnostic center for alcoholics built on the grounds of D.C. General Hospital within the next 3 years. However, a request for $320,000 for plans and specifications for the hostel was rejected by Congress. As the Director of Public Health has recognized, chronic alcoholics require community-oriented treatment so that they can gradually adjust to urban living.[102] Confining them in a rural institution and then suddenly depositing them back in the city without extensive aftercare support is likely to cripple the rehabilitative process. Incarceration at Occoquan will be little more helpful when a health facility is used rather than penal institution unless substantial aftercare facilities are provided in the District. The indigent, homeless derelict requires room and board in an outpatient residential facility if there is to be any real chance for his rehabilitation. The Commission recommends that the Department of Public Health continue to develop plans for an in-town treatment center and appropriate aftercare facilities, and that a supplemental appropriation for such purposes in fiscal 1967 be sought from Congress.[103]

The Department's efforts to develop an emergency care clinic for alcoholics have also been disappointing. After several months of planning the District obtained a grant in April 1966 from the Office of Law Enforcement Assistance of the U.S. Department of Justice for a 50-bed emergency-care unit for intoxicated persons.[104] This facility is designed to treat acute alcohol intoxication. It will be located in a mid-town area, will be open on a 24-hour basis, and it will accept volunteer patients and intoxicated persons picked up by police officers and brought to the facility. It is estimated that patients will average 4 days in the unit, which means that it could serve approximately 4,500 patients a year. Such a facility can perform an important function in an overall treatment program, and it could be of substantial assistance in aiding the Court of General Sessions to respond to the crisis precipitated by the *Easter* case. Although the original grant proposal indicated that the facility would be open in November 1966, the Department of Public Health recently notified the Department of Justice that implementation would be postponed until March or April 1967.[105] In contrast, St. Louis was able to initiate such a project within 1 month after the grant was awarded.[106]

Reorganization of the District's efforts in the alcoholism field would ensure a more expeditious and successful implementation of its comprehensive plan. Fragmentation of effort is already a problem. A recent order of the District Board of Commissioners directs several District agencies to develop programs for alcoholics which, at some subsequent time, will be coordinated by the Director of Public Health who has "primary responsibility for initiating such cooperative arrangements." [107] The Department of Public Health, however, can hardly execute this responsibility with a staff of only a single professional charged with the development of programs for both alcoholism and drug addiction. The Commission recommends that responsibility for alcoholism program development should be centralized in the Department of Public Health, which should increase its staff resources devoted to alcoholism. We recommend also that the Department solicit the advice and guidance of experts in this rapidly changing field to ensure a sound, creative program for the Nation's Capital.

LEGAL PROCEDURES AND PRACTICES

As chronic alcoholism is increasingly recognized as a public health problem, existing practices of the police, prosecutor, courts, and correctional officials must be substantially changed. Every effort must be made to eliminate conflicts between the treatment needs of the chronic alcoholic and the practices of law enforcement officials.

The Commission recommends a two-track system for handling the public inebriate:

> (1) The first track is a non-criminal process for the person who is intoxicated in public and cannot care for himself, but who is not disorderly. Such a person will be taken into protective custody and brought to a medical facility. After initial examination and emergency care, he will be "dried out" for a short period (3–4 days) on a voluntary basis and then channeled into a medically advisable, voluntary treatment program. Civil commitment under a carefully limited statute would perhaps be available as a last resort only for severely debilitated alcoholics.
>
> (2) The second track is a criminal process for the person who is both intoxicated in public and disorderly. He will be arrested for violation of a criminal statute and taken to a medical facility for initial examination and emergency care. If the offender is a chronic alcoholic, efforts will be made to direct him to a treatment program, and criminal charges will be dropped. If he is not a chronic alcoholic, the prosecutor will exercise his discretion either to initiate a criminal proceeding or dismiss the charges, depending on the severity of the offense, the violator's prior record, and other relevant considerations. Forfeiture of collateral will be available to enable these offenders to terminate criminal proceedings.

[102] *District of Columbia* v. *James G. Boyd*, Crim. No. D.C. 16852, D.C. Ct. of Gen. Sess., pp. 58–59 (Trial Transcript, June 21, 1966).

[103] The 1947 Act states that treatment facilities are to be in the District of Columbia. 24 D.C. Code § 506 (1961). In the fiscal 1967 Appropriations Act, however, Congress provided that funds for the treatment of alcoholics may be used outside the District of Columbia. Dr. Leopold E. Wexberg, then Director of the Alcoholic Rehabilitation Program, warned in 1953 that although the outpatient clinic "is adequate for nondestitute alcoholics who apply for treatment voluntarily," it "is able to help only a small part of the cases referred from courts and penitentiaries" because these destitute alcoholics "cannot be benefitted by an outpatient clinic without adequate residential facilities." L. E. Wexberg, "The Outpatient Treatment of Alcoholism in the District of Columbia," 14 Q.J. Stud. in 514, Alcohol 514, 524 (1953).

[104] U.S. Dept. of Justice, Office of Law Enforcement Assistance, List of Approved Projects, § vi, Grant No. 019 (1966).

[105] The Washington Post, Oct. 22, 1966, p. B1.

[106] Ibid.

[107] Order No. 66-744, § 3(b), May 26, 1966.

Development of such a two-track process requires not only a full range of treatment facilities but also extensive legislative and administrative changes.

Removal From the Streets

The Commission believes that public intoxication alone should not be a crime in the District of Columbia. Criminal sanctions should be restricted to individuals who, in addition to being intoxicated, behave in a disorderly manner so that they substantially disturb other citizens. Persons who are so drunk that they cannot care for themselves should be taken into protective custody by the police, and taken immediately to an appropriate health facility.

Amendment of the Public Intoxication Law. Comparative arrest figures from other major cities suggest that the Metropolitan Police Department is particularly rigorous in enforcing the public intoxication statute in the District of Columbia. Compared with other cities over 250,000 in population, the District of Columbia police in 1965 made more than three times the number of intoxication arrests per unit of population.[108] Whereas the number of intoxication arrests in the District of Columbia in 1965 was 44,218, Cincinnati (population 502,550) had 6,205 arrests,[109] and St. Louis (population 750,026) had 2,445, down from 3,761 in 1964 and 7,897 in 1963.[110] Few cities, whatever their size, have intoxication arrest figures approximating the District's.[111] Moreover, the long-term trend of intoxication arrests in the District has been upward.

Nine years ago the Karrick Report recommended that "appropriate action be taken by the Chief of Police to encourage the policeman on patrol to make a more determined effort to send persons who are simply intoxicated directly to their homes and avoid, where possible, arrest and detention." [112] Nonetheless, many people who are neither disorderly nor incapacitated continue to be arrested, since the existing statute makes it a misdemeanor simply to be intoxicated in public. Only about 12 percent of all drunkenness charges are accompanied by a disorderly conduct charge.[113] Although police criteria attempt to limit arrest discretion, they focus primarily on the degree of intoxication rather than on the behavior of the inebriate. Experience since the Karrick Report indicates that reliance on internal Department controls is not the most effective mechanism for developing proper arrest standards under the intoxication statute.

The Commission recommends that the public intoxication law be amended to require specific kinds of offensive conduct in addition to drunkenness. Other states have laws which require both intoxication and a breach of the peace before an arrest may be made.[114] In the City of New York and the State of Illinois there are no public intoxication statutes; these jurisdictions rely on disorderly conduct laws to arrest intoxicated persons who invade the rights of others.[115]

The Chief of Police has suggested that "most arrests for drunkenness have some element of disorderly conduct" and that the proposed amendment would not materially decrease the number of arrests.[116] However, we recommend that the proposed amendment be drafted to define a narrow range of behavior that would make the inebriate subject to arrest. A substantial interference with other citizens should be required. Persons who are simply noisy, unable to walk properly, or unconscious should not fall within the reach of such an amended intoxication statute or the existing disorderly conduct statute. The effect of the proposed amendment to the intoxication statute would be a substantial reduction in the number of intoxicated persons arrested. This proposal, of course, would be of no avail if the police resorted routinely to the far-reaching provisions of the District's disorderly conduct statute, rather than the amended intoxication law. The Commission believes that the handling of persons who appear to be intoxicated should be governed by the provisions of the proposed intoxication statute and not left to police interpretation of the broad disorderly conduct statute.

A New Protective Custody Statute. Amendment of the public intoxication statute to require an element of disorderly behavior should be accompanied by legislation giving the police and public health personnel authority to take into "protective custody" and detain until sober any person who is so intoxicated he cannot care for himself. Such a statute would enable police or other public officers to remove incapacitated persons from the street without invoking criminal sanctions inappropriately.

Authority for protective custody rests in a statutory recognition of the common law power of the police to civilly detain on an emergency basis persons dangerous to themselves. This common law authority was recognized by the United States Court of Appeals in analogous circumstances relating to the mentally ill.[117] It is implicit in General Order No. 6, 1962 Series, of the Metropolitan Police Department, authorizing police removal of semi-conscious or unconscious persons to a hospital for examination. Authority of this type is exercised in St. Louis where persons intoxicated on private property (not an offense) are taken into "protective custody," given medical treatment and released when sober.[118] It also accords with New York law which recognizes the propriety of the use of force by any citizen to detain persons temporarily or partially deprived of reason where "necessary for the individual's protection or restoration to health." [119] Finally, it is practiced by the police regularly when they rush epileptics and heart attack victims to hospitals without first obtaining an informed consent.

Consideration should be given to using public health personnel to take incapacitated inebriates into protective custody. This could avoid the traditionally punitive relationship of the police officer to the alcoholic and free the police from an onerous task which detracts from their other duties. Experiments along this line in New York City and Boston have shown potential and ought to be pursued in Washington.[120]

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[108] Federal Bureau of Investigation, Uniform Crime Reports, 108–09 (1965).

[109] Letter from the Cincinnati Police Dept., April 17, 1966. Over the past 10 years the Cincinnati figure has hovered around 6,000 arrests.

[110] Supra note 18.

[111] E.g., other figures for 1964 were reported as follows: Cleveland (population 876,050), 14,907 arrests, Cleveland Police Dept., Ann. Rep. 24 (1964); San Francisco (740,316), 24,213 arrests, San Francisco Police Dept., Ann. Rep. 39 (1964); Los Angeles (2,479,015), 72,083 arrests, Los Angeles Police Dept., Ann. Rep., 13 (1964).

[112] Karrick Rep., 132.

[113] MPD letter. Approximately 45 % of intoxication arrestees are able to post collateral and thus avoid criminal prosecution; most of these were probably not seriously incapacitated when arrested. See supra note 5.

[114] E.g., 14 Ala. Criminal Code § 120 (1958); 58 Ga. Ann. Code § 608 (1965).

[115] New York Penal Law § 722 (1965); 38 Ill. Stat. Ann. § 26–1 (1963). See also the American Law Institute Model Penal Code § 250.5 (Proposed Official Draft, 1962).

[116] MPD letter.

[117] *Orvis* v. *Brickman*, 196 F. 2d 762, 767 (1952).

[118] Letter from Curtis Brostron, Chief of Police, St. Louis, Mo., Oct. 15, 1965.

[119] New York Penal Law § 246(6).

[120] Address by E. Blacker on "Aftercare Residential Program Planning: Boston's Program for the Chronic Drunkenness Offender," Before the North American Association of Alcoholism Programs, Albuquerque, New Mexico, Oct. 10, 1966.

EMERGENCY CARE

Law enforcement and medical authorities agree that public inebriates frequently need prompt medical attention and that persons apparently intoxicated may in fact be suffering from some more serious illness. Moreover, proper treatment for chronic alcoholics requires their immediate introduction into a nonpunitive milieu. All public inebriates, whether arrested because of disorderly conduct or taken into protective custody, should receive emergency medical care.

The proposed emergency care unit is a crucial stage in the Commission's two-track plan. The unit would diagnose all public inebriates to determine their medical needs and whether they are chronic alcoholics. It would then advise the inebriate, the Corporation Counsel and the court of the most appropriate method for dealing with the inebriate's condition. The Corporation Counsel has agreed to cooperate in the operation of the unit by dropping charges against offenders who desire to remain at the unit for several days.

Under the procedures proposed by the Commission, the incapacitated inebriate would be detained only until he attains sobriety. However, if he wishes to remain in the unit for several days on a voluntary basis, he would receive more extensive medical care and diagnosis. Depending upon available resources in the community, the attending physician would then refer the patient to an appropriate treatment program of inpatient or outpatient care.

Several alternatives would also be available for dealing with the disorderly inebriate who is under arrest while at the emergency care unit. He would continue to have the option of posting collateral. If he did not do so, a medical judgment would be made as to whether he is a chronic alcoholic. If chronic alcoholism were diagnosed, the Corporation Counsel would either nolle prosse the case, leaving the individual to follow voluntarily the treatment advice of unit medical personnel, or seek a commitment order under the 1947 statute. If the offender is found not to be a chronic alcoholic, the prosecutor could proceed as in an ordinary disorderly conduct case.

The single 50-bed unit now planned cannot meet the need for detoxification facilities in the District.[121] Until a sufficient number of emergency care units are established, alternative arrangements should be made so that medical care is provided for all public inebriates. We recognize that this will necessitate substantial adjustments of police procedure and the expansion of medical services. Experience in St. Louis during the past 3 years, however, demonstrates that both can be accomplished if responsible officials place high priority on the health needs of intoxicated individuals.[122]

STATUTORY COMMITMENT FOR TREATMENT

The intoxicated individual who is taken into protective custody would not be subject to prosecution. Upon attaining sobriety he would be free to leave the medical facility. Those in need of further care would be so advised by attendant physicians. Experts say that the vast majority of chronic alcoholics, typically passive and dependent personalities, would voluntarily join in an effective, comprehensive treatment program.[123] However, it may eventually prove necessary to provide authority for the compulsory treatment of severely debilitated alcoholics who refuse treatment.

The Commission recognizes that the constitutionality of a civil commitment law for alcoholics, in the absence of a criminal charge, is far from clear. In the recent cases of *Lake* v. *Cameron* and *Rouse* v. *Cameron*,[124] there was a division within the Court of Appeals as to the standards under which the government may deprive an admittedly ill person of his liberty. The decision in *Driver* v. *Hinnant* takes the position that the civil commitment of alcoholics is permissible [125] but the *Easter* decision appears to restrict such power to persons who are a "menace to society," although it also stated that the court was not "called upon to speculate as to the range and nature of permissible detention which could be authorized by Congress beyond that contemplated in the act of 1947." [126] Nevertheless, a narrowly drawn statute, providing for short-term commitment of severely debilitated chronic alcoholics who pose a direct threat of immediate injury to themselves, might be a useful adjunct to a treatment program.[127]

Effective implementation of the Commission's plan will probably require some modification of the 1947 statute, which may still be used for disorderly inebriates. As the Department of Public Health develops the necessary facilities and services, it would be preferable for the statute to provide for commitment to the Department rather than to specific facilities. At that time consideration should also be given to replacing the 90-day commitment with an indeterminate sentence not to exceed 1 year, as recommended by the Karrick Report, with appropriate safeguards. Procedures could be abbreviated without diminishing protection of the defendant's rights. The Commission recommends that issues relating to the operation of the 1947 statute be reviewed by the Judicial Conference of the District of Columbia.

JUDICIAL PROCEDURE

As new procedures are developed for handling public inebriates, it would be an opportune time to enhance the dignity of the judicial process in the D.C. Branch of the Court of General Sessions. Efforts by the court and prosecutor to schedule hearings in advance would permit the defendant arrested for an alcohol-related offense to come into court in presentable condition. In many cities a special effort is made by the judge to talk with the defendant about his problems, carefully advise him of his basic legal rights, and inform him of the treatment facilities available in the community.[128] This brief expenditure of time makes for a more meaningful experience for the defendant, assists the judge in evaluating his capacity for change, and may have therapeutic significance.[129]

[121] Report of the Ad Hoc Committee on Alcoholism of the D.C. Public Health Advisory Council, 17–18, June 24, 1966.
[122] Supra note 17.
[123] Meeting of Alcoholism Consultants to the Commission: Dr. David J. Pittman, Dr. Ebbe C. Hoff, Dr. Robert Reiff, Dr. Richard F. Docter, and Mr. James Rooney, Feb. 15, 1966, Washington, D.C.; Blacker, supra note 120; T.F.A. Plant, some thoughts on Public Drunkenness and Skid Row (June 1966) (mimeo.). See, generally, Proceedings, First North American Conference on Halfway House Alcoholism Programs (Granville House, Inc., St. Paul, Minn., June 19–22, 1966).
[124] 356 F. 2d 761 (D.C. Cir. 1966).
[125] Supra note 66.
[126] 361 F. 2d at 55.
[127] The National Institute of Mental Health is presently considering sponsoring a comprehensive research project on the legal problems of drunkenness and alcoholism including civil commitment.
[128] Supra note 32.
[129] Ibid.

As long as drunkenness offenders remain subject to penal sanctions, the Commission believes that they should be provided with counsel. The impact of legal assistance in these cases may be great. In New York City counsel are now assigned to all defendants in the section of the Criminal Court that deals with drunk-and-disorderly men. In March 1965, prior to assignment of counsel, 1,590 homeless men were arraigned; 1,259 pleaded guilty, 325 were acquitted and 6 were convicted after trial. In March 1966, 1,326 were arraigned; 1,280 were acquitted, only 45 pleaded guilty and one was convicted after trial.[130] In the District at least one Legal Aid attorney should be assigned to the D.C. Branch to interview defendants to see if they desire counsel. Experience with one assigned attorney will help guide future planning for more extensive representation.

Sentencing practices in the court should also be improved. Under the proposed procedures, only disorderly inebriates who are not chronic alcoholics would come before the court for sentencing. Some of them may be incipient alcoholics, however, and might well benefit from some of the sentencing procedures used in intoxication cases elsewhere in the United States, which appear to have shown positive results.[131] The judges of the Court of General Sessions should attempt to agree on specialized sentencing procedures for defendants who have serious drinking problems.

CORRECTIONAL PROGRAMS

Probation services and prison programs for individuals with drinking problems continue to be significant. Neither *Easter* nor the changes proposed by the Commission obviate their importance for incipient alcoholics and for alcoholics who are convicted of crimes other than public intoxication.

As the burden of handling chronic alcoholics shifts to the Department of Public Health, the Probation Department of the court should concentrate its efforts on persons convicted of serious crimes. The Department should prepare complete presentence reports to assist the judges in choosing a proper sentence.[132] Where probation rather than imprisonment is the sentence, the Department should provide intensive personal contact and field supervision. For those probationers with drinking problems, the Department should rely on the range of outpatient services offered by health authorities and private agencies, instead of limiting the probationer to weekly lecture meetings of dubious value. The special alcoholism unit should be integrated into the overall operations of the office. Finally, the new resources recommended by the American Correctional Association should enable the Probation Department to provide a modern, meaningful probation program for offenders with drinking problems.[133]

The Department of Corrections must also prepare a program for persons who have problems with alcohol. These people need special assistance of the type provided during the 1960 experiment at the Workhouse. A program of post-institutional services should be developed; the chronic alcoholic who is convicted of a crime other than public intoxication should be referred to the appropriate treatment resource upon release.

CONCLUSION

The statutory and administrative changes suggested by the Commission should provide a sound framework for transferring responsibility for chronic alcoholism from law enforcement agencies to public health authorities. These reforms were overdue long before the *Easter* decision. They are now urgently needed.

The Commission's recommendations will not provide the final solution to the problem of the derelict alcoholic. Many of these men have poor prognoses and may never become self-sufficient. For these unfortunate people, simple humanity demands that we stop treating them as criminals and provide voluntary supportive services and residential facilities so that they can survive in a decent manner.

There can be no improvement, however, unless substantial resources are devoted to the establishment of a comprehensive treatment program. In 1947 and again in 1957 public officials recommended substantial revisions in the community's approach to public intoxication, yet change was minimal. The public crisis caused by the *Easter* case has once more brought to the community's attention the quiet despair of thousands of Washington's derelict alcoholics. The community's answer to the *Easter* crisis must not again be expedient, punitive remedies aimed only at removing the problem from public concern; it must reflect a determination for the first time to grapple with the deep-seated disabilities of the city's derelicts.

SUMMARY OF RECOMMENDATIONS

IMMEDIATE ACTION

1. All persons detained for public intoxication or for being drunk and disorderly should be taken initially to a medical facility.
2. The Department of Public Health should assign sufficient personnel to the D.C. Branch of the Court of General Sessions so that all persons detained for public intoxication or drunk and disorderly can be promptly diagnosed.
3. The Corporation Counsel should prosecute only those public intoxication and drunk and disorderly defendants who have not been already adjudged to be chronic alcoholics and should raise the defense of chronic alcoholism where appropriate in any criminal case.
4. The Legal Aid Agency should assign an attorney to the D.C. Branch of the Court of General Sessions.
5. The Alcoholic Rehabilitation Clinic staff should be increased so that outpatient services can be offered to adjudicated chronic alcoholics and voluntary patients and so that weekend and evening hours can be established.

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[130] Address by B. J. Botein on "The Criminal and Family Courts," Governor's Conference on Crime, New York, N.Y., April 22, 1966.

[131] In San Diego, for example, a graduated sentencing structure has been developed and provides the following penalties: (1) Fine and release for first offenders; (2) 30-day sentences for second offenders within 3 months of the first offense suspended on condition that they attend at least three Alcoholics Anonymous meetings and abstain from drinking alcoholic beverages for 1 year; (3) 60-day sentences for third offenders, suspended on condition that they follow the recommendations of a rehabilitation clinic; and (4) confinement for fourth offenders. Between July 1962, when the program began, and January 1965 there was a 50 percent decrease in drunk arrests despite an 11.5 percent population increase. G. Crawford, Rehabilitation of the Alcoholic Addict by Use of Court Probation, (1965) (mimeo.).

[132] App. (ACA), 691–92.

[133] App. (ACA), 723–31.

6. The Rehabilitation Center for Alcoholics at the former Women's Reformatory at Lorton should be established as a temporary facility with the full range of planned treatment services.

7. Supplemental appropriations for fiscal year 1967 should be sought for high-priority services and facilities: expanded detoxification centers, an inpatient diagnostic and treatment center in the District, and a comprehensive aftercare program including residential facilities.

LONG-TERM ACTION

8. The Department of Public Health should become the central planning agency for the treatment of alcoholism and should develop a comprehensive treatment program for persons with drinking problems. All other agencies with related programs should be required to plan and coordinate their activities in accord with Department of Public Health supervision. In order to execute these duties properly, the Department of Public Health should enlarge its Office of Drug Addiction and Alcoholism Program Development and enlist the assistance of expert consultants.

9. The public intoxication statute should be amended to require disorderly behavior as an element of the offense.

10. Police and public health personnel should be authorized by statute to take into protective custody intoxicated persons who are incapacitated.

11. All persons arrested for disorderly intoxication or taken into protective custody as incapacitated inebriates should be taken to an emergency care unit for medical attention and diagnosis followed by appropriate prosecutive action or treatment referral.

12. The Corporation Counsel should be guided in his exercise of prosecutive discretion by Department of Public Health diagnostic experts.

13. The Court of General Sessions should develop a uniform sentencing policy for disorderly inebriates.

14. The Alcoholic Rehabilitation Unit of the Probation Department of the Court of General Sessions should be disbanded.

15. Under the guidance of the Department of Public Health, the Department of Corrections should establish a treatment program for prisoners with drinking problems.

16. After an appropriate period of experimentation with voluntary treatment of alcoholics under a comprehensive program, the Judicial Conference of the District of Columbia should consider the need for and the constitutionality of a civil commitment statute for chronic alcoholics and amendment of the existing Rehabilitation of Alcoholics statue.

ALCOHOL PROJECT OF THE EMORY UNIVERSITY DEPARTMENT OF PSYCHIATRY

Contents

INTRODUCTION:

HISTORY:

In the city of Atlanta, Georgia, which has a metropolitan area population of one million people, there are an average of 50,000 arrests each year for plain public drunkenness. This accounts for 60% of arrests for all causes made by the Atlanta City Police.

Of these 50,000 arrest cases, 20,000 "pay out" after a four hour sobering up period and do not appear in "drunk court" the following morning. The other 30,000 cases do appear in court and are tried by the Municipal Court judges at the rate of an average of 100 cases each court day. This astonishing situation, common to all cities in the United States, has been going on in Atlanta for years and continues to increase in size as the city grows larger.

This report, issued in mimeographed form on September 23, 1963, is the culmination of a comprehensive study by the Alcohol Study Project of the Emory University Department of Psychiatry, the City of Atlanta, and Fulton County, Georgia. It was jointly financed by the city and county and a local business and industry group.

The alcohol study team was composed of members of the Department of Psychiatry at Emory University, including Bernard C. Holland, M.D., chairman of the Department of Psychiatry, and James A Alford, M.D., study director. The advisory committee to the alcohol study team was composed of representatives from business and industry, the Community Council of the Atlanta Area, Inc., the City of Atlanta, Fulton County, and professional and civic organizations.

Some of the data set forth in this report was used in the preparation of the Commission's chapter on drunkenness.

Approximately five years ago the Municipal Court judges became very concerned with this problem because it was occupying more and more of the Court's time, and one of two things was happening. The judges found they could either spend less time on other matters relevant to their duties or they would, of necessity, have to speed up their handling of the "plain drunk" cases. As a result of the ever increasing number of cases which were being handled by the Municipal Court, both of these processes followed, but the "plain drunk" case suffered the most. Inadequate time was allotted to the cases both in court and by the probation officers because the load was so great it was impossible to do otherwise.

Five years ago the judges began to ask, "What can we do about this problem of the chronic court offender cases?" Certainly it was evident that repeatedly arresting these individuals, trying them, sentencing them, and having them pay fines, serve time, or both was not the answer. Even binding these individuals over to a higher court as habitual drunkards did not alter the problem beyond the extent that a man spending 12 months in prison at least wouldn't be re-arrested and appear in court during that time. A large percentage of those who did serve 12 months in prison were back in jail for "plain drunk" within hours or days after being released from prison.

At about this time the judges were approached by several individuals, some of whom were ex-alcoholics with varying periods of sobriety behind them, who volunteered their services as a Helping Hand Society to do whatever they could to help these individuals caught in the revolving door of drunkenness—arrest—jail—release—drunkenness, etc. The leaders of this group were such men as Mr. Jake Brooks, who at one time had himself been in

the revolving door of drunkenness, and Mr. Ernest Wright, a leader in the Negro Community who had worked closely with many of these individuals as a counselor in employment for the Georgia Department of Labor. Mr. Henry Jackson, who had had 18 years of extensive experience working with alcoholics, was added to the Municipal Court staff as the Director of the Alcoholic Rehabilitation Program.

Judge James E. Webb assumed the lead in accepting these individuals' offers to help the chronic court offender. He set up a system whereby individuals he saw in court for plain public intoxication could request that they be probated to the Helping Hand Society. At the discretion of the Judge and representatives of the Helping Hand individuals were accepted on the program, and for a probation period of 60 days he was expected to cooperate with the Helping Hand. The program consisted of three essential things: (1) being a friend to the individual with a drinking problem (2) help him find the essentials of life which many did not have—food, clothing, and a place to stay; (3) provide fellowship for the individual in a new environment away from drinking establishments—this consisted of evening meetings at the Court House for the purpose of discussing together their mutual problems, and an attempt was made to make religion a part of these peoples' lives again or for the first time.

As many of the chronic court offenders began to form healthy relationships with their new-found friends in the Helping Hand, some of them remained sober and no longer were being seen in court regularly. Some returned to express their gratitude to the judges for the new program.

However, because of the lack of proper facilities to carry out the functions of the Helping Hand, the process, although successful with some, was unable to reach the majority of the chronic court offenders, and the Municipal Court case load continued to grow at an alarming rate. (Drunk arrests increased from 40,821 cases in 1957 to 53,180 in 1960.)

In 1961, Judge Webb and the leaders of the Helping Hand Society decided that if an increase in facilities for the treatment of alcoholism were at their disposal, they could do a better job of rehabilitating larger numbers of the chronic drunk court offenders. With this in mind they approached the Greater Atlanta Community Council, Inc. requesting that this proposal be given consideration. The Community Council felt that the matter warranted further study before any action be taken on the matter of providing the facilities requested.

The City of Atlanta, Fulton County, and a group of interested, dedicated business leaders of Atlanta agreed to provide the funds for a one year study to be made by the Department of Psychiatry of Emory University. This study was to be designed to gather data, analyze the data, and make recommendations based on this data to better deal with the problem of the chronic drunk court offender. The study began on July 1, 1962 and ended June 30, 1963.

THE ALCOHOL STUDY

The Alcohol Study Team from the Department of Psychiatry, Emory University, was made up of Bernard C. Holland, M.D., Chairman of the Department of Psychiatry, Senior Investigator; James A. Alford, M.D., Psychiatric Resident, Study Director; James Z. Bowcock, M.D., Research Fellow; Peter Bourne, M.D., Research Fellow; Miss Marjorie Davidson (deceased), Clinical Psychologist; Mrs. Gwenn Bourne, Consultant in Clinical Psychology; Miss Jane Gavin, Psychiatric Social Worker: Ernest Wright, Consultant in Negro Problems; Mrs. Margaret McDougall, Mrs. Robina Hume, Mrs. Ruth Ramsey, and Mrs. Charlotte Lawler, Social Work Case Aides: and Mrs. Ruth Dolan and Mrs. Jesse Oppenlander, Volunteers.

Upon first approaching the study of the problem we were faced with many questions. With what individuals are we really concerned? How big is the problem? How many people are involved? What type of persons are we dealing with? What are the present facilities and agencies in Atlanta attempting to work these people? Are the existing facilities and agencies successful? If not, why not? Is this problem any bigger in Atlanta than in cities of comparable size? What do other cities do about the problem?

It was finally decided that the people who were returning to "drunk court" repeatedly—the chronic court offender—were the ones about whom there was the most concern. These were the people who were literally "dumped in the lap" of the city to take care of—or more specifically on the doorstep of the police station. At this point the revolving door or merry-go-round began—jail—court—stockade—street—jail, etc.

It finally evolved that the question we were trying to answer was, "Is it possible to decrease the number of drunk court appearances in a way that would be beneficial both to the individual court offender and to the city of Atlanta?" Obviously we could decrease the number of drunk court cases quickly in ways that might be beneficial to the individual but not to the city of Atlanta or vice versa. For example, we could wipe out overnight (as was done in New York City some years ago) the whole figure for "plain drunk" arrests (50,000 per year), simply by changing the statute that says it's a crime to be publicly intoxicated in Atlanta. But, obviously, this would only be ignoring an existing problem and within a period of days we would have a skid row area that would be a blight on the city of Atlanta. This we do not now have, thanks to the efficiency with which the Atlanta police remove intoxicated persons from public places. Another way to decrease drunk court appearances would be to hold the arrested person for a period of several hours and then release him without trial (as is also done in some cities). Still another way to decrease the number of drunk court appearance cases would be to give every person found guilty of public intoxication a longer sentence (say 6 to 12 months). This de-

creases considerably the number of times any one person can appear in court in a year or a lifetime, considering some individuals now appear as many as 20 to 25 times per year.

But none of these methods would mutually benefit the individual and the city of Atlanta. Therefore, a method must be devised that would not only decrease the number of drunk court appearances but also be rehabilitating to the individual and at the same time improve the efficiency with which the city of Atlanta is handling the problem.

Before any method of accomplishing either of these goals can be devised certain basic assumptions must be made and accepted. One of the most basic questions that must be answered and agreed upon is this: Are we dealing with individuals whose only problem is that they are breaking the law, and therefore should be punished, or, are we dealing with *sick people* who are breaking the law and, therefore, should be rehabilitated as they are being detained for their own and the public's protection?

One of our basic assumptions at the beginning of the study was that most of the people arrested for drunkenness were alcoholics many of whom also suffered from other mental and physical illnesses. It has been shown by our study that these assumptions are correct.

STUDY METHODS

Keeping in mind that we were asking the question, "Can the number of drunk court appearances be decreased in such a way that would be beneficial both to the individual and to the city of Atlanta?", we set out to gather data. In looking for the answer to this question we hoped to gain information which would be useful in making recommendations for treatment facilities for the repeat drunk court offender.

Our initial problem was concerned with the manner of obtaining information. In general, 5 different approaches were used. These were as follows:

1. Analysis of police department records on drunk arrests. The records for 1961 were analyzed in some detail with the aid of the Computer Center at Emory University.

2. Study of approximately a 10% sample of the repeat court offenders by means of a questionnaire and psychological tests, and a chest x-ray study of 1,050 individuals who appeared in court.

3. An intensive interview study of 28 randomly selected repeat court offenders. This included much more extensive psychological testing, religious evaluation and home visit evaluation by social workers.

4. (A) General observation concerning arresting procedure, court handling, and incarceration; (B) Causes for appearance in "drunk court" viewed from an economic standpoint; (C) Geographic distribution of drunkenness in Atlanta by place of arrest.

5. A financial study was done in which estimates of cost were determined relating to the present methods of handling drunk arrest. Also, estimates of cost of alcoholism to the entire community were determined.

Analysis of Police Department Records

The Atlanta Police Department records information concerning each arrest and its disposition on IBM data processing cards. All these records for drunk and drunk and disorderly arrests for the year 1961 were obtained and analyzed at the Computer Center at Emory University. The records consisted of nearly 100,000 IBM cards, one card for each arrest and one card for the disposition of each arrest. The information from this source consisted of age, sex, race, date and hour of arrest, place of residency, and disposition of each case.

Questionnaire Study

Although it was known that approximately 50,000 arrests were made each year in the city of Atlanta for drunkenness, and 30,000 of these appeared in court, it was not known how many individuals were actually involved since many people were arrested repeatedly each year. Consequently, in order to determine the size of the sample to be studied, it was first necessary to obtain a reliable estimate of the number of individuals involved in the court appearances for drunkenness. This was done by taking a random sample of 400 court appearances from the 1961 police department records. From this it was determined that 12,000 individuals accounted for the 30,000 court cases and that half of these appeared in court only one time in the 12 month period. Therefore our questionnaire study was to focus on the remaining 6,000 individuals who were in court 2 or more times in 1961 and accounted for 24,000 court appearances.

The questionnaire was designed to gain information pertaining to the factors thought possibly to play a part in an individual's repeat court appearances for drunkenness. The initial section of the questionnaire deals with identifying data such as name, age, sex, race, marital status, present address, and religion. This is followed by a section dealing with information concerning the arrests of the individual, health status, educational status, present and past occupational and work history, present living situation, economic status, and previous treatment for drinking.

In addition to the questionnaire, 3 psychological tests were given to each individual. These were the Beta test, the Alcadd tests, and the Trail Making tests. The Beta test is an intelligence test which can be used to evaluate both literate and illiterate subjects. The Alcadd test is designed to provide an objective measurement of alcoholic addiction. It consists of a series of 65 questions. The Trail Making test is designed to evaluate the presence or absence of organic brain disease.

In addition to the above, information was obtained from the police record on each subject for the previous two years in order to determine the number of arrests, court appearances, time spent in jail, and total amount of

fines paid for this period. Also, arrests for other charges were determined. Survey chest x-rays were taken on a large number of the study group in connection with evaluating the physical status of this group.

A sample of 640 individuals, which is approximately 10% of the population with which we are concerned, was studied by means of the questionnaire and psychological tests. Collection of data extended from November 1962 until April 1963. Each week day a group of from 8 to 13 subjects were selected randomly from the court tickets picking any individual who had appeared in court at least one time before in the previous 12 months. This procedure was carried out with both the White and Negro male with an attempt being made to keep the overall numbers approximately equal. Due to the lesser frequency of appearances of females, both White and Negro, and to obtain an adequate sampling of these, each White female repeater and most Negro female repeats were selected for the study.

The selected individuals were placed on suspended sentences with the understanding that they would cooperate with the study. In general, the subjects were most cooperative and appreciative of being taken for the study. The purpose of the testing was explained to the individual as well as the fact that the information requested had no connection with the court or police, and was confidential. The study sample was then taken to Grady Hospital where, after receiving coffee and cigarettes, the questionnaire and psychological tests were administered by a team of four trained social workers and volunteer workers. Individual assistance was required by approximately one-third of the subjects, to complete the questionnaire. The time required to complete the questionnaire and psychological test was usually about 2½ hours.

The Intensive Interview Study

A group of 28 subjects, 14 White people and 14 Negroes, were studied. Each individual was interviewed for one hour on each of four visits. A complete life history was taken in an effort to understand the environmental factors and experiences bearing on each individual's psychodynamic development. Three psychological tests, the Rorschach, Wechsler Adult Intelligence tests, and "Draw-a-Person" test were administered by a person thoroughly trained in their administration in order to determine each individual's personality structure and mental status. Next, the subject was seen by a chaplain in order to determine what religious influences were present. Where possible a home visit or a visit to some close relative was made by a social worker to corroborate information given by the subject and to further evaluate environmental factors and to obtain additional information related to the individual's past history.

The methods involved in this part of the study will be elaborated further in the section pertaining to the intensive interview study.

GENERAL OBSERVATION, COST STUDIES, AND TREATMENT PROGRAMS

Methods pertaining to these parts of the study will be described in the sections dealing with these aspects.

ANALYSIS OF POLICE DEPARTMENT RECORDS

As a part of the study an analysis has been made of the police department's records concerning arrest and court appearances for drunkenness.

Arrest

Over the past six years there has been a fairly constant percentage of drunk arrests compared to total arrests and averages 60.3%. The total arrest figures excludes traffic cases.

Figure 1.—Arrests for Drunkenness 1957–62

Year	Total arrest	Drunk arrest	Drunk arrest of total (Percent)
1957	67,666	40,821	60.2
1958	66,686	40,031	60.0
1959	74,224	46,110	62.2
1960	84,708	53,180	62.8
1961	87,407	49,805	57.0
1962	83,360	49,398	59.3

As noted from Figure 1 the proportion of drunk arrests has remained fairly constant even though there has been a significant increase in the total arrests. The increase in drunk arrests amounts to approximately 17.0%. However, the increase in the population of the city of Atlanta during this six year period has amounted approximately 8.0% based on estimates of the population. This indicates that the percentage of drunk arrests shows a greater increase than the population increase.

The proportion of drunk arrests by estimates of the population of the city of Atlanta is shown in Figure 2.

Figure 2.—Arrests for Drunkenness Compared with Population for Atlanta

Year	Population for Atlanta	Drunk arrest	Percent of population
1957	461,520	40,821	8.84
1958	470,165	40,031	8.51
1959	478,810	46,110	9.63
1960	[1] 487,455	53,180	10.90
1961	496,100	49,805	10.03
1962	504,000	49,398	9.80

[1] Based on 1960 census.

Compared with the figures in the uniform Crime Report for 1961 issued by the FBI, Atlanta has a drunk arrest rate which is five times greater than average for forty-eight other cities with over 250,000 population. We do not feel that this is due to a greater amount of drunkenness in Atlanta, but rather reflects the efforts of the

Atlanta Police Department in keeping public drunkenness at an absolute minimum.

Over the period analyzed there has been a slight rise in the proportion of drunk arrest figures for Atlanta. However, based on population figures for the five county metropolitan area there has been a progressive decline in the proportion of drunk arrests in Atlanta compared with the population as shown in Figure 3.

Figure 3.—Arrests for Drunkenness Compared With Population for Metropolitan Area

Year	Population, metropolitan area	Drunk arrest	Percent
1957	898,900	40,821	4.54
1958	928,800	40,031	4.31
1959	974,700	46,110	4.73
1960	[1] 1,070,188	53,180	4.95
1961	1,490,000	49,805	3.32
1962	1,820,000	49,398	2.71

[1] Based on 1960 census.

This would indicate that the vast majority of those individuals moving into the metropolitan area are not involved in drunk arrests. This fact is sustained by another finding of the study. That is that 77% of the White and 96% of the Negroes appearing in the drunk courts give their present address as Atlanta. It should be pointed out that these figures do not mean that, as in the case of the population of Atlanta, approximately one out of every ten persons is arrested for public drunkenness in any given year. Rather, as previously known and as shown by the study, a great number of the arrests are made up of individuals who are arrested repeatedly each year. As will be shown later, actually about ½ of all the arrests are made up of a relatively small group of about 6,000 individuals.

An analysis of the police department records for the year 1961 has been made. A breakdown of all arrests for drunkenness and drunk and disorderly by age, race, and sex, is seen in Figure 4.

Determination of the median age, indicated in arrows, shows that of the White male to be 41 years, 37 years for White females, 39 years for Negro males, and 35 years for Negro females. The median ages are slightly less for the Negro than for the White when compared by sex. A percentage distribution of the arrests by race and sex is seen at the bottom of Figure 4. In 1961 the population of Atlanta was 61.2% White and 38.8% Negro.

A tabulation of arrests by months of the year is shown in Figure 5. Other than a slight decrease in the coldest months there is very little variation.

An analysis of arrests by days of the week supports what we feel is a significant difference between Whites and Negroes. That is that much of the drinking by the Negro is on a cultural basis rather than on the basis of alcoholism. We feel the fact that a little over 70% of the Negro arrests occur on Friday, Saturday, and Sunday, supports this hypothesis.[1] See Figure 6. If their drinking were on an alcoholic basis the arrests would be more evenly distributed throughout the week as it is with the

Figure 4.—Drunk Arrests for 1961 by Age, Sex, and Race

Ages	White male	White female	Negro male	Negro female
20–21	867	218	1,055	328
22–23	475	72	619	170
24–25	560	72	739	191
26–27	565	101	807	220
28–29	740	97	1,180	289
30–31	850	109	1,195	368
32–33	919	133	1,395	392
34–35	1,030	172	1,309	327
36–37	1,112	202	1,396	327
38–39	1,298	199	1,577	398
40–41	1,386	206	1,476	352
42–43	1,405	190	1,443	274
44–45	1,075	112	1,235	207
46–47	1,005	109	1,085	178
48–49	1,069	129	1,103	148
50–51	1,044	95	1,039	190
52–53	847	69	857	101
54–55	786	47	646	82
56–57	591	40	601	74
58–59	449	31	415	40
60	1,605	70	1,350	138
Total [1]	19,687	2,473	22,525	4,794
Percent of total arrest by sex and race	39.78	5.00	45.52	9.68

[1] Total of drunk arrests for 1961 was 49,479—100 percent.

Figure 5.—Arrests for Drunkenness for 1961 by Months

Months	Number of arrests	Total (Percent)
January	3,580	7.20
February	3,640	7.32
March	4,581	9.32
April	4,332	8.70
May	3,982	8.02
June	4,469	8.99
July	4,343	8.70
August	3,875	7.78
September	4,280	8.60
October	4,337	8.72
November	4,078	8.20
December	4,308	8.65
Total	49,805	

Whites. This is a generalization and is not meant to imply that many of these people are not alcoholics. Many of them are alcoholics but probably not as many proportionally as in the White arrest group.

Two other factors play a part in increasing the weekend arrests of Negroes as compared with the Whites. First, a great many of the Negroes arrested work as laborers and are paid on Friday evening. Secondly, illegal liquor is more readily available to the Negro and thus provides him with a source of alcohol on Sunday when legal alcohol can not be purchased.

Place of residence is recorded for each arrest. The data concerning this is seen in Figure 7.

The great majority of those arrests for drunkenness reside within the city of Atlanta. A higher percentage of the White people live elsewhere as compared with the Negroes.

Nearly 60% of the arrests for drunkenness go to court. The remaining 40% are able to pay out prior to going to court by paying what amounts to a $15.00 fine. Those who do not have the $15.00 go to court.

[1] This seems to be true with both White and Negroes, that is, more were arrested over the weekend but the percentage of arrests during that period is greater in the case of the Negro than the White.

Figure 6.—Arrests for Drunkenness for 1961 by Days of the Week

Days of week	White males		White females		Negro males		Negro females		Total
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	
Monday	2,168	11.0	290	11.5	1,750	7.8	423	8.8	4,631
Tuesday	2,398	12.2	297	11.8	1,495	6.6	347	7.3	4,537
Wednesday	2,214	11.3	318	12.6	1,438	6.4	273	5.7	4,243
Thursday	2,187	11.1	304	12.1	1,712	7.6	319	6.7	4,522
Friday	3,254	16.6	382	15.2	3,957	17.6	687	14.4	8,280
Saturday	5,259	26.8	602	24.2	8,216	36.6	1,827	38.1	15,914
Sunday	2,177	11.1	301	12.6	3,918	17.4	909	19.0	7,322
Total	19,657	100	2,521	100	22,486	100	4,785	100	49,449

Figure 7.—Place of Residence

Place	White males		White females		Negro males		Negro females	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Atlanta	14,384	73.1	2,008	81.2	21,579	95.8	4,620	96.3
Metropolitan area	2,111	10.7	174	7.0	295	1.3	37	.8
State of Georgia	1,581	8.0	77	3.1	174	.8	18	.4
Out of State	888	4.5	73	3.0	85	.4	8	.2
Not stated	722	3.7	141	5.7	----------	1.7	111	2.3

Disposition of Case Arrests for Drunkenness in 1961.

The disposition of cases is seen in Figure 8.

Figure 8

Total arrests for drunkenness	Cases paying out—did not go to court		Cases going to court	
	Number	Percent	Number	Percent
49,805	20,171	40.5	29,634	59.5

Disposition of Court Cases

Disposition	Number of arrests	Total (Percent)
Dismissed	788	2.6
Suspended	5,685	19.1
Probated	104	.3
Option of serving time or paying fine	19,029	64.3
Straight time	2,459	8.3
Bound over to county court	1,569	5.3
Total	29,634	100.0

The majority of cases going to court are given an option of paying a fine, usually $15.00 to $25.00, or serving time at the city stockade, usually for a period of 13 to 27 days. These are the cases which have appeared in court two to four times in the previous twelve months.

The next largest group are those that are suspended. This occurs when the individual has not appeared in drunk court previously or if he has not appeared for an extended period. Also, a person may receive a suspended sentence in extenuating circumstances.

The third largest group is made of cases receiving straight time, usually thirty days, and occurs when the individual has appeared in drunk court five or more times in the previous twelve months. The individual may be bound over to the county courts for habitual drunkenness when he has appeared numerous times previously. In this circumstance the individual may be probated by the county or sent to a state prison for periods of eight months to a year.

As stated previously the primary attention of this study was to focus on those individuals repeatedly appearing in drunk court. It was first necessary to obtain an estimate of the number of individuals involved. To do this a sample of 500 cases appearing in drunk court in 1961 was selected from the police department's IBM records. Care was taken to make certain that no individual was represented twice in this sample. Records were then pulled on each individual to determine the number of arrests and court appearances in the previous twelve months on a charge of drunk or drunk and disorderly. No records could be found on 56 individuals. From this data the frequency distribution of arrests by race and sex was determined for the previous twelve months. This data is seen in Figure 9.

The percentage distribution by race and sex is seen at the bottom of Figure 9. The percentages for the Negroes are somewhat increased and those for the Whites decreased compared with the distribution given in Figure 4. The reason for this is that the sample of 444 cases was drawn from those individuals who had gone to court rather than just arrested. Thus it is seen that a higher percentage of Negro arrests go to court as compared with the White. From this data it is possible to determine the total number of arrests for drunkenness in the previous twelve months for the sample of 444. For the entire group there were 1264 arrests, 35.0% being accounted for by White males, 3.8% by White females, 51.7% by Negro males, and 9.4% by Negro females.

Figure 9.—Arrests for 12-Month period by Race and Sex for Sample

Number arrests in 12 months	White male	White female	Negro male	Negro female
1	79	11	74	14
2	19	3	59	9
3	16	2	25	5
4	10	5	24	4
5	9	1	9	2
6	2	0	12	3
7	6	0	9	2
8	2	0	6	4
9	3	0	3	0
10	3	0	2	0
11	2	0	0	0
12	0	0	0	0
13	1	0	0	0
14	0	0	2	0
15	1	0	0	0
16	1	0	0	0
Total	154	22	225	43
Percent of total	24.7	5.0	50.6	9.7

The data relating to drunk court appearances is seen in Figure 10.

Figure 10. Court Appearance for 12-Month period by Race and Sex for Sample

Number of court appearances	White male	White female	Negro male	Negro female	Total number of court appearances
1	91	13	93	18	215
2	20	3	59	6	176
3	18	3	21	5	141
4	8	3	21	3	140
5	5	0	5	2	60
6	3	0	10	4	102
7	5	0	6	2	91
8	0	0	5	3	64
9	3	0	0	0	27
10	0	0	2	0	20
11	0	0	0	0	0
12	0	0	0	0	0
13	0	0	2	0	26
14	0	0	1	0	14
15	1	0	0	0	15
16	0	0	0	0	0
Total	154	22	225	43	1,091

This group of 444 individuals accounts for a total of 1,091 court appearances in a twelve month period. The White Males make up 30.7% of the court appearances, White females 3.7%, Negro males 53.8% and Negro females 11.8%. Again we see the reflection of the fact that a higher percentage of the Negro arrests are brought to court as compared with the White arrests. Stated in other terms, the Negroes are not as financially able to pay out as frequently as the Whites.

The sample accounted for 1,091 court appearances in a twelve month period which is 3.7% of the total court appearances in 1961 for drunkenness. Since we know the number of court appearances accounted for by the sample of 444 individuals, it is possible to obtain a reliable estimate of the number of people involved in the 29,634 court appearances in 1961. Thus the number of people involved is found to be 12,060. Of the sample of 444 people, 215 or 48.4% are in court only one time in a twelve month period. Therefore 51.6% are in court 2 or more times in a year. This means that of the 12,060 people coming to court on a charge of drunkenness, only 6,222 are there 2 or more times in 12 months. We have used the term chronic drunk court offender to apply to this group. This is the group upon which the study has focused its attention.

From the figures presented it is possible to determine that this group of 6,222 people accounts for 80.2% of all the drunk court cases and at least 47% of all drunk arrests, and probably more.

Summation

We find that a very large portion of the arrests in the city of Atlanta, with the exclusion of traffic arrests, are due to public drunkenness and that the police department has assumed an increasing vigil in connection with this problem. This has, no doubt, contributed greatly to the prevention of the development of the skid row areas which are present in most other cities comparable in size with Atlanta. As stated by one of our study subjects, who had lived in the skid row areas in several overlarge cities, he could not feel comfortable looking and living like a derelict in Atlanta.

With the increase in the population of Atlanta there has been an increase in the absolute number of arrests for drunkenness but the increase in the population of the metropolitan area, with the exclusion of the city, has not greatly affected the number of drunk arrests.

The Negro makes up a disproportionate number of drunk arrests and a greater still disproportionate number of court appearances. We feel that much of the Negro drinking is on a cultural basis rather than on the basis of alcoholism and as his status improves then there will be a decline in the disproportion of his arrests and court appearances.

A relatively small number of individuals makes up a larger part of the drunk arrests and an even larger part of court appearances. It is this group in which arrests for public intoxication represents a symptom of a disease. We can not hope to prevent public intoxication but we can treat those relative few who make up the bulk of the problem.

QUESTIONNAIRE STUDY

Although the analysis of this part of the study is not completed it is felt that it would be worth while to note some of the more interesting findings to date. This will deal with only the White and Negro males.

As noted previously the questionnaire was designed to gain information pertaining to the factors thought possibly to play a part in an individual's repeated court appearances for drunkenness. On this basis the data has been analyzed by comparing the various factors in terms of the number of court appearances during a twelve month period. Each factor under study has been analyzed by comparing the results of three court appearance groups and for each race and sex. The court appearance groups consist of those individuals coming to court one to

two times, three to six times, and seven or more times in a twelve month period.

Study Sample

The questionnaire study sample consists of 638 individuals, 259 White males, 222 Negro males, 79 White females, and 78 Negro females. The total sample of 638 is divided such that approximately one third falls into each of 3 court appearance groupings. The sample accounted for 3562 court appearances over a 12 month period.

The following data applies only to the finding in the White and Negro males. The data for the females has not yet been processed.

Identifying Data—(Age, marital status, place of birth, religion)

The average age of the White males is 48.0 years. There is a tendency for those in the higher court appearance group to be older than those in the lower group. The same trend, but to a lesser degree, is found in the Negro males whose average age is 42.9 years.

Fifty-four percent of the White males are either separated or divorced and 20% of the Negro males are either separated or divorced and 23% of the total group were never married.

Only 31% of the White males and 33% of the Negro males were born in the Atlanta area, the remainder moving here from elsewhere in the state or out of the state.

The most common religious affiliation was Baptist, being present in 62% of the White males and 65% of the Negro males. The next most common affiliation was Methodist and accounted for 13% of the White males and 11% of the Negro males. In both races there was a tendency towards an increase in the percent of Methodists in the higher number of court appearance groups. No religious affiliation was claimed in approximately 10% of both races.

Arrest

In response to the question whether the individual were drunk at the time of arrest, 86% of the White males and only 58% of the Negro males responded affirmatively. In both races there was an increase in affirmative responses with an increase in the number of court appearances, this being much more pronounced in the Negro males. In the 1–2 court appearance group only 48% of the Negro males stated they were drunk compared with 82 percent of the White males in the same grouping.

The majority of arrests took place on the street with 49% of the White males and 59% of the Negro males' arrests occurring here. The next most common site of arrest was in a bar, grill, or tavern; these accounting for about 17% in both races. The most frequent place of drinking was in a bar, grill, or tavern as opposed to a home, or on the street, or elsewhere. Forty-eight percent of the White males and 38% of the Negro males became intoxicated in a bar, grill, or tavern.

The highest percentage of Negro arrests occurred from 6–12 p.m. whereas, just as many White males' arrests took place between noon and six o'clock as between six o'clock and midnight. Fifty-seven and a half percent of both the White and Negro males stated the arresting officer was friendly while 11.3 percent of the Negro and 5.4 percent of the White stated the officer was unfriendly. Twenty-six and one-tenth percent of the Negro arrests were made by Negro officers.

Health Status

In response to asking the individual if he thought he were seriously ill, 25% of the White and 14% of the Negro arrests answered affirmatively. Of those stating that they were ill or injured half of the White and one third of the Negro felt their ability to work was impaired. Seven and three-tenths percent of the White males and 5% of the Negro males stated that they had had tuberculosis. There was a definite correlation with the increasing number of court appearances in both races. Fifteen percent of the White males and 10% of the Negro males stated that they had had a "nervous breakdown" but there was no correlation with the increasing number of court appearances. Ten percent of the White males and 3.6% of the Negro males had been hospitalized in a mental hospital previously.

Education Status

Only 50% of the White males went beyond the eighth grade. There was no correlation between the number of court appearances and level of education. The Negro males did demonstrate a correlation of the level of education with the number of court appearances. Fifty percent of the Negro males in the 1–2 court appearance group went through the ninth grade, whereas 50% in the 3–6 court appearance group went through the eighth grade, and 50% in the 7 or more court appearance group went only through the seventh grade.

Occupation and Work History

Seventy-seven percent of the Negro males were classified as having an occupation of an unskilled nature, while 32% of the White males were classified in this group, 45% of the White males were classified in the semi-skilled group. A large number of painters were present in the White group. Forty and nine-tenths percent of the White males had had special job training while only 24.8% of the Negroes answered affirmatively to this question. Fifty-two percent of both races were looking for employment. Fifty-seven and a half percent of the unemployed Negro males had not had work for more than a month and 56% of the White males were in a similar situation. Thirty-seven and a half percent of the Negro males and 54.1% of the White males had worked

409-074 O - 70 - 7

less than six months in the past year. Twenty-six percent of the White males and 14% of the Negro males were receiving some type of financial assistance. At the time of arrest, 42% of the White males and only 6% of the Negro males had money available to pay a fine.

Economic Status and Living Situation

Less than 9% of the White males and less than 3% of the Negro males own either a home or a car. Approximately 30% of both races states that financially they are not self supporting. Thirty-two percent of the White males and 50% of the Negro males contributed to the financial support of someone else. Thirty-nine percent of the White males and 22% of the Negro males live by themselves.

Drinking Patterns and the Frequency of Arrests When Drinking.

It would seem from the data that both the White and Negro males in the higher court appearance groups (7 or more) are arrested with greater frequency when drinking than those in the lower court appearance groups. That is, those in the lower court appearance group drink more frequently without being arrested than those in the higher court appearance groups. Twenty per cent of the White males in the high court appearance group stated that they were arrested every time they drank. Only seven per cent of the Negro males in the same category made a similar statement. The vast majority of both White and Negro males drank in the company of others rather than alone. Concerning drinking companions, the White males stated that these individuals became intoxicated more frequently than the drinking companions of the Negro males. Also, the drinking companions of the White males more frequently had served time at the stockade than the drinking companions of the Negro males. Eighty per cent of the drinking companions of the White males in the high court appearance group had similarly served time in the city stockade, whereas only 65% of the Negro males had done so. Approximately 90% of the Negro males and 88% of the White males stated that they had previously tried to control their drinking. There was very little fluctuation in their results in terms of court appearance groups for both the White and Negro males. In terms of previous assistance in trying to control their drinking, 45% of the White males and 20% of the Negro males stated that they sought help in some form. Seventy-five percent of the White males and 64% of the Negro males felt that they had a drinking problem for which they wanted help. This varied to a greater extent in terms of increasing court appearances with the Negro males than with the White males.

Psychological Tests

The average score for the Alcadd test which purports to give an objective measure of alcoholism, was very similar for the White and Negro males. In both groups there was a trend towards higher scores in the higher court appearance groups. The results of these tests would suggest that there are a significant number of alcoholics in the lower court appearance group but even more in the higher court appearance groups. The results of tests concerning the regularity of drinking were very similar for both White and Negro males. The Negro males scored slightly lower than the White males on tests related to the preference for drinking over other activities. Results concerning the lack of control over drinking indicate that the White males scored higher in this area than the Negro males. Information concerning the rationalization for drinking showed that both the White and Negro males scored approximately the same. Tendencies towards excessive emotionality were overall equal in White and Negro males. However, the gradations between low court appearance groups and high court appearance groups is greater in the Negro males than in the White males. On the basis of the intelligence tests employed, the average I.Q. for the White males was 92 and that for the Negro males was 76. There was a tendency for the White males in the higher court appearance group to have a lower I.Q. than those individuals in the lower appearance group. The trend was similar for the Negro males to a lesser degree. The scores for the tests dealing with the detection of organic brain disease would indicate this condition to be more frequent in the higher court appearance group than in the lower. This trend is seen in both the White and Negro males, but the trend in both groups is rather slight.

Summary

A preliminary analysis of the data obtained from the questionnaire study indicates that there are a number of significant factors playing a part in many of the individuals' repeated court appearances for drunkenness. There are steps that can be taken to reduce the number of repeated appearances.

On the basis of the individuals' responses as to their opinion concerning their state of intoxication at the time of arrest, a significant number of individuals felt that they were not drunk. This is in accordance with our personal observations. There is, however, little question that the majority of those arrested for drunkenness are in fact severely intoxicated. The city ordinance dealing with this problem has as its goal the public safety through the detention of individuals who are potentially a menace to themselves or to others. And in accordance with this goal, it is inappropriate to arrest those who do not fall into this category. While the overall number is small, nevertheless there remains a significant number of individuals who are arrested for public intoxication and who are not drunk at the time of arrest. In order to assure that the individuals in this category are not unjustly arrested, it would be reasonable to institute the use of some objective means for evaluating drunkenness. As the situation now exists, a person arrested for public drunken-

ness in essence is assumed to be guilty and must prove his innocence. Frequently the determination of the state of intoxication is done by arbitrary means and, as noted previously, in most cases this is adequate. However, in order to assure the individual's rights, objective tests should be employed in cases where the individual might request it and where there is some doubt as to the state of intoxication.

A significant number of those arrested for drunkenness were arrested in an establishment selling alcohol. While it is no doubt difficult to enforce those ordinances dealing with the sale of alcohol to individuals who are intoxicated, it would seem that an effort to further implement these ordinances is warranted.

A significant number of individuals in the study group stated that they were seriously ill. A number of these had illnesses unrelated to alcoholism but, in fact, probably played a significant role in the development of the individual's excessive use of alcohol. Efforts toward the correction of these physical defects should be of benefit in attempting to rehabilitate these individuals. Information pertaining to the educational status, occupation and work history suggests important factors to be considered, not only in terms of treatment of alcoholism but also, in terms of its prevention. Many of the individuals fall into the category of unskilled labor. The type of employment that these individuals can obtain is extremely limited and is at best of an uncertain nature. While we do not intend to imply that this situation causes alcoholism, there is little question that job uncertainty and insecurity is a definite promoting factor toward the development of alcoholism. The solution to this difficulty can, in the present instance, be partially alleviated by efforts directed toward job training and in the changing of our educational system to extend the scope of vocational training. Admittedly, much of this is beyond the scope of our present endeavors; but, nevertheless, it is of considerable importance in terms of prevention and rehabilitation.

A point of considerable importance is revealed concerning the response to the question concerning previous assistance in attempting to control the individual's drinking. The majority of individuals had never received any assistance in trying to control their drinking. From our experience, we have found that a large number of the repeat court offenders can be benefited with some type of realistic approach. To be realistic, the approach has to be geared to meet needs of this particular group of individuals. Approximately half of the individuals were not employed at the time of their arrest. Many of the individuals had no permanent place to live. One could not expect any type of treatment to be effective unless they deal with these types of problems. On the basis of the psychological tests, the vast majority of the individuals in the study would be considered alcoholics. Their repeated arrests are the manifestation of their disease; and the approach to decreasing the number of court appearances is to treat their disease, rather than expecting improvement by merely punishing them for their offense.

REPORT ON SURVEY CHEST X-RAYS

As a part of the study program, and an effort to better evaluate the health status of the individuals in drunk court appearances, survey chest x-rays were taken on 1,050 individuals appearing in drunk court. The usual procedure was to x-ray each individual as he emerged from the courtroom without regard to the number of previous court appearances. Approximately 90% of those x-rayed were male, 10% female. Of the males, approximately half were White and half Negro. The female population was broken down to approximately 60% Negro females, 40% White females.

The x-rays were taken utilizing a portable survey unit. The equipment, as well as the technician to operate the machine, were provided by the Fulton County Health Department. The x-ray films were interpreted by the Director of the TB Unit of the County Health Department. The findings of this part of the study are based on the readings of the survey x-rays except when a possibility of TB existed. In this instance, where an individual had a film compatible with tuberculosis, the records of the Health Department were checked. In this manner a number of individuals having x-ray films compatible with TB were found to be patients with tuberculosis known to the County Health Department. In those cases where no record existed on the individual and in which the individual failed to come in for follow-up evaluation, the individual was placed in the status of "possible tuberculosis" or the status categorized as "compatible with tuberculosis."

Of all the individuals x-rayed, 19 were found to have some type of chest pathology. Of these, 4% were found to have some heart abnormality detectable by x-ray and 10% were found to have some lung abnormality exclusive of those with possible manifestations of tuberculosis. In this latter group are included cases of fibrosis and emphysema, lung nodules, abnormalities of the vasculature about the heart, and chest deformities. Of the 1,050 survey chest x-rays, 57 individuals were found to have findings compatible with TB, considered to have possible TB, or were found to definitely have had TB. Of this group, 55% were White, whereas 45% were Negro. Of the group of 57 individuals, 23 were known definitely to have had TB and 7 of these were found to have active TB.

As a basis of comparison, the results of a survey study conducted at the Southeastern Fair in September, 1962, is presented. At that time a total of 1600 survey films were taken, and of these, only 2 cases of TB were discovered, both of these being inactive. Therefore, the rate by comparison in the drunk court population is approximately 10 times that of the population studied at the Southeastern Fair.

Summary and Conclusion

On the basis of the survey x-rays studied, a very high percentage of the individuals appearing in drunk court have some type of physical abnormality detectable by chest x-ray. A significant number of these have manifest

tuberculosis. The high incidence of tuberculosis in this population is not altogether surprising in view of the debilitated condition of many of these individuals. Many of these individuals are from time to time housed at the City Prison Farm; and, as such, they constitute a health hazard for their fellow inmates. Because of this and the fact that this population is one of the last remaining reservoirs of tuberculosis in our society, it would seem desirable as well as beneficial to the community to establish some type of tuberculosis case-finding program in this group of individuals. To the credit of the County Health Department, many of the individuals with manifest tuberculosis are known to them. The Health Department, however, has considerable difficulty in maintaining adequate follow-up on some of these individuals, due to the individuals' lack of a permanent address and, in many instances, irresponsible nature. Since many of these individuals do repeatedly make appearances at the City Stockade, it might be advisable to indicate on these individuals' records at the Stockade that they have had TB and recheck them from time to time as they appear at that institution. This might greatly facilitate the follow-up by the County Health Department. And, as indicated previously, routine surveys of the population at the City Prison Farm would be of considerable value both to the community and to the health of the individual.

AN INTENSIVE STUDY OF DRUNK COURT OFFENDERS

Because of the limitations of mass testing and screening techniques in terms of obtaining data pertinent to psychodynamic formulations and personality assessment, an attempt was made to obtain this information by an intensive study of a selected group of individuals appearing in court.

Initially it had been planned to see 50 individuals, 25 White and 25 Negro. However, because of the limitations of time it was possible only to see 14 of each race. At the outset it was decided to devote a week to each individual, and during that time to investigate them as fully as possible in all facets of their present life and past history. This was done in four different ways. First, the subject was interviewed by a psychiatrist for four separate one hour sessions, during which time an attempt was made to obtain a picture of their background and past history in terms of their emotional development, early home life, and adult pattern of existence. It was hoped thereby to elicit an understanding of the psychodynamics of these individuals as well as the environmental stresses with which they had had to deal and perhaps as a result to find a clue to reasons for their present predicament. Second, they were subjected to extensive psychological tests, primarily the Wechsler adult intelligence tests, the Rorschach personality tests, and the "draw-a-person" test. Third, they were interviewed by a psychiatrically oriented minister for an evaluation of their religious status. Specifically the aim was to ascertain what part religion had played in their early life, and whether it had influenced either positively or negatively their relationship with alcohol. The fourth approach was for a social worker to visit the home, and not only verify the information already obtained, but also to evaluate the impact of alcoholism on the home and the family.

In addition to these various methods of gathering information all other sources such as employers, friends, and neighbors were contacted whenever they were able to give further meaningful information.

The result was that overall, a picture was obtained of these people which showed who they were, what their backgrounds were, and what potential they had for treatment. It further gave some insight into the pathogenesis of alcoholism, and the natural history of its development in an individual.

The findings proved that despite racial or social differences the underlying pathology leading to alcoholism was laid down in the early years of the individual's life and tended to express itself in a fairly similar personality pattern. Most of the subjects studied were found to have three important characteristics. First, they had very low tolerance of frustration. Day to day incidents which the average person can tolerate produced in these people tremendous anxiety, anger, and depression. Second, they showed a very poor capacity to accept failure, with the inability to do even the most insignificant things without producing great anxiety. Third, these tended to be very sensitive people with a high level of affectivity. They can readily make a warm relationship, and are in general very attractive individuals.

Although this underlying pattern tended to be present in one form or another in all those seen, the actual manner in which the alcoholism expresses itself seems to vary from one patient to another according to a variety of environmental influences such as the parents' attitude towards drinking, the education, the race and the social background. Given two people equally predisposed to alcoholism and subject one of them to extreme emotional pressure, because of his background, his lack of education and perhaps his current environment, and he will tend to resort to heavy drinking long before his stress-free counterpart. To carry this a little further, if the stresses on an individual with only a slight predisposition to alcoholism are great enough, he may begin to resort to the heavy use of alcohol long before another stress-free person who has a much stronger psychic predisposition to alcoholism. However, when the second individual does begin to drink his dependence upon it is likely to be far greater and considerably more pathological. In the same way, it will be proportionately more difficult to treat the person in the second case than in the first. This is so because, in the first instance, the dependence upon alcohol is more nearly a reflection of the overwhelming stresses of the environment rather than an inherent dependence. Satisfactory results can then be obtained primarily in assisting the individual in making his environment more tolerable. Gradations naturally exist between the two extremes, but this difference was found to represent an important finding in the understanding of the differences between various alcoholics who were seen. This is probably best exemplified in the differences that were noted between the White and Negro subjects. It

seemed that in many instances the White individuals had a far greater psychic dependence on alcohol than the Negro, and that the latter used alcohol more because of the stresses resulting from their position in society. In the Negro, because of his oppression there is a sea of repressed emotion which he is unable to express because of his fear of retaliation and his very real survival problem. Because these feelings have to be kept so vigorously under control the Negro can allow himself almost no emotionality either on the negative or the positive side and as a result they tend to be very apathetic. It is only when he drinks that he can allow himself to let down the barriers and the seething emotions can be expressed. After such an outburst he can then return to a state of emotional placidity with his feelings under control. The episode of drinking, which may have been only a single night's party, acts like a safety valve for what might otherwise have blown loose.

It also seemed apparent, although it could not be categorically stated, that the majority of White individuals appearing in court repeatedly were destitute and of the typical skid row type, being generally unemployed and with very short periods of time when they were not either drunk or incarcerated. Many of the Negroes, though they might have been arrested as often as the Whites, tended to be employed, even if irregularly, and able to hold jobs for varying lengths of time. Periods of sobriety tended to be longer. There was some evidence to suggest that a level of intoxication was required for arrest in the Negro which was lower than in the White, and that once arrested a Negro was less likely to be able to "pay out," even though he had not reached such a level of destitution, or dependence on alcohol. This seemed to be borne out on a statistical basis on the questionnaire study.

Considering all the individuals studied, there was a noticeable presence of a history of the fondest parent of the subject also being the most submissive. This has been reported in other studies, but was noted to be particularly true amongst those seen in this group. This relationship was particularly true of the White subjects, and in almost all instances one parent was overly protective, and when it was not the mother she was usually domineering, and controlling. In both groups the early loss of one parent due to their death was a feature appearing recurrently, and this tended to be the one with whom they had a particularly close relationship. The subjects in several instances recalled the tremendous and prolonged emotional impact that this event produced in their lives even though they might have reached adulthood at the time.

Very striking in the early history of the Negro subjects was the very high degree of family disorganization, and the predominantly insecure environment in which most of them grew up. Parental desertion or rejection, physical violence, and a very early independence and ability to fend for oneself were characteristic of those seen. Although in the Negroes' childhood this was predominant, in adult life there was little difference in this respect in the races, with nearly all those seen being either divorced or separated. However, this latter situation was generally a product of drinking whereas the disorganization of their early backgrounds was a result of prevailing social conditions.

Two historical facts were related frequently by the subjects. First, many of them had been born on farms, and although they drank prior to adopting an urban life, it was not until they did this that it became a problem to them. Secondly, many of the men described how their heavy drinking began in the military service. Although this is a highly structured environment, the ready availability of alcohol and the absence of other recreational activity made it an almost universal social activity. Several of the men were discharged from the service because of their drinking, but in all instances where this had been the beginning of their trouble, they began to drink more heavily after their discharge. It can probably be assumed that the structured and protective environment of the service, although it fostered heavy social drinking tended to prevent the more progressive stages of alcoholism. It nevertheless is apparent that this is one area where preventive measures could be most effectively applied.

Diagnostically speaking, the majority of those seen could be considered to be severely neurotic, although one White and three Negro subjects were felt to be schizophrenic. Two of these individuals had highly complex delusional systems, which were severely incapacitating to them in their daily life. Besides the emotional disease that appeared to be present, many of the subjects could be classified as mentally retarded, and in fact the average I.Q. level for all the Negro subjects was in this range. This, however, may be a somewhat distorted picture as the obvious presence of organic brain disease, presumably from prolonged alcohol ingestion, will affect the I.Q. score. It was felt that the presence of organic brain disease was probably greater in the Negro than the White, and was primarily attributable to the fact that the type of alcohol drunk over several years tended to contain more impurities.

Psychological Testing

Intelligence Testing. Of the 28 intensive study cases, the White patients average 96 I.Q. and the Negroes only 71 I.Q., in spite of the fact that the White group included a young man of imbecile level almost totally dependent on his uncle. The Negroes had markedly poorer information with reference to current events. Their knowledge of the world was scanty indeed, reflecting much poorer education than the Whites. Their ability to produce work on a Coding test was also poor, mainly because they were confused due to a psychotic state or rigid due to brain damage. The Negroes showed more cerebral damage than the Whites, which is probably due to the fact that they consume inferior liquor. Some of the Negro testees gave the impression of being out of touch with the world in which they live because of poor intelligence, damage or disturbance. Some of the Negroes seemed more lost than did the White young man testing at ap-

proximately 40 I.Q., because he lived with other Whites of a higher intellectual level, whereas the low level Negroes appear to congregate in lodging houses, never hearing or learning anything new.

Personality Tests. On these tests, there was not a great deal of difference between the Whites and the Negroes, both races tending to be poor at cooperation, refusing cards on the Rorschach and becoming angry when asked to Draw-a-Person. Some threw the blocks away on the Intelligence Test because they caused too much anxiety. The Whites seemed to be less tolerant of frustration than the Negroes and less tolerant of bodily discomfort. The Whites definitely had the self-pampering tendency mentioned by research workers on alcoholics—they were full of excuses for their failures and asked that their immediate needs be met with coffee, cigarettes, etc. The Negroes are probably more accustomed to discomfort and are consequently more tolerant of it. Except when a patient had failed in all spheres of life and had perhaps given up and made the stockade his home, all testees became very anxious at failure.

The general pattern on the Rorschach tests was that of difficulty in interpersonal relationships, the patients tending not to incorporate the color at all in their concepts, yet they are people in whom feeling (that is, affection and love) has been developed. This no doubt makes rejection and failure all the harder to bear. Some of the White patients showed a lot of stress within the personality, so that alcohol might be being used to relieve them of this anxiety; others (more colored than white) showed poor identity with people; but as this usually correlated with low intelligence, it is not surprising in this study.

Many showed a dislike for authority, answering poorly or refusing Card IV on the Rorschach. This card suggests an authority or father figure. Research by Florence Halpern of the Bellevue Hospital in New York mentions the presence of the prestige drive in alcoholics, that is, that they have a great need to put themselves over as important or to be grandiose. In fact, they show poor reality testing because of the need to see themselves as a success. As the subjects of our study come from "the bottom of the barrel" so to speak, it is perhaps not surprising that this prestige drive showed only in one patient and he was one of well-to-do parents.

After testing these patients one felt that much of the trouble centered around their inability to handle frustration and their inability to accept failure, in any form. Constant jailing encourages them to give up the battle; it does not teach them to handle frustrating situations. Many showed great dependency needs because of their upbringing where the parents wanted them to be dependent in order that they, the parents, could be in control. In return the patient gave great affection. Dependency and affection are not qualities to be despised; but in a place like a jail, there is no feedback for these qualities. The dependency provided by the jail is in a very constricted channel. Both their dependency needs and their need for affection could be satisfied in the Halfway House, while the patient would be able to enlarge his horizon and have some hope of becoming less dependent.

Research workers in alcoholic studies have shown that patients who failed to cooperate well on personality tests (for example refusing cards, refusing to draw a person, etc.); those who give less than a 30% reaction to color (that is, too little emotional relationship); and those who show no anxiety on the Rorschach, have a poor prognosis for recovery. Nearly all our Negro patients fit all the above categories but it does seem that these we are testing give such constricted records due to racial oppression and lack of education, especially the complete lack of education of the sub-normal group, that this northern research is hardly applicable to the study here in Atlanta. Many of the Whites showed lack of cooperation and these gave a poor prognosis. However, as these alcoholic patients are so dependent and in need of affection, to improve the drinking habits of the more promising ones may lessen somewhat the drinking of the others who are their friends.

Religious Evaluation

Our study indicates that, with only 3 exceptions, the people interviewed were members of some church. Membership in the Baptist Church was highest. There were a few Methodists and one Episcopalian.

Early participation in the church was fairly regular being a part of the family's activity. There is no indication of participation, for the most part, beyond that of "just attending." It was felt that it is more out of family influence than of a conscious understanding of involvement in the church.

In some instances, it is to be seen in the light of the church having been the center of community activities. This provided the only social and emotional outlet most of the people interviewed experienced during early years.

That the relationship with the church was superficial is seen in the light of the lack of contact with leaders and little or no understanding of religion except in the most punitive and concrete terms.

Perhaps this lack of involvement and the inability to form relationships is to be seen as a deep deprivation. This points to the lack of significant relationships during early years and the crippling of the emotional life to the extent that most all the people who had been married were either divorced or separated.

Presently, there is no indication of people interviewed having significant relationships.

Summary. Most of the people interviewed had some relationship to the church.

The ages ranged from mid 20's to early 50's.

The marital status reveals a high degree of divorce and separation.

Where there is current church affiliation, in most instances it is the same as that of the patient's family.

Activity in the church during early years ranged from none to moderate with no one indicating deep involvement or understanding of the church.

Present activity ranged from none to irregular, thus indicating the absence of influence in the life of the alcoholic.

Of the 28 people interviewed, only 2 answered affirmatively to the question, "Have you talked with a minsiter?"

It was interesting to note the cultural socio-economic level from which most of the people interviewed came. They come, for the most part, from the lower-lower to the lower-upper with some few from the middle-lower.

Family prohibition against drinking ranged from none to strong.

In only a few of the families represented was alcoholism seen as a problem.

The positive influence of religion ranges from none to very little.

Social Workers' Assessment of the Home and Family

Both White and Negro social workers were used to gain the desired information, but in spite of this, the families and neighbors of the Negro subjects tended to be very anxious to hide any information they might have, and would even deny knowing the individual when he was inside the house at the time. The Negro subjects also frequently gave false addresses, or had moved when the social worker visited them.

Overall, it was felt that the impact of alcoholism on the homes and lives of those associated with these people was of an extraordinary magnitude. In one instance, a man who began drinking when his father died was left jointly, with his mother, two apartment buildings and also owned his own home. After fifteen years he was completely destitute, and his mother's sole means of support was what she received from Social Security. However, despite the highly destructive effect many of these people had had on their families, they generally had been able to retain their interest and desire to help them. Although in some instances, the members of the family had abandoned hope of finding help, when they heard why the social worker was there, they expressed a tremendous desire to be of assistance if there was any chance of rehabilitating the individual. Frequently, this family member tended to be the overprotective, domineering parent who perhaps more than any other had contributed to the development of their drinking problem. The closest relative given by these people was almost invariably a parent and although they were usually not living with them, they were still overly dependent upon them.

Almost all these families were living in lower class surroundings although many had achieved considerably higher social status in the past. There were, however, instances where the families had had and maintained middle class status despite the effect of the alcoholism, but it was in these families that they had tended to reject the subject because of his drinking.

The interest of the family member in their problem was a feature characteristic of the White subjects, and those from the Negro middle class. The families of lower class Negroes, if they were even still in contact with the subject had little concern about his drinking, perhaps because in many cases it was a common method of emotional release for themselves also. The social acceptability and the universality of drinking in the Negro lower class was probably the most important factor in determining the different drinking patterns in the Negro.

Summary. Basically it was felt that the underlying personality structure tended to be similar in all the subjects studied and that all who were selected did fit the criteria as alcoholics. The sociological influences resulting from the Negro's position in society seemed to be paramount in causing the excessive use of alcohol. There was a signifcant degree of brain damage present in those studied and the I.Q. level tended to be at a borderline mentally retarded level. From a religious standpoint it seemed that although the subjects had had close contact with the church in their early life, it had usually been viewed in a punitive light. Overall, it was felt that religion had had little or no influence on their present problem. These are people requiring a great deal of support, whose backgrounds have been shattered, so that to adequately rehabilitate them completely, new environments must be structured for them.

ARRESTING PROCEDURE, COURT HANDLING, AND INCARCERATIONS

The arrest of an individual by one of the City of Atlanta police officers may be made on the basis of a call received by the officer, a warrant for the individual's arrest, or because the officer observes that the individual is not conforming to the law. The individual is taken into custody and the officer makes out a citation against him. This citation includes such information as the subject's name, and place of the offense and of the arrest. Later, the disposition is added to this citation.

The subject is then brought to the city jail by the officer or is picked up by the paddy wagon. He is delivered to the back door of the jail and is admitted by the turn-key, who searches him and takes all his valuables, sharp objects, and any loose things he may have in his possession. These are marked and sent to the station captain's office. If the prisoner is drunk, his eye glasses are also taken. The turn-key then takes the finger prints of the prisoner's index fingers and places these on his in-jail card. This is repeated when the prisoner leaves the jail as a precautionary measure to be sure that the proper person is released. In case of a felony or suspicion of other crimes, the prisoner is sent to the fingerprint expert to be completely fingerprinted. This is done in the fingerprinting room on the ground floor of the city jail and these prints are done by the fingerprint expert. All charged with committing felonies must be photographed.

The turn-key then takes the prisoner's in-jail card and the citation and gives them to the secretary, who puts a G# on every one. The G number signifies the case number. The citation is made out with three duplicates. The original copy is the court card, and this is filed in the court box. The first carbon copy is the one which goes to the IBM room and a permanent record card is made from

it. The prisoner receives a copy of the citation and the officer also keeps a copy. The in-jail card is placed in the in-jail box. The prisoner is then taken to the proper floor of the jail depending on his offense. All prisoners with any degree of intoxication must wait here at least four hours. This is considered to be the length of time it takes to reach a level of sobriety.

At the end of the four hour period, the prisoners may make bond or pay out. On a plain drunk charge the bond is $50.00 and costs approximately $5.00, depending on the bonding company. Otherwise it is $15.00 fine without having to go to court.

Each morning before court, the court clerk and the bailiff pick up the court citations and check the past records of each prisoner. A permanent record card is made after each case has been to court and the offense and disposition is recorded. For the drunks, the sentence are based on a twelve month period of time, dating from the date of the arrest under question. The number of arrests within the past twelve months and the dispositions are recorded by the bailiff and clerk on the court citation. If a prisoner has a long arrest record and has bailed out or left on a bond and has not served his sentences, and the clerk or bailiff catches this before the prisoner's four hours are up, they place him on "hold" which means that he is not allowed to pay out or bond out. However, the majority of these prisoners who can pay out do so before the records are checked and thus are free and do not have to serve their time. After the records are checked, they check the box with the cash collaterals and take out the citations of those who have paid out. The rest of the citations are then taken to the court room.

The "drunk court" is held each morning except Sunday and is for all prisoners who plead guilty and are charged with plain drunk. The prisoners with the exception of those charged with felonies are brought down to the detention rooms by the bailiff at about 9:00 a.m. to await the beginning of court. There are four detention rooms, one each for white males, white females, Negro males and Negro females. All those who wish to plead guilty for being drunk are taken into court and the bailiff calls the roll. Here they await the arrival of the judge to begin court. This is usually around 10:30 a.m. The seats in the court room are segregated by sex and race.

When the judge begins the court session, he starts with the Negro males, then Negro females, then goes to the white prisoners. He calls up approximately 15–20 at a time and hands out the sentences which are based on the prisoner's record for the past 12 months. The sentences are usually as follows:

Number of arrests in past 12 months:	Sentence
1st	15/13 ($15 or 13 days in stockade).
2d	Do.
3d	Do.
4th	27/25 ($27 or 25 days in stockade).
5th	30 days in stockade.

If 30 days has been served within the last 12 months, the prisoner is bound over. The prisoner has a chance to say something if he wishes, but the procedure seems to be very hurried in an effort to get those sentenced to the stockade there before lunch.

Those prisoners who plead not guilty are held until the afternoon court sessions. These sessions are held according to the time of the arrest. The officers who made the arrest must appear in these courts in order for the prisoner to be sentenced. It is actually a fruitless effort on the part of the prisoner to plead not guilty, since it is the prisoner's word against the officer's. However, many prisoners take this chance in case the officer does not show up in court, in which case the charge is dismissed.

After the prisoner has been sentenced, the disposition is placed on the court citation and the judge signs it. It is then returned to the record room and the permanent card is completed. The court citation slip is then filed in the probation office by G number.

Analysis of the Causes for Appearance in Court on Charge of "Drunk", Viewed from an Economic Standpoint

This is an attempt to analyze only absolute facts behind why a man has to appear in court charged with being drunk, and care has beeen taken to exclude all variables or hypotheses.

The underlying unalterable fact is that he has been arrested, and charged with being drunk. It is not considered here whether he was in fact drunk, or whether he was even drinking; this is immaterial.

After his arrest he can either pay out or appear in court the next morning; he has only the two choices. If he does not pay out, it is a safe conclusion that it is because he does not have $15.00 available. Therefore, appearing in court can be equated with not having $15.00. On the one hand the individual himself may not have $15.00 for the fine, or he may have no other source such as friends or credit. It is conceivable that he may have $15.00, but not want to spend it on the fine, in which case one can assume that he wants to go to the stockade rather than spend his money.

Returning to the basic premise that he himself does not have $15.00 at this given time, it has to be because his expenditure equals or exceeds his income. This being true—either his income is too low, or his expenditure is too high. If his expenditure is too high it must be because of one of two reasons, either he is spending it on others or on himself. If his overspending is on himself it can be for essentials and therefore justifiable, or it can be on non-essentials and therefore alterable. Among the non-essentials is alcohol, and the individual may either be spending money on this, or on all other non-essentials.

If his expenditure is not considered too high then his lack of $15.00 must be attributable to the fact that his income is too low. If he is not eligible to work, or even if he does work he may receive some or all of his income from one of the social agencies. If his income is still too low, then what they are paying him is just not enough. However, this is an aside and basically either he will work or he will not work. If he works, then the trouble is that his pay is just too low. If he does not work, then

it is either due to the fault of the individual or the fault of the job. If it is the fault of the job, there can be only two reasons, either there are no jobs available, or they pay less than he could obtain by an alternate source of income.

If the fault is with the individual, it will be for one of four reasons. Either he does not have the training, or he does not have the education. Alternatively, he may have either physical or mental disabilities preventing him from working. Physical handicaps can be either acquired or congenital, and if acquired, may be due either to the excessive use of alcohol or to other injuries. Mental disabilities may be due to three basic factors, and I.Q. level which is too low, organic brain disease which may or may not be due to the excessive use of alcohol, and thirdly, to emotional disturbance.

Emotional disturbance, whether neurosis or psychosis, may either be associated with the excessive use of alcohol or not. If it is then the use of alcohol, it may or may not in itself be incapacitating the patient.

This analysis is solely directed at determining the reasons why a man appears in court, in many instances repeatedly, and in no way attempts to explain why he may be alcoholic. However, by utilizing this scheme to evaluate an individual who appears in court, one is enabled to decide which area is producing incapacitating effects on him. Basically, the areas are those of work and excessive financial demand on him, whether or not this latter is due to expeditures on alcohol. As far as his job is concerned, one can break it down into whether he has some type of disability preventing him working, or whether the employment situation itself is to blame. Only by a method of careful exclusion on a systematic basis can one arrive at the conclusion that alcohol is to a greater or lesser degree contributing to his court appearance.

A STUDY OF THE GEOGRAPHIC DISTRIBUTION OF DRUNKENNESS IN ATLANTA BY PLACE OF ARREST

The period chosen for this particular phase of the study was the week of January 15th–22nd, 1962. All arrests for drunkenness during these seven days were selected, irrespective of the outcome of the case. These included both Negro and White, male and female. The location at which the arrest was made was recorded on a street map of the City of Atlanta, and marked with a map tag. In all, these amount to 385 White, and 442 Negro arrests during this period. When every individual arrest had been marked on the map, several significant facts emerged:

(1) Greater than 90% of all the arrests fell within a two mile radius of the city jail. These apprehensions took place in a square mile bounded on the north by 10th Street, to the south by University Avenue, to the west by Ashby Street, and to the east by Boulevard. This general distribution bore no relations to race.

(2) The type of distribution for White and Negro were markedly different. The White arrests tended to be widely scattered over a large area, yet with considerable grouping, whereas the Negro arrests, while generally restricted to a smaller total area, showed a diffuse picture in those areas. The Negro offenses tended to involve single arrests, while the Whites were more often arrested in pairs, threes or more. Moreover, White arrests more often occurred in the vicinity of licensed liquor retailers.

(3) As a further development of the above, it was noted that 80%+ of the White arrests occurred in the downtown business areas, and along several main thoroughfares such as Whitehall Street, Ponce de Leon, and Marietta Street. A relatively small percent were arrested in residential areas, even in the very low income sections. The majority of the Negroes, on the other hand, were, with three significant areas expected, arrested away from the business sections. Most arrest, were taking place uniformly through the poorer Negro residential areas. The three exceptions, which were admittedly sites of high arrest, were Forrest Avenue, Decatur Street, and Hunter Street. In all these areas there is a heavy concentration of bars. From this distribution it would seem that the whites, by virtue of their overwhelming presence in the non-residential areas, are probably more likely to be of the vagrant or semi-vagrant type, and may tend to be problem drinkers on a psychiatric basis more than due to social subcultural differences. The Negro with arrests predominantly in his own residential areas may be drinking primarily due to the demands of his subculture, with a relatively stable psychiatric picture. The uniformity and density of arrests is probably due to heavy policing in these areas.

(4) Although the majority of white arrests occur at or in the vicinity of establishments retailing alcoholic beverages, there are several places such as the Union Mission and the bus station, where alcohol is not readily obtainable, and yet where there appear to be an inordinately high number of arrests.

(5) In a large low income residential area south of Georgia Avenue, where a large proportion of the arrests take place, there was almost a complete absence of either liquor stores or bars. This suggests that in this region the population is consuming primarily "moonshine" and other illicit alcohol and alcohol substitutes. The other Negro residential area with a high number of offenses, south of Hunter Street, corresponds with a fairly high number of bars and liquor stores. Throughout, white arrests tend to follow closely the density of places retailing alcohol.

(6) There are many sections of town, mainly upper income areas, where there were no arrests, although there is every reason to believe there is a proportion of alcoholics living here. One must assume that generally speaking these people are never arrested.

THE FINANCIAL BURDEN OF ALCOHOLISM
ON THE CITY OF ATLANTA

In considering the price which a community pays for the support of any group of its less contributing citizens, it would be naive indeed to believe that this could be obtained purely in terms of dollars and cents. The financial ramifications of any social problem involving violations of the law extend far further than the mere cost of arresting and punishing the offenders. Any estimate that might be made should, therefore, allow for the price of physical and mental ill health, loss of work potential, and increased dependency on social agencies which the problem might cause. On the other hand, there is likewise a danger of attributing all social ills to a given factor, merely because it is present when in fact it is not causative at all.

For the benefit of this particular study and to assess the economic impact of alcoholism on the community as a whole, the problem will be considered at three different levels. The sum total of these three areas can then be considered to represent the overall cost of excessive drinking to the one million citizens of Atlanta. The first area to consider is what it actually costs the city government a year to arrest, try, and incarcerate those individuals who are found drunk on the streets. Secondly, there is a large burden placed on the family, a burden directly attributable to alcoholism. Third, there is the largest area, that involving loss of productivity. Every major industry is faced with this problem in the form of lost work days and inefficiency on the job. The combined effect on all the employers of the city represents a very significant loss of potential income for the community as a whole.

1. *Cost to the city budget for arresting, trying and incarcerating the publicly intoxicated*

Of the three areas this is the one that can probably be most accurately estimated, although an element of subjectivity is necessary even here.

All figures quoted are for the fiscal year January 1st–December 31st, 1961.

1. As far as the city budget is concerned there are six areas of expenditure and income which are directly affected by an arrest for drunkenness:

(*a*) The cost of apprehending an individual.
(*b*) The cost of maintaining him in the city jail prior to his appearance in court.
(*c*) The court costs.
(*d*) The cost of incarceration at the City prison farm.
(*e*) The income derived from fines.
(*f*) Saving to the city by use of prison labor to maintain city parks, etc.

Before considering actual figures, it is important to stress that it is frequently pointed out by members of the Police Department that no decrease in the number of drunks in the city, however great, would permit a diminution in the number of men on the force or any real saving in the departmental expenditure. What it would do, they claim, is to allow them to provide better service to other areas, which now they are forced to neglect because of their preoccupation with the drunk. It is estimated that the average time required for an officer to arrest a single drunk is 15 minutes. In a single year (1961) this represents a total of 15 x 498,607 minutes or 12,000 hours. Assuming a 40 hour week, this represents the total time worked by six men every week for a year. It would therefore seem justified to assume that the truth lies somewhere between the two extremes, that a real cut in expenditures or man power might be possible, but that it would not be of the magnitude which the figures might suggest.

In the year of 1961, the total cost of running the Police department was in the region of $4.5 million. Broken down to the expenditure for each Division this represented as nearly as can be calculated:

(1) Service Division	$803,333.13
(2) Detective Division	724,982.39
(3) Traffic Division	963,199.89
(4) Uniform Division	1,910,654.59
(5) Training Division	61,588.61

(A) *The Cost of Apprehending an Individual.* In estimating the cost of arresting an individual for public drunkenness only the Uniform Division and to a lesser extent the Traffic Division would be involved. It would probably be correct to say that essentially all 49,867 arrests for drunkenness were made by the Uniform Division. There are 368 individuals working an average 40 hour week in this Division which in one year amounts to a total of 766,000 work hours, of which 12,000 hours are spent arresting drunks. Hence it would be fair to say that the cost of making these arrests would be the same proportion of the total Divisional budget $1,910,654.59 as 12,000 hours is of 766,000 hours, or $29,950.

Similarly, in the Traffic Division there were 3,694 violations involving the use of alcohol. As most of these involved automobile wrecks, and as in most instances the arresting officer was required to appear in court, the average time expenditure was considerably higher, and the average was considered to be about two hours. This means that the total work hours expended for these offenses was 3,964 x 2 or 7,388 work hours. Excluding the 106 policewomen, there are 157 individuals working in the Traffic Division who in the course of one year work a total (157 x 40 x 52) of 326,800 work hours. Excluding the salaries paid to the part time policewomen, the Divisional budget is $890,982.39. Therefore, as in the previous calculation, the cost of making these arrests is that proportion of $890,982.39 that 7,388 is of 326,800, which is $210,100.00.

In summary, therefore, the cost of making arrests for drunkenness and drunken driving are:

(1) 49,867 arrests for drunkenness	$29,95
(2) 3,694 arrests for drunken driving	20,100
	50,050

(B) *The Cost of Maintaining the Arrested Individual in the City Jail Prior to his Appearance in Court.* Although arrests for drunkenness comprise the greater pro-

portion of the total arrests, 49,867 of a total of 87,407, it is wrong to assume that the cost of maintaining them in the jail would also be greater. In general the drunk has a shorter record made on him (a single card), and he spends a considerably shorter time in the jail than those charged with more serious offenses. Approximately forty percent of those arrested for drunkenness spend only four hours in jail whereas those arrested for robbery or vagrancy may spend as long as three or four days. No official estimate is made of the cost per day of maintaining an individual in the jail or of the proportion of time spent there for any given offense. However, the jail has four floors of which two and a half are used exclusively to house those arrested for drunkenness. It would then be more accurate to say that the cost of maintaining those arrested for drunkenness represents approximately five eighths of the total cost of running the jail. The jail is maintained by the Service Division of the Police Department, and those arrested for drunkenness probably account for five eighths of the time involved in the other functions of this Division. Therefore, as a rough estimate one can say that the same proportion of the budget of the Service Division is spent on the drunk. That is:

$$\$803,333.13 \times \tfrac{5}{8} \text{ or } \$502,083.20$$

This means that the cost of maintaining in the city jail 49,867 individuals for drunkenness, and 3,694 individuals for drunken driving, is $502,083.20 per year.

This figure will include not only the jail costs but also all other areas covered by the Service Division, including transportation.

(C) *The Court Costs.* The Municipal Court, being housed as it is in the Police Headquarters, is able to keep its annual budget at a relatively low level, and one may consider that part of the total cost of operation is included in the above figure for the Service Division of the Police budget.

Of the total of 49,867 individuals arrested for drunkenness, approximately 29,000 appear in Court. However, of the 37,602 individuals arrested for offenses other than drunkenness, nearly all had to appear in Court. It would be correct then to say that less than one half of the Court's time is involved with the drunk, and more specifically it could be estimated at 40%.

The annual budget of the Court is $97,849.69, and 40% of this is $39,139.88. This sum of $39,139.88 therefore represents the cost of trying and sentencing 29,000 individual cases of drunkenness.

Cost of maintaining Traffic Court in 1961 was $388,400.54. Of 156,533 violations, 3,694 involved the use of alcohol. The approximate cost of processing these cases is $3{,}694 \times \frac{\$388{,}400.54}{156{,}533}$, or about $9,160.

(D) *The Cost of Incarceration at the City Prison Farm.* The City Prison Farm is run almost exclusively for drunks; and for the sake of this study, one can assume that all the inmates are there for drunkenness. The average census at the Farm is above 600 people. Therefore, the "man days" served in one year would total 600 x 365 or 219,000. The annual budget in the year 1961 for this institution was $380,504.07. Therefore, the per day per capita cost of keeping an individual is approximately $\frac{\$380,504.07}{219,000}$ or $1.69 per man day.

Of those who appeared in Court, only 2,459 sentences of 30 days were given compelling the individual to go to the Stockade, and a further 19,029 were given a choice of serving time or paying a fine. If this latter group all served their full time, the Stockade would be unable to accommodate them. Very many individuals, therefore, either pay their fine or serve only a portion of their sentence, and then pay out at a rate of a dollar a day for the rest. It is apparent, therefore, that of the total number of people arrested, the Stockade and its budget of $308,504.07 is used for a relatively small proportion, particularly in view of the fact that most of the people there at any given time will have served several sentences there in the course of one year.

(E) *Revenue From Fines and Collateral.* In the year of 1961, 20,171 arrestees paid a collateral of $15.00 each and "paid out" without coming to Court. This represented 20,171 x 15 or $320,000.00 revenue for the city. The other source of income is obtained from people who pay fines after completing a part of their sentence at the City Prison Farm.

This figure can only be obtained approximately by subtracting the actual man days served from the total man days given in sentence. This gives an approximate figure for the number of days sentenced for which the individual paid a dollar a day fine instead. This is 321,147 man days less 219,000 man days actually served, which is 102,107 man days of approximately $102,107.00.

Therefore, the total revenue for the city in 1961 was approximately $320,000.00 and $102,107.00 or $422,107.00.

(F) *Saving to the City by Use of Prisoners for Maintenance of City Parks, etc.* This area is the one where there is the greatest element of subjectivity. One authority in City Hall said that the prisoners served no useful function, saved the city no money, and what work they did do could easily be left undone, or could equally well be performed by people already employed by the city. On the other hand, however, it is the personal opinion of another official in an equally enlightened position that these people save the city tens of thousands of dollars every year.

Definitely on the positive side one can say that those individuals employed at the Police Headquarters to work "station house fines," and those who do construction work on the city's roads perform a significant function for which voluntary labor would otherwise have to be hired. To a lesser degree, other work gangs in the parks and other public places, although their productivity may be very low, perform jobs which otherwise would have to be done by hired labor.

The amount saved can only be approximated by a reasonable estimate which would be $50,000.

In summary, then, the expenditures are:

(*a*) $50,050.00
(*b*) $502,083.20
(*c*) $39,139.88
(*d*) $308,504.07

This represents a total of $899,777.15. The revenues are:

(*e*) $422,107.00
(*f*) $50,000.00

Or a total of $472,107.00

This represents a net loss for the city of $427,670.15 or an expenditure of about $8.08 per person arrested. However, this gives a very erroneous picture, as in fact the city actually makes a profit on those people who put up $15.00 collateral prior to coming to court. Those people who never pay a fine and always end up at the stockade are the people who are costing the city the greatest proportion of the cost. An individual who is arrested repeatedly throughout the year may cost the city $400 or more in a single period of six months. It is therefore this group of chronic repeaters who constitute the real financial burden on the city.

To break down the cost for each procedure on every individual we have the following figures:

(1) To arrest a man only for drunkenness	$0.60.
(2) To arrest a man for drunken driving	5.44.
(3) Cost of maintaining in jail prior to court appearance	9.40.
(4) Court cost	1.35.
(5) Traffic court cost	2.48.
(6) Stockade	1.69 per man, per day.

The total cost for arresting, trying, and incarcerating a man for 30 days is $62.15.

2. *The Impact of Alcoholism on the Budgets of the City's Social Agencies*

Although alcoholism is in itself a costly disease to the individual, his employer, and to the judiciary departments of the city where he lives, the economic ramfications are so extensive as to defy complete assessment. The secondary effects of ill health, marital discord, child neglect, and unemployment, to name a few, will not only in some way touch almost every member of the community; it will also place a burden on social agencies which otherwise would not occur. The father who is frequently in jail for his drunkenness may have a wife and children who are forced to get support from public welfare; who, because of their lowered standard of nutrition, are more susceptible to physical disease; and who are more likely to have to call on the services of such agencies as Family Service, Legal Aid Society, and the juvenile authorities. The individual himself, besides what he costs the city for arresting and imprisoning him, may also be living at the Union Mission, have increased need for attention at Grady Memorial Hospital, and when attempting to recover may need assistance from an organization such as Vocational Rehabilitation.

In an attempt to assess just how much this problem costs the social agencies of Atlanta, a letter was sent to forty such organizations, in which they were asked to approximate the percentage of their total budget which they felt was directly or indirectly affected by alcoholism. Where possible they were asked to estimate an exact dollar cost. The response proved somewhat disappointing in that only seventeen of the agencies replied, and many of these felt that the task was beyond the bounds of even an intelligent guess. The director of other organizations seemed oblivious to the economic impact of alcoholism, and doubted that it had any effect on their own budget, although individuals under treatment by the study group were known to be receiving support from these agencies. A further impediment encountered in making their estimate was that the variation of involvement from one service facility to another was considerable. For instance the Jewish Social Service Federation was aware of only two cases of alcoholism in the past several years, whereas the Atlanta Union Mission spends $39,000 from its annual budget of $65,000 on alcoholism.

However, although all estimates were of necessity very much educated guesses, the majority of agencies contacted that dealt only incidentally with the alcoholic and his family and were non-sectarian felt that it involved approximately 3–4% of their respective budgets. As there is a notorious tendency to underestimate this cost, the higher figure of 4% was taken for the purpose of calculation.

In the city of Atlanta there are over 350 organizations providing social services of one sort or another. The sum total of all their budgets in 1962 was $120,000,000 of which $105,000,000 is from taxes, and $15,000,000 is from private donation and other sources. Included in this figure is the $8,253,186 budget of Grady Hospital. Taking the above figure of 4% for the average percentage of agencies' budgets involved by this problem, and applying it to the figure of $120,000,000 we have an expenditure of $4,800,000.

This figure of $4,800,000 is approximately what the problem of alcoholism costs the social agencies of the City of Atlanta.

This figure is large, and at best only a crude estimate, although there is good reason to believe that because of the innumerable unseen ramifications of this disease, this cost figure may still be on the low side.

3. *The Cost of Alcoholism to Industry and the Community as a Whole*

The third area of expenditure to be considered is the loss of productivity caused by alcoholism. This represents a loss of potential earning power for the individual, and a considerable cost to industry. According to the National Council on Alcoholism, approximately 3% of the nation's working force has an alcohol problem. However, this figure does not apply equally to all areas of the country; and as the earning power of the individual also varies from region to region, the actual cost will not be consistent. It is a fairly well established fact that

the answer to alcoholism lies in prevention rather than cure, and that the earlier such tendencies can be detected in an individual, the better his chance of recovery. There is still a tendency for the alcoholic's family to protect him and hide his disease until it has reached an advanced stage, which means therefore that it is upon the man's employer that the burden of early detection and treatment tends to fall. Many organizations feel that the cost and man power required to set up a program for this purpose is too high to be justifiable. However, the loss of productivity, and financial saving possible, is frequently overlooked or underestimated.

In an attempt to estimate this cost in the city, the personnel directors of eight corporations and institutions were asked to estimate what they thought the problem cost their organization. Two failed to reply, and one stated that he did not believe the problem existed to any significant degree amongst the employees of his institution, and hence the cost was negligible, although several of his employees are known to be alcoholics by this study group. Of the five who were able to supply meaningful information, their total number of employees amounts to 3,875 individuals. The individual cost estimates were as follows:

	Employees	Cost per year
(a) A construction company	115	$16,000
(b) A beverage company	760	3,000
(c) A municipal government	5,400	17,440
(d) An airline	9,000	60,000
(e) A heavy industry	15,600	700,000
Total	30,875	796,440

These figures represent time lost from work due to drinking, particularly Mondays and after pay days. They also include the cost of training personnel to replace individuals whose problem has become so incapacitating that it has been necessary to fire them.

According to the Atlanta Chamber of Commerce, in March 1963 there were 458,900 persons employed in the greater Atlanta area. From the above figures the cost per employee per year for these companies can be estimated as $25.70. Therefore, with a total employment force of 458,900, the financial loss will be $25.70 x 458,900 or $11,780,000 per year.

Considering this figure for the economic loss that this problem causes for the city's employers, and assuming Atlanta's population to be one million persons, this means that drinking costs every man, woman and child $11.78 per year in the lost productivity of the community as a whole.

If we were now to summarize these three areas, and add together the three figures, we would have a total of ($427,670.15, $4,800,000 and $11,780,000) $17,007,670. This compares with $29,000,000 which is the total budget of the city government for one year.

High though this figure may be, it still does not take into account the other costs of property damage, and other secondary effects of alcoholism. Above all it does not encompass the tremendous human suffering and anguish which the alcoholic can cause to both himself and those around him. Perhaps this is the greatest cost of all, but it is something which can never be measured in terms of dollars and cents.

PILOT REHABILITATION PROGRAM

The use of Antabuse as a Potential Method of Treatment in the Repeat Drunk Court Offender.

In an attempt to determine suitable methods of treatment, several procedures were tested on those who were appearing repeatedly in court for public intoxication. Among these the drug Antabuse was one, and the early success of the study program with the drug seems to suggest its suitability in this group of individuals.

Antabuse is a drug which was discovered in Denmark more than fifteen years ago, and was found to act as a powerful deterrent to the use of alcohol. The patient takes an Antabuse tablet daily, and provided he does not drink he experiences no effect from the drug. However, should he consume any alcohol, even in the smallest quantity, he will suffer a very severe reaction within minutes. This consists of marked flushing, palpitations, nausea, and sometimes unconsciousness. Those who have combined Antabuse and alcohol frequently report a feeling of impending doom, which is extremely terrifying.

Although this drug enjoyed considerable favor when it first became available it was gradually used less during the '50's for several reasons. First, its use required the constant support and interest of the administering physician, and in a busy practice this was not always possible. Secondly, it was difficult or impossible to expect the patient himself to take the responsibility of ensuring that he received the tablet every day. Because of this, many physicians tended to disregard the many very significant assets of this drug. More recently, it has again come back in vogue.

When the study commenced, the Ayerst Pharmaceutical Company gave the group a complimentary supply of Antabuse to evaluate its use in this group of alcoholics. It was then offered on a voluntary basis to all those offenders with whom the study team came in contact. Although in terms of percentages the response was somewhat disappointing, over a nine month period a considerable number of individuals did ask to be treated. In fact, a total of 64 people were treated on a voluntary basis, and of these 20 were Negro, and 44 were White.

Method. The method used was that generally recommended in the literature, and relied basically upon the interest and cooperation of a third party, usually a relative of the patient. Upon receiving a request for treatment, the individual was given a physical examination, and a medical history was taken, and further basic information concerning his drinking pattern and arrest status was gathered. Only those with a history of

myocardial infarction (heart attack), those exhibiting overt psychotic behavior, and those with apparent cerebral vascular disease were excluded from the group. The use of the drug was then explained to the patient, and the family member. Each was asked whether they would be prepared to enter into a period of long term treatment with the drug, and particularly the relative was asked whether they would take the responsibility of ensuring that the patient received the prescribed daily dose of Antabuse and see that the tablet was thoroughly chewed, and followed by ample water in their presence every day. The patient was then given the first tablet in the doctor's office. However, this was only done if the patient had been sober for a minimum of twelve hours. Before he left he was again advised of the reaction which would occur if he drank, and warned that he could not safely drink until 10 days after his last tablet. He was further asked to sign a release saying that he understood the possible danger he might incur if he did drink, and he was also given an identification card, saying he was on Antabuse, and giving the emergency treatment for a reaction. The relative was asked to contact the physician if the patient should for any reason stop the medication.

After the first week the patient was again seen and the dosage of 0.5 gm. a day was cut to 0.25 gm. From this point on he was seen biweekly.

The members of the team were fully aware of the limitations of the drug, and hastened to point out to the individual that Antabuse merely represents a method of staying sober, doing little to alter the underlying psychiatric disease. He or she was encouraged to use the period of sobriety to avail themselves of such organizations as A.A. and various religious groups. Furthermore, every attempt was taken to help the individuals obtain a job, and also arrangements were made so that they might obtain treatment for any physical ailment they might have. Many of the individuals had severe anxiety and in most instances the Antabuse was combined with a tranquilizer, generally Sparine.

Results. Since September of 1962, 64 individuals were started on Antabuse on a voluntary basis. Of these 64, 17 came only one time, and it was assumed that they were not adequately motivated, decided that treatment by this method entailed more than they anticipated, or they came merely to satisfy the wishes of a family member without any intention of cooperating. This then left a total of 47 whom it was felt had had an adequate trial on Antabuse. The periods of sobriety obtained varied from 9 months to 3 weeks, with an average of 87 days.

Of those 64 started on Antabuse during this period there were 20 Negroes, 16 men and 4 women; 44 Whites, 40 men and 4 women. On May 31, 1963, 32 cases were still active, 4 of whom were no longer taking Antabuse but were still sober. These 32 consisted of 14 Negroes, 11 men and 3 women; and 18 White, 16 men and 2 women. Of these considered active, the majority had been totally abstinent since starting on medication, but a few had had one or more periods of remission, although they were again sober and on Antabuse by the 31st May, 1963.

Approximately one fourth of the total of 64 individuals had tried to drink while on Antabuse, and had experienced the reaction. However, in general those who did this subsequently adhered very closely to the regime and were in many ways the most successful patients.

Few significant side effects were noted, but there were several patients who reported being drowsy, and about one third reported slight nausea initially. The former problem was overcome by having the individual take the tablet at night, and the latter by taking it together with food rather than on an empty stomach.

Cooperative Program With the Court

Because of the significant early success with many individuals who in the past had been considered incorrigibles and because of the continuing suspicion among many of the drunks of any new method of treatment, it was suggested early in February, 1963, by T. C. Little, that he start probating the drunk court offenders to Antabuse treatments. Every day there were men in court who implored the Judge to allow them to do something other than serve time at the Stockade. These men were then offered the alternative of taking the Antabuse tablet every morning at the Court for the duration of their sentence, and at the same time being able to spend the rest of the twenty four hours free. The response was very considerable, and soon many of the chronic offenders were on treatment. Some used it merely as a method of avoiding being jailed and either failed to return after the first day, or concealed the tablet in their mouths to later spit it out.

Essentially the same method of administration was used as was used with the volunteer group. When a man was selected by the Judge, he was sent to the study group and evaluated from a physical and psychiatric standpoint. If he was found suitable he was given his first 0.5 gm tablet by the doctor and then returned to the Court staff to take from them his subsequent daily dose. The relationship of the physician to the patient was essentially the same as in the volunteer group, with the only difference being that the Court takes on the role of the family member and the responsibility of administering the drug under the supervision of the physician.

Between February 15, 1963 and May 31, 1963 a total of 132 persons were placed on Antabuse. On the latter date 61 were still actively taking the drug, and 71 were inactive. However, of the 71 inactive, 17 completed their sentence and then did not wish to continue on Antabuse. However, among those still active are many who originally entered the program with considerable misgivings, but who were so pleased with the success they achieved while under sentence that they wished without reservation to continue subsequently. Perhaps the most spectacular in this group are several individuals who prior to treatment had served as many as ten years for drunkenness—consecutive 30 day increments, and who after starting on Antabuse have now gone several months in a state of so-

briety and have been able to hold steady jobs during this time.

Early in this phase of the program it was found that many of the men after many years of drunkenness, and incarceration, had no place of abode when released and kept sober. They had the possibility of going to the Union Mission or to one of several cheap hotels. However, because of their own sobriety they were anxious to stay away from any place where they might encounter people still drinking. The outcome was that the "Helping Hand" meeting rooms at 186½ Decatur St. were renovated by the men themselves, and turned into a "Halfway House." It was able to house and feed around 20 men, primarily on a shoe string budget from mostly private donations, and with the earnings of the men themselves. Nevertheless its success proved two things. First, with Antabuse, together with an attempt to care for these peoples' basic needs, including job placement, it was possible to rehabilitate even some of the worst offenders. Its success also served to underscore the fact that this type of facility is essential if the skid row man is ever to escape from the bottom of the barrel. A "Halfway House" allows the individual to be rehabilitated in the environment which he must ultimately live in.

As a part of the treatment program weekly group meetings were held where problems concerning the functioning of the "Halfway House" and other problems could be discussed.

The side effects encountered with the program of Court administered Antabuse differed little in type from the volunteer group. However, the incidence and range was far greater, presumably the psychological rejection of the drug being considerably more frequent in this group, not all of whom were truly motivated by a desire for permanent sobriety. The most commonly encountered side effects remained lethargy, and nausea, and there were 3 cases of temporary impotency. None of these proved serious enough to warrant discontinuance of the drug. In fact only one individual had to be terminated on the drug, and this was because of the development of an allergic dermatitis.

Discussion

When this study project was enbarked upon in July 1962, it was not at that time planned to devote much of our resources to the area of treatment, but rather during this initial phase to spend it evaluating and studying only the problems involved. However, it rapidly became clear that to make adequate recommendations, the feasibility of using various treatment methods in this group of individuals had to be investigated. Antabuse was one obvious choice, but even it had been planned for only a very restricted group. However, the rather startling success in a few key individuals created such interest in the Court personnel and others involved in the study that, perhaps prematurely, the group was precipitated into a full scale treatment program without adequate facilities. Although the results are promising it is doubtless that with better organization of the selection of subjects, and administration of the drug, the results on a percentage basis might have been even more impressive.

The efficiency of this drug in the skid row drunk of this type has definitely been proven. However, in the 132 individuals treated through the Court only an insignificant fraction were either women or Negro. Because of the small number of women seen in Court compared with men it was not possible to adequately assay the drug in the female population. On the other hand, however, perhaps the most successful group treated on a voluntary basis were the Negro men. Of 16 who were placed on the drug, 11 were still sober on May 31, 1963, and those 5 who were not dropped out of the program after the first visit and presumably never took Antabuse regularly. Several explanations are available to explain this success which far exceeds what was achieved with the White arrestees. First, the Negro man, to have enough initiative to see treatment on a voluntary basis in our society, needs to be not only sincere, but highly motivated. Secondly, because of the submissive nature which has been culturally induced, the Negro will adhere to a treatment regime which is laid down for him with less resistance than many White patients. The third point of significance is that this further emphasizes that the Negro drinking problem is in many ways sociologically determined and a reflection of his position in society rather than representing a psychological dependence on alcohol.

Antabuse, it must be emphasized, is only a method of maintaining temporary sobriety, and cannot be construed in any way as a cure for the disease. What it does do is to allow an individual to stay sober long enough where he can perhaps with the help of others manipulate his environment so that his life becomes tolerable without alcohol. The important advantage of keeping a man sober with Antabuse, rather than sober by incarceration, is that it enables him to remain in the environment where he must function in the future, and hence forces him to adjust to it without alcohol. Sobriety in jail is tolerable to many individuals merely because they are removed from the stresses of their life—the outside world. Antabuse also is no panacea. For many individuals it has reduced the number of drunk court appearances and allowed them an opportunity to be gainfully employed with consequent benefit to both the individual and the community. During the period of the cooperative Antabuse program there were 1,118 fewer arrests than for the same period the previous year. This amounts to a substantial financial savings to the city. We feel that the Antabuse program contributed greatly to this reduction in arrest. It must be emphasized that while permanent rehabilitation is the ultimate goal, practically, for many of the repeat court offenders we hope to obtain only a reduction in the number of arrests and to increase periods of productivity for the individual. This has proven to be possible. Many men cannot function in the world as we know it without alcohol, and when forced to do so by taking Antabuse or any other method they undergo a psychological disintegration. This in fact happened with 4 individuals on the program.

Our conclusions from this excursion into the realm of treatment are that with appropriate selection to choose the most suitable candidates and adequate personnel for administration of the drug under a physician's guidance, this drug has a tremendous place in the treatment of the repeated drunk court offender: Not only this, it could well be made the backbone of any overall rehabilitation program, and might be made a prerequisite for other forms of treatment.

The Establishment of Neighborhood Treatment Units for the Most Refractory Negro Slum Areas

Early in the study it became obvious that there were certain Negro slum areas where a large number of arrests were made, and where heavy drinking or drunkenness was an indigenous problem. A large number of the people in these areas were at a mentally retarded level, and not only were unemployed but in many instances unemployable. What support they had came from various sources. This income was occasionally supplemented by day jobs such as loading trucks, and other temporary employment. Bootleg whiskey is amply supplied to these areas, and those selling it not only deliver it to the homes or rooms of their customers, but also allow them ample credit. Heavy drinking is almost universal and many of these people have been drunk every day as far back as they can remember.

Although they are frequently arrested, it is difficult with the superficial relationship possible in the strained atmosphere of the court and jail to induce these people to accept treatment or to feel that a life of sobriety had anything to offer them. However, in a few instances where it was possible to gain some rapport and enough confidence in the physician was established, these patients proved to be very suitable for treatment, and spectacular successes were achieved with many individuals. Until this point, the only authority figures that these people had come into contact with in their day to day life were those associated with either exploitation or punishment. As a result they had been very hesitant to place their trust in anyone in this position, even a physician, and it took some considerable time to gain their confidence. However, after a few individuals had been helped, it was found that these people themselves did more to allay the fears of their neighbors than anything done by the study team.

With White subjects, particularly if they came from upper socioeconomic group, either through the efforts of their family or on their own initiative they are likely sooner or later to seek out an institution or agency for help with their drinking problem. This is not so with the group we have described, in part because it is difficult for them to conceive that, when all those around them drink, they have any benefits to gain from abstinence.

Because of this it was felt that if these people were to be helped the study group must go to them rather than vice versa, particularly that this should be done if possible before they appeared in court. This meant that some arrangement had to be made to contact and assist these people in the areas where they lived, and even if it involved a long period of time their confidence had to be won before anything further could be done for them. It was decided, therefore, that a series of neighborhood clinics should be established in these various parts of the city where trained personnel would be available at specific times in an attempt to help alcoholics living in the area. Specifically, these would be single rooms or store fronts which would serve as offices and be staffed by the members of the personnel from the treatment center. Depending on the availability of professional staff, there would be someone present at the unit either part or full time. Ideally, a permanent staff would be present every day in each of four units in different locations in the city.

The function of the unit would be fourfold:

(1) To establish a working relationship and attitude of trust, and cooperation with those alcoholics who lived in the region of the unit.
(2) It would capitalize on the rapport, once established, to educate the people in the controlled use of alcohol, and also attempt to convince them of the advantages of sobriety.
(3) A third function following on (1) and (2) would be to refer to the main Treatment Center on Butler Street any individual who was motivated to receive therapy either on an inpatient or outpatient basis. This would extend to the realm of physical illness associated with drinking, in attempting to persuade those so afflicted to obtain treatment from Grady Hospital.
(4) In the fourth phase it would be hoped that those working at the unit could then follow up the individuals who had been treated at the central Treatment Center, and who had been placed on Antabuse or other medication.

It should be emphasized that the basis of a program such as this would be the helping relationship which the staff of the unit established with those inhabitants in the area where they are located, and thereby introduce the concept of treatment and rehabilitation for those with a drinking problem.

There are at present four Negro slum areas where it was felt a unit of this type would be advantageous. Generally speaking these are in the following geographical areas:

(1) Northside Drive, S.W., Mitchell St., S.W. and Hunter St., that network of streets within proximity to the Neighborhood Union Health Center, Norris Brown College, Greensferry Ave., S.W. and Northside Drive.
(2) Highland Ave., N.E., Forrest Ave., N.E., that network of streets in proximity to Georgia Baptist Hospital.
(3) That region south of Georgia Avenue bounded by Capital Avenue and Pryor Street.
(4) In the area south of Bankhead Highway.

It is hoped that Urban Renewal property could be made available to house these units. It is assumed that when demolished, so also would be the slum area they served. Although ideally and eventually it would be hoped to place units in all four areas, because of the present staff shortage a single unit would be set up, and the area selected as most suitable is that described as (1).

For such an approach this recommendation is unique, with no known comparable service existing anywhere in the country. It is designed specifically for the problem of the drinker in the Negro slum areas who in this study was found to comprise a large number of the arrests. Combining both prevention and cure, it is probably the most fundamental approach to the problem that we can hope to achieve.

From the preceding information we can see that we are dealing with a situation which is a very costly thing in terms of dollars, manpower, and human suffering.

Each year there are 6,000 chronic court offenders, 6,000 one time court offenders, and unknown numbers of persons arrested one or more times for public drunkenness who do not come to court at all. Of the 6,000 chronic repeaters a high percentage are alcoholics, according to psychological tests administered. In as much as there is very little significant difference between the percentage of alcoholics in the higher court appearance cases and the lower court appearance cases, one could speculate that there are a significant number of alcoholics among the non-repeaters as well as those arrested for public intoxication who do not appear in court (by virtue of the fact that they had $15.00 to "pay out"). So the total number of individuals with whom the police force becomes involved because of "plain drunkeness" is probably 20,000 per year, and the majority of these are alcoholics. In addition to the number who are alcoholics there are many who suffer from some other emotional or physical illness of which their drinking is a symptom.

These people are costing the city of Atlanta $427,670.15 per year or $8.08 for each arrest made. As was stated earlier in the report, the expense to the community as a whole is estimated as $17,007,670.00 per year.

In as much as the majority of these people are alcoholics, but are being handled as criminals, this seems to be the first big area of discrepancy. According to the laws of Georgia, the legislature has officially recognized that alcoholism is an illness and a public health problem affecting the state's general welfare and economy. The American Medical Association and the World Health Organization both recognize that alcoholism is an illness, and furthermore, recognize that alcoholism is an illness that can be treated and abated and the sufferer of alcoholism is one worthy of treatment and rehabilitation.

It is almost universally accepted that alcoholism is an illness, but in fact this is only intellectual acceptance. Emotionally, alcoholics are still thought of by many as degenerates, criminals, weaklings who have self-imposed their entire problem. The indivdual who is in the low or low-low socioeconomic group who is an alcoholic has even more prejudices directed toward him.

In Atlanta it is a crime to be publicly intoxicated, and 50,000 people are arrested annually for this crime. This is no discredit to the Atlanta Police Department. In fact, it is a credit to their efficiency, and as a result of this efficiency Atlanta is not blighted with an ugly skid-row section which is so common to nearly all cities of comparable size. Public drunkenness is not tolerated in Atlanta and the offender is quickly arrested and incarcerated for a minimum of four hours until he is no longer a nuisance or threat to others or a danger to himself. Even though an occasional individual is arrested who isn't acually intoxicated or an occasional acutely critically ill person is jailed rather than hospitalized, it is far better to arrest these few than to ignore the problem entirely. Many lives are undoubtedly saved and much human suffering is prevented by virtue of the fact that these individuals are taken to jail and observed and frequently administered to. Also, after the individual has been arrested the treatment he receives from the police, the personnel of the Municipal Court, and the City Prison Farm cannot be criticized. He is treated with as much sympathy, kindness, and understanding as it is possible with existing conditions under which he must be handled.

Unfortunately, the entire system is directed toward handling individuals who have committed misdemeanors, not for treating sick alcoholics whose symptoms are considered a crime—and intoxication (including public intoxication) is one of his symptoms.

It is our contention that, since most of the individuals who are arrested in Atlanta for plain drunkenness are alcoholics, and are in need of treatment for this illness, then the entire system for handling these people must be revised. In addition, a new facility, an Intensive Treatment Center, is urgently needed to provide essential services not available presently. This new facility would coordinate its program with other already existing community services to effectively treat and rehabilitate the chronic arrested alcoholic.

Recommendations

We would not change the statute that says public intoxication is a misdemeanor. We would allow this to remain as the means whereby these individuals are brought to the attention of the facilities which are best equipped to handle the individual's problem. Starting with the arrest itself, it would be beneficial if each police officer had more training in the recognition of "intoxication" and its various causes. A person can be intoxicated with alcohol, drugs, injury, or disease. A police officer should be trained, within limits of course, to recognize the various forms of intoxication. If alcoholic intoxication is minimal or absent and the arrestee manifests symptoms of intoxication, he should be hospitalized and a medical evaluation be made. If the case is compatible with alcoholic intoxication and the person's condition is not considered serious, he should be detained in jail, under medical supervision, until the intoxication is alleviated.

At this point—once the individual is detoxified or "sobered up"—an evaluation should be made to determine whether the person is alcoholic. If this is the case, he

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should be screened carefully by a team of physicians, psychiatrists, psychologists, social workers, and vocational rehabilitation experts. According to the evaluation of this team, a disposition should be made.

If the individual is a so-called "normal" person who accidentally became intoxicated from social drinking, he might be released—with or without paying a fine. If the individual is found to be an alcoholic or is suffering from some other illness, a method of treatment should be offered to him.

The evaluating team of experts would have to make the decision as to whether he needed treatment or not—the same as in other mental or emotional illnesses. Once it was decided that the individual needed treatment, it should be instituted at the proper facility.

Many people who are arrested for public intoxication and who are in need of treatment for alcoholism could afford private medical care. Some would qualify under the state program that now exists. Some are suffering primarily from a mental or emotional illness and the alcoholism is secondary. These people should be treated in the proper existing facilities.

The people with whom we are primarily concerned are the alcoholics who are repeatedly arrested for public intoxication who have no resources for private medical care and for whom there are no presently existing facilities to treat their alcoholism. It is with these people in mind that we have formulated the following recommendations. Recognizing, of course, that all of the recommendations herein made could not be instituted immediately, we will formulate this plan recommending first things first, making the best of existing facilities.

As we have already stated, one of the first recommendations would be to intensify the training of police officers in the recognition of intoxication and in a better understanding of the disease alcoholism.

Next, the present existing jail situation should be entirely revised. At present, there are no facilities for treating the acutely intoxicated individual. The arrestees are put into a common cell which contain only steel-slatted bunks, which the men refer to as "barbecue racks." It is common to see several individuals in various states of alcoholic unconsciousness lying on these bunks and on the concrete floor, unattended except for the turn-key, who has neither the training nor the time to administer to the needs of an acutely sick person. It would be our recommendation that at this point a medical screening of all alcoholic prisoners be done. Those in need of any medical attention should be immediately transferred to Grady Hospital for this medical care.

As for the Municipal Court setup, we would suggest no physical change. We do question the necessity of each of these persons who have been arrested for public intoxication being "tried" by a judge and a specific sentence being meted out based on the number of previous arrests, rather than on the needs of the individual case. It might better be that the legal procedures now existing should be revised so that an individual can be processed from the time of his arrest until disposition of his case has been made by the multi-discipline team previously mentioned. If the individual then refuses to accept the recommended treatment, the Court might then step in and commit him to this treatment.

Once the person accepts or is committed to treatment, this would usually begin at the City Prison Farm. At present, this is primarily functioning as a punitive facility in that the prisoners are sent there to serve a sentence for public drunkenness. This consists primarily of confinement for all and work details for those who are physically fit. There are virtually no reaction facilities at this institution. A gymnasium which was provided for recreation is filled with long tables which are usually unused or are used occasionally for bunks for the overflow of prisoners when the prison becomes too crowded. No effort is made to evaluate the physical or mental condition of the prisoners except for those who complain of ill health or show grossly abnormal behavior.

More than 95% of the city prisoners are there because of public drunkenness. As stated earlier, the majority of these people are alcoholics who are suffering also from mental and/or physical disabilities. It is our opinion that the 5% or less inmates who are there for some other misdemeanor might better be made to conform to an alcoholic rehabilitation program than for the other 95% to be treated as criminals.

Undoubtedly the capacity of the city prison should be increased. The prisoners are overcroweded in all areas—dormitories, bathroom facilities and dining room. There is no room for recreation, reading, or relaxation. However, enlarging this facility would be in the relatively distant future. What can be done in the immediate future? First of all, the concept of this facility must be changed from one of punishment to one of rehabilitation. It must be recognized and accepted that for practical purposes *all* of the inmates are individuals who are suffering from some phase of alcoholism. Therefore, every inmate who comes there should, first of all, be evaluated from this standpoint. Once the evaluation is made, and if confinement is recommended, then a program of work and play and treatment could be instituted for the purpose of turning out an individual who is less sick when he leaves than when he came to the institution. If the work details include exactly the same ones that are now included, this would not be amiss. However, the individual's needs as well as the city's needs should be taken into account when an individual is assigned to a given detail.

A very active program of counseling, group therapy, Alcoholics Anonymous, and other recognized methods of treating alcoholism should be instituted at the City Prison. In summary, from the day a man arrives at this institution until he leaves he should recognize that he is being treated as a sick person who needs help and that his rehabilitation is being started here.

Once a man is ready to leave the City Prison Farm, facilities in the community must be available to him for further help. At the present time, when a person is released from the City Prison he is returned to the city jail and turned loose. In many cases he hits the streets of Atlanta in poor physical and emotional condition.

His clothes are the same dirty ones he wore on his last drunk. He is penniless, homeless, and temporarily friendless. He heads for the only place where he might find help—the heart of the city where his buddies who are not in jail can usually be found. He needs a meal, a room, a drink, and a job. He can easily get a drink, oftentimes a meal, sometimes a room. Jobs are hard to come by for a man with very little education or skill who already has a poor work record and who is limited in what he can do because of physical and mental reasons.

Therefore, he must have somewhere to go. In our proposal we recommend that this be a city-county operated intensive treatment center for alcoholic rehabilitation. At present we have in mind the temporary conversion of the former Colored Nurses' Home at 43 Butler Street. This property, owned by Emory University, has been offered as a site for the Alcoholic Rehabilitation Center. It is ideally located, being near the Atlanta Police Station, and near Grady Memorial Hospital, where excellent medical facilities are available. At this facility there would be offices for the following personnel: one clinical director, a psychiatrist, half time; one internist, half time; one administrative director; a social worker, full time; two social workers, full time; one registered nurse, full time; two social work case aides, full time; and a man and wife who would live at the facility.

Also in the intensive treatment center there would be kitchen and dining room facilities; sleeping rooms for approximately 30 men, both white and Negro; and recreation facilities such as a lounge, television room, and reading room.

The facility would use a psychiatrically oriented multi-discipline approach to the management of alcoholism and its related problems. By using the above named staff it is hoped that the services of existing agencies now in the Atlanta area which are already involved with alcoholics and their families could be better coordinated. This would include the Department of Welfare and Labor, Family Service, Vocational Rehabilitation, and other agencies.

The Intensive Treatment Center would be the core of the entire alcoholic rehabilitation program and be responsible for the coordination of all activities directed toward handling the alcoholics (particularly the arrested alcoholics) of the City of Atlanta and Fulton County. It would be responsible for the setting up and operation of a medical facility at the city jail, for the formulation of a rehabilitation program at the city prison farm, and for the functioning of the Intensive Treatment Center itself.

Another function of the Intensive Treatment Center would be to follow outpatients after they have left the formal treatment program.

In addition to the above named facilities, it would be very important to have at least one city-county operated halfway house which would be used as a model for other halfway houses in the area. These other halfway houses might be city-county operated or they could conceivably be sponsored by churches, foundations, or civic service organizations. The nucleus of such a halfway house is now in operation at 95 Merritts Avenue. The function of a halfway house would be primarily to provide a home for individuals who are nearly ready to move back into society but still need a stable, structured environment in which to live until they have confidence in their own adaptive capacities.

In summary, let us diagram the proposed facilities for handling the arrested drunk we recognize as an alcoholic in need of treatment and rehabilitation.

From this diagram we can see that this is a very flexible program. An individual who is arrested for public intoxication would first of all be taken to the jail, which is now a treatment facility. From here he might conceivably go directly to any of the other facilities involved, under the supervision of the Intensive Treatment Center. For example, an individual may have been living at a halfway house and has three to six months of sobriety behind him. Then he goes on a binge. He is arrested for public drunkenness, taken to the city jail, detoxified, re-evaluated, and the decision is made to send him back to the halfway house the next day and he is back where he was a short time before—sober and working. Now if this individual repeated this performance shortly thereafter, it might be the opinion of the Intensive Treatment Center that he move back into that facility, be put back in the city prison if necessary, hospitalized in a general hospital, or committed to the state mental hospital. In any case, however, the first and most important step is to get him detoxified and treat him like the sick person he is.

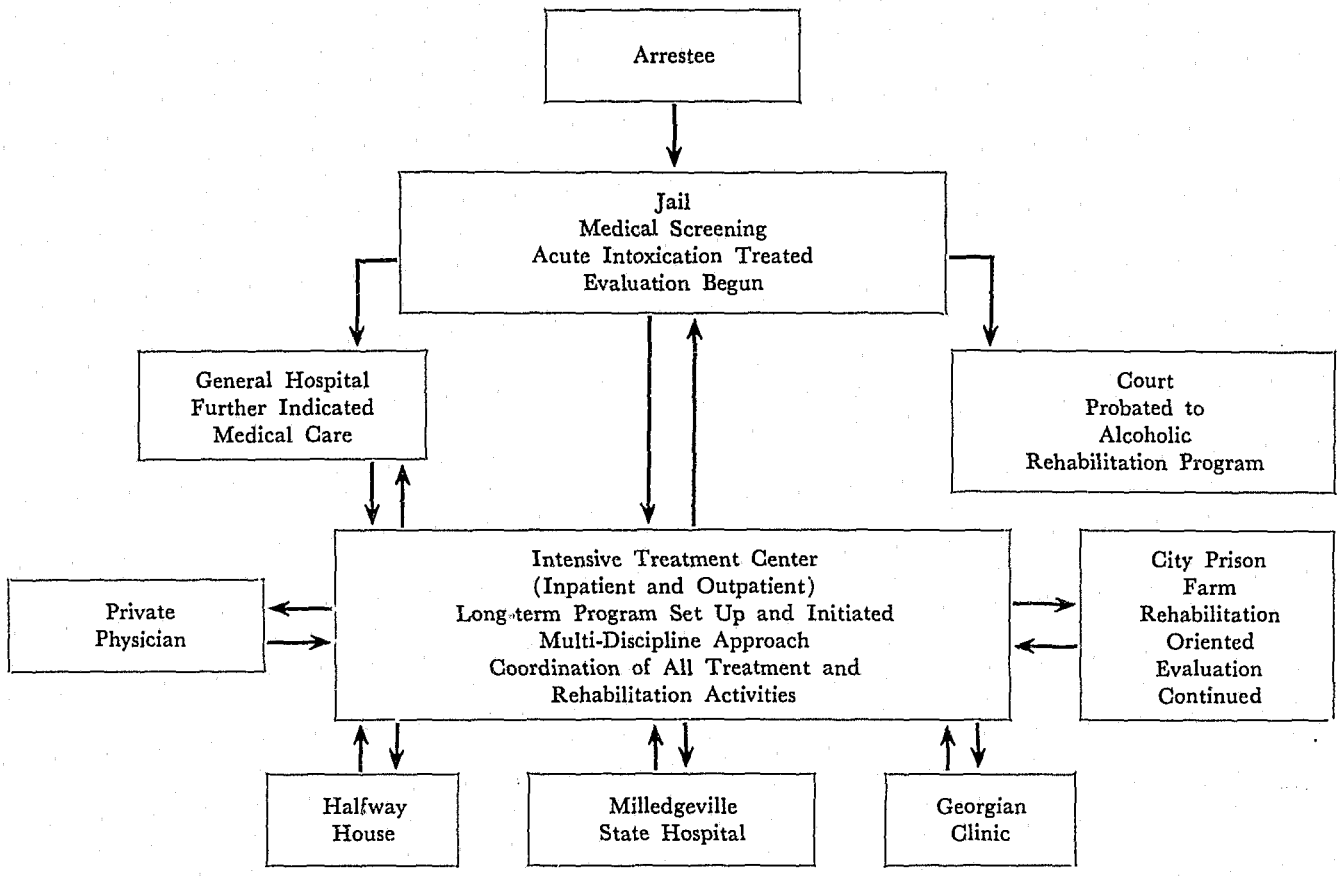
Elsewhere in this report there is a detailed description of neighborhood facilities for the Negro alcoholics. This program would be incorporated as an integral part of the overall alcoholic rehabilitation program and would be supervised by the personnel from the Intensive Treatment Center.

Cost of Program

In order to institute the above recommendations it would cost the city of Atlanta and Fulton County $98,000.00 for the 1964 program. This would pay the salaries of the personnel named above, would allow the barest minimum for renovating and equipping the Intensive Treatment Center, provide meals for an average of 30 inpatients, and pay for the drugs used at the Intensive Treatment Center.

As each phase of the program is developed and more services are provided for more individuals the cost of the program will rise. Conceivably, however, the various costs to the city and county mentioned earlier in this report would decrease. Whether there would actually be a savings to the city and county is doubtful. However, if half of these people can be reasonably well rehabilitated it would make for a vast savings in manpower and human suffering. Also, the secondary costs of unemployment, welfare benefits, inefficiency, loss in tax dollars, etc., would be vastly reduced.

Our feeling is that at the present time the $427,670.15 spent on arresting, incarcerating in the city jail, trying, and keeping these people at the city prison farm is not



being used to its fullest capacity. This is said not in criticism of any existing facility. All of the functions being performed by the police force, the courts, and the city prison are essential. However, unless all of these efforts are rehabilitation oriented there is no conceivable way that the problem of public drunkenness can in any way be abated and it will continue to grow at the same or a greater rate than it has in the past.

SUMMARY OF RECOMMENDATIONS

1. That a new facility, an Intensive Treatment Center, be established with City and County funds to provide inpatient and outpatient services using a multi-discipline approach. That these services be coordinated with all other treatment and rehabilitation services for alcoholism.
2. To continue the present Helping Hand Halfway House, with some City and County funds made available for this facility, as a model for the establishment and development of other halfway houses in the community.
3. That at least one Alcoholic Information and Referral Center be established, on an experimental basis, in one of the neighborhood areas of particularly heavy drinking, this Center to be staffed primarily with volunteers.
4. To provide better training to policemen in the recognition of "intoxication" and its various causes.
5. That there be medical screening in the city jail of all intoxicated prisoners immediately following the arrest of these persons. That those in need of any medical attention be immediately transferred to Grady Memorial Hospital for this medical care.
6. That the legal procedures now existing be revised so that an individual can be processed from the time of his arrest until disposition of his case has been made by the multi-discipline team previously mentioned.
7. That some of the approaches to alcoholics at the city prison farm be modified so that treatment and rehabilitation can be carried out in this setting. That an effort be made in the city prison farm to evaluate the mental and physical condition of the alcoholic prisoners and a program of rehabilitation be instituted for each of these persons.

THE RECENT COURT DECISIONS ON ALCOHOLISM: A CHALLENGE TO THE NORTH AMERICAN JUDGES ASSOCIATION AND ITS MEMBERS*

by Peter Barton Hutt

In March 1966 the United States Court of Appeals for the District of Columbia Circuit, sitting *en banc* in the *DeWitt Easter* case,[1] unanimously held that a chronic alcoholic cannot be convicted for his public intoxication. That decision, together with the Fourth Circuit's similar decision in the *Driver* case,[2] represent an urgent mandate to take the problem of the chronic inebriate out of the criminal law, and to handle it from now on under public health, welfare, and rehabilitation programs.

These appellate decisions do not, however, spell out how this mandate is to be implemented. An appellate court cannot inject the actual substance of justice into the lives of each of the derelict inebriates who daily come before the Nation's criminal courts. That task is uniquely the opportunity, and indeed the duty, of trial court judges.

To the chronic inebriate, indeed, the trial judge before whom he appears is the entire judicial system. Research has uncovered the startling fact that the only public intoxication case ever to reach the appellate level in the entire history of the District of Columbia courts is the *Easter* case. And it must be remembered that, prior to the *Easter* decision, public intoxication was the basis for about 50 percent of the criminal arrests, and 75 percent of the commitments to prison, in the District of Columbia each year.[3]

Thus, in a very real sense, a trial judge's handling of the individual inebriates who appear before him is far more important than the appellate court opinions that guide him. For it is the trial judges, not the appellate courts, who possess the power fully and effectively to implement the *Easter* and *Driver* decisions in every community throughout the country. And if they fail to exercise that power, the appellate court decisions could have little impact.

With this in mind, this paper will describe the historical background of the recent appellate decisions, the holdings in the *Easter* and *Driver* decisions, and the duty that these decisions now impose upon trial judges and other public officials. Finally it will outline the type of noncriminal procedures that should be substituted as soon as possible for the present criminal handling of inebriates.

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I

Under early English common law, public intoxication was not, in itself, a crime. Drunkenness was tolerated unless it resulted in some form of breach of the peace or disorderly conduct.[4] Mere intoxication in public was first made a criminal offense by English statute in 1606.[5] And it remains a criminal offense in most jurisdictions in the United States today.[6]

*This paper was presented to the 1966 International Conference of the North American Judges Association on Nov. 3, 1966, at Colorado Springs, Colo., and was subsequently edited and annotated for publication.

[1] *Easter* v. *District of Columbia*, 361 F. 2d 50 (D.C. Cir. 1966) (en banc), rev'g 209 A. 2d 625 (D.C. Ct. App. 1965). The District of Columbia did not seek certiorari in the U.S. Supreme Court.

[2] *Driver* v. *Hinnant*, 356 F. 2d 761 (4th Cir. 1966), rev'g 243 F. Supp. 95 (E.D.N.C. 1965). The State of North Carolina did not seek certiorari in the U.S. Supreme Court. This case arose on a writ of habeas corpus after the North Carolina Supreme Court had rejected Driver's constitutional argument. *State* v. *Driver*, 262 N.C. 92, 136 S.E. 2d 208 (1964).

[3] See *Report of the President's Commission on Crime in the District of Columbia* 474 & n. 1 (1966) [hereinafter cited as the *D.C. Crime Commission Report*].

[4] See, e.g., *Moser* v. *Fulk*, 237 N.C. 302, 74 S.E. 2d 729 (1953); *Drunkards*, 19 C.J., § 6, at 797 (1920).

[5] 4 James I, c. 5 (1606). Under present English law it is a criminal offense, punishable by imprisonment, to be drunk and disorderly. Under clause 59 of the Criminal Justice Bill (No. 141) presented to the House of Commons by the Home Secretary on Nov. 29, 1966, punishment for drunk and disorderly would be limited to a fine not exceeding £50, thus eliminating imprisonment for this offense. Clause 59 would not become effective, however, until "the Secretary of State is satisfied that sufficient suitable accommodation is available for the care and treatment of persons convicted of being drunk and disorderly."

[6] Exceptions to this general rule are Illinois and New York City, where disorderly conduct is the only pertinent offense, and in Alabama and Georgia, where both intoxication and a breach of the peace are required for an offense. See *D.C. Crime Commission Report* 496. In New York City, however, nondisorderly inebriates were regularly arrested in spite of the statute. See Murtagh, *The Derelicts of Skid Row*, Atlantic Monthly, March 1962, at 77; Murtagh, *Comments*, 16 Inventory 13 (July-Sept. 1966); Murtagh, *Arrests for Public Intoxication*, 35 Ford. L. Rev. 1 (1966). This practice was stopped by providing court-appointed counsel for all inebriates charged with disorderly conduct. Judge Murtagh, then the Administrative Judge of the Criminal Court of the City of New York, issued an order to the court clerks on May 13, 1966, which directed them to refuse to issue a criminal complaint "whenever the facts stated for inclusion in a complaint are insufficient to make out the offense charged:"

> Since March 1, 1966, some 3,151 derelicts have been arraigned in part 10 on a charge of violating section 722, subdivision 2, of the penal law [prohibiting disorderly conduct]. All have been represented by the Legal Aid Society. Of these, 289, or less than 10 percent, have pleaded guilty, probably because they desired shelter. The remainder, 2,862, stood trial and only 7 were convicted.
>
> This experience establish. what we have all known, namely, that arrests of this kind are almost invariably without justification.

The criminal responsibility of chronic alcoholics for conduct produced by their intoxication has been the subject of many court decisions over the years. In a series of cases decided between 1850 and 1900 a number of alcoholic defendants contended that, because their drinking was involuntary, they should not be punished for their resulting antisocial behavior. These defendants relied upon the well-established common law rule that involuntary behavior cannot be punished as criminal.[7] The rationale of this involuntary behavior exception to the criminal law is that it would be inhuman, as well as futile, to punish an individual for behavior which he lacked the capacity to control.

Unfortunately the courts rejected this contention, and ruled that alcoholism could provide a defense to a criminal charge only when it amounted to insanity.[8] In order to reconcile this result with the involuntary behavior rule, the courts resorted in these early decisions to a legal fiction. All drinking by a chronic alcoholic was deemed, as a matter of law rather than as a matter of fact, to be voluntary. These courts concluded that even the alcoholic had once been a voluntary drinker before becoming an alcoholic, and therefore should be held legally accountable for his subsequent disease. On the basis of this legal fiction, a chronic alcoholic was held criminally responsible for being intoxicated in public, as well as for any other antisocial conduct caused by his drinking, even though that intoxication and resulting conduct were the involuntary and unavoidable products of his alcoholism.[9]

In only one reported decision was this general rule rejected. In the case of *State* v. *Pike*,[10] decided in 1869, the defendant was charged with murder. The New Hampshire Supreme Court held that if the defendant could prove that alcoholism were a disease and that the murder was the product of his alcoholism, he could not be held criminally responsible for it.[11] But the *Pike* decision stood alone for almost a century.

It is difficult to explain judicial adherence for such a long period of time to the legal fiction that, because alcoholism is a voluntarily acquired disease, an alcoholic's drinking must also be deemed to be voluntary. It has long been the rule, for example, that other voluntarily acquired diseases excuse what would otherwise be criminal conduct.[12] One is left, then, with the observation that the history of judicial precedents in the field of alcoholism is explainable primarily as reflecting moralistic principles,[13] and a consequent reluctance to accept modern medical knowledge. As one prominent professor of criminal law has suggested, "traditional attitudes of hostility toward drunkenness render rational and just determinations more difficult" in this area of the law.[14]

II

This was the state of the criminal law pertaining to alcoholism prior to 1966. And one finds total agreement—among the police, the public prosecutors, the judiciary, the correctional officials, and workers in the fields of public health, welfare, and rehabilitation — that the handling of the country's public drunkenness problems under this criminal law approach has been a dismal failure.[15] Perhaps because of this widespread disenchantment with the use of criminal sanctions to handle a major problem of public health and human degradation, in early 1966 two U.S. courts of appeals handed down the landmark decisions in the *Easter* and *Driver* cases that have completely reversed the prior law.

In *Easter* v. *District of Columbia*,[16] all eight judges of the U.S. Court of Appeals for the District of Columbia Circuit held that the well-settled common law principle—that conduct cannot be criminal unless it is voluntary—precludes conviction of a chronic alcoholic for public intoxication. Four of these judges also based their decision upon constitutional grounds,[17] but the remaining four concluded it was unnecessary to reach that question.[18] The decision reflected the court's unanimous conclusion that chronic alcoholism is now universally accepted as an illness. The court reasoned that, because public intoxication is an inherent symptom of chronic alcoholism, the alcoholic's intoxication cannot be condemned as criminal.[19]

In *Driver* v. *Hinnant*,[20] the U.S. Court of Appeals for the Fourth Circuit—which includes the States of Maryland, Virginia, West Virginia, North Carolina, and South Carolina—held that to convict a chronic alcoholic for public intoxication, and thus to ignore the common law principle followed in the *Easter* decision, violates the prohibition against cruel and unusual punishment contained in the Eighth Amendment to the United States Constitution.

Both decisions flatly reject the long-standing legal fiction that a chronic alcoholic's drinking must be deemed to be voluntary.[21] Instead, they accept, as established facts, that chronic alcoholism is a disease, and that the chronic alcoholic drinks involuntarily as a symptom of that disease.[22] Both decisions hold that a sick person may not be

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[7] See Hale, *Pleas of the Crown*, ch. IV; 4 Blackstone, *Commentaries*, 20–21.

[8] See, e.g., *State* v. *Potts*, 100 N.C. 457, 6 S.E. 657 (1888); *Flanigan* v. *People*, 86 N.Y. 554 (1881); *Choice* v. *State*, 31 Ga. 424 (1860).

[9] See the cases collected in Note, *Intoxication as a Criminal Defense*, 55 Col. L. Rev. 1210 (1955); in Hall, *Intoxication and Criminal Responsibility*, 57 Harv. L. Rev. 1045 (1944); and in Note, *What Intoxication Will Excuse Crime*, 36 L.R.A. 465 (1913), accompanying *Harris* v. *United States*, 8 App. D.C. 20, 36 L.R.A. 465 (1896).

[10] *State* v. *Pike*, 49 N.H. 399 (1869).

[11] Judge Doe's concurring opinion, a classic in the criminal law, admonished the legal profession not to permit ancient medical beliefs, long since discredited, to become encrusted as legal principles. Id. at 438. He recognized that "when disease is the propelling uncontrollable power, the man is as innocent as the weapon" and thus that, if alcoholism had driven an individual involuntarily to commit murder, he could not be convicted for even so serious an involuntary act. Id. at 441.

[12] See, e.g., *United States* v. *McGlue*, 26 Fed. Cas. No. 15,679 (C.C.D. Mass. 1851); *United States* v. *Forbes*, 25 Fed. Cas. No. 15,129 (E.D. Pa. 1845); *United States* v. *Drew*, 25 Fed. Cas. No. 14,993 (C.C.D. Mass. 1828).

[13] See, e.g., Leviticus 10:9; Deuteronomy 21:18; Proverbs 20:1, 23:31, 31:4; Isaiah 5:11, 28:1; Habakkuk 2:5, 2:15; Luke 1:15; 1 Corinthians 6:10; Ephesians 5:18.

[14] Hall, supra n. 9, at 1045.

[15] See, e.g., representative comments collected in App. B of the *Easter* decision, 361 F. 2d at 56–60, and in Brief for Appellant, *Easter* v. *District of Columbia*, D.C. Cir. No. 19,365 (Nov. 22, 1965).

[16] Supra n. 1.

[17] 361 F. 2d at 53–55.

[18] Id. at 60–61.

[19] Id. at 51–53.

[20] Supra n. 2.

[21] The court in *Easter* held that :

> A sick person is a sick person though he exposed himself to contagion and a person who at one time may have been voluntarily intoxicated but has become a chronic alcoholic and therefore is unable to control his use of alcoholic beverages is not to be considered voluntarily intoxicated. *361 F. 2d at 55.*

The court in *Driver* pointed out that:

> The chronic alcoholic has not drunk voluntarily, although undoubtedly he did so originally. His excess derives from disease. *356 F. 2d at 764.*

[22] Counsel in both *Easter* and *Driver* argued that alcoholism is not properly regarded as just a form of mental illness, but rather is a separate and distinct disease. The decisions in both cases accepted this argument. In *Easter*, for example, the court stated that "whatever its etiological intricacies it is deemed a sickness which is accompanied with loss of power to control the use of alcoholic beverages." 361 F. 2d at 52. Judge Murphy of the D.C. Court of General Sessions has ruled that evidence of chronic alcoholism is insufficient to raise the defense of mental illness. *District of Columbia* v. *Phillips*, Crim. No. DC–855–67, Apr. 26, 1967, reprinted in 113 Congressional Record 45584 (May 16, 1967) (daily ed.). Two other courts have concluded that alcoholism is not a mental illness. *United States* v. *Malafronte*, 357 F. 2d 629, 632 n. 8 (2d Cir. 1966); *United States* v. *MacLeod*, 83 F. Supp. 372 (E.D. Pa. 1949).

convicted merely for exhibiting a symptom of his disease in public, and therefore that no chronic alcoholic may be convicted for his public intoxication.[23]

It makes no difference, from either a legal or a practical viewpoint, whether this result is compelled by the common law, as the *Easter* case holds, or by the Constitution, as the *Driver* case and four of the judges in the *Easter* case hold. The effect is the same. No longer may the age-old problem of the chronic inebriate be handled by the criminal process. As a result of these decisions, a new method of handling this problem must be found.[24]

III

This information is essential background. But the most important questions lie ahead. What do these decisions mean for the future of law enforcement, and of public health and rehabilitation, throughout the country? And what obligations do they impose upon the trial judges of this country to institute new procedures in their courts to implement them?

Of course, two decisions cannot be expected to halt, overnight, practices that have been accepted as daily routine for fully 360 years. It will take a community of effort, among all public officials and interested private citizens, to make these decisions meaningful. It is therefore essential to understand the roles that community officials should play in undertaking new procedures for handling chronic inebriates.

A. Once a judge becomes aware, through any information, of any kind, from any source, that a defendant charged with public intoxication may have available to him the defense of chronic alcoholism, he is clearly obligated to make certain that the defense is adequately presented. Cases in the District of Columbia involving the analogous defense of mental illness hold that even if the defendant protests, the judge is required to inject the defense into the case *sua sponte*, to make certain that an innocent man is not convicted.[25] Failure to do so is a reversible abuse of the trial judge's discretion. And a decision handed down by the U.S. Supreme Court in March 1966 is wholly consistent with that position.[26] There is no reason why these precedents, applicable to the analogous defense of mental illness, should not be equally applicable to the defense of chronic alcoholism.

This means, of course, increased responsibility for trial judges. Under the *Easter* and *Driver* decisions, each trial judge is obligated to take affirmative action to bring to an immediate end the traditional revolving door handling of the chronic court inebriate in his own court.[27] No judge may properly remain neutral, simply waiting for a defendant to raise the defense of alcoholism.[28]

Statistics suggest that approximately 90 to 95 percent of the drunkenness offenders who cannot afford to post and forfeit collateral, and who therefore must appear in drunk court, have serious drinking problems.[29] This statistic, in itself, places upon trial judges an obligation to inquire into the possibility of the defense of chronic alcoholism for virtually every drunkenness offender who appears in the courts. A failure to undertake this inquiry would amount to a derogation of judicial responsibility.

These decisions also mean the demise of the so-called court honor programs for alcoholics, which have sprung up all over the country as the judiciary's *ad hoc* answer to the failure of communities to handle alcoholism as a

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[23] The question has arisen whether the defense of alcoholism afforded by the *Easter* and *Driver* decisions will extend beyond the offense of public intoxication. Both defense counsel and the Government argued in the *Easter* litigation that, if the defense of chronic alcoholism were recognized by the courts, it would, like insanity, be available as a defense to a criminal charge for any activity caused by it. Nothing in the *Easter* decision refutes this position. Judge Murphy of the District of Columbia Court of General Sessions has adopted this position in the only written opinion on the question, in a case involving a charge of disorderly conduct. *District of Columbia* v. *Phillips*, Crim. No. DC–855–67, Apr. 26, 1967, reprinted in 113 Congressional Record 45584 (May 16, 1967) (daily ed.). The sixth circuit has indicated agreement with this position by characterizing *Easter* and *Driver* as "the recent leading cases holding that chronic alcoholism may be a defense to a charge of unlawful conduct, because of a lack of responsibility on the part of one so afflicted." *Fultz* v. *United States*, 365 F. 2d 404, 407 (6th Cir. 1966). Alcoholism has, of course, been available as a defense to any crime in New Hampshire since 1869. *State* v. *Pike*, 49 N.H. 399 (1869). Law review comment, collected in n. 24, has generally agreed that there is no logical basis for limiting the *Easter* and *Driver* rationale only to the offense of public intoxication. See also, Hutt & Merrill, *Is The Alcoholic Immune From Criminal Prosecution?*, 6 Mun. Ct. Rev. 5 (1966), reprinted in 25 Legal Aid Briefcase 70 (1966) and in 113 Congressional Record A1524 (Mar. 23, 1967) (daily ed.).

[24] The law review commentaries on the *Easter* and *Driver* decisions have recognized their importance and generally approved their result. See Murtagh, *Arrests for Public Intoxication*, 35 Fordham L. Rev. 1 (1966); New York State Bar Association Committee on Public Health, *Report on Alcoholism* (Dec. 31, 1966); Note, *Alcoholism, Public Intoxication and the Law*, 2 Col. J. of L. & Soc. Prob. 109 (1966); Note, 1966 Duke L. J. 545 (1966); Comment, 4 Houston L. Rev. 276 (1966); Comment, 18 S.C. L. Rev. 504 (1966); Note, 12 Wayne L. Rev. 879 (1966); Note, 52 Cornell L. Q. 470 (1967); Note, 27 La. L. Rev. 340 (1967); 33 Brooklyn L. Rev. 324 (1967); 8 Ariz. L. Rev. 351 (1967); 12 S. Dak. L. Rev. 142 (1967); 46 B.U.L. Rev. 409 (1966); 15 Catholic U. L. Rev. 259 (1966); 54 Geo. L. J. 1422 (1966); 55 Ky. L. J. 201 (1966); 44 N.C. L. Rev. 818 (1966); 3 Tulsa L. J. 175 (1966); 11 Vill. L. Rev. 861 (1966); 23 Wash. & Lee L. Rev. 402 (1966); 7 Wm. & Mary L. Rev. 394 (1966); 13 Howard L. J. 203 (1967); 19 Ala. L. Rev. 183 (1966); and 2 Ga. St. Bar J. 239 (1965).

[25] *Whelan* v. *United States*, 120 U.S. App. D.C. 331, 346 F. 2d 812 (1965) (en banc); *Overholser* v. *Lynch*, 109 U.S. App. D.C. 404, 288 F. 2d 388 (1961); rev'd in part on other grounds, 369 U.S. 705 (1962).

[26] In *Pate* v. *Robinson*, 383 U.S. 375 (1966), the Court unanimously held that, when a defendant's competence to stand trial becomes suspect, the trial judge must sua sponte conduct a hearing on that question. Testimony at trial indicated mental disorder and irrational behavior. A majority of the Court held that the trial judge's failure sua sponte to inquire into the defendant's competence in the face of this information was a denial of due process of law, even though neither the defendant nor his counsel had raised the question. Two justices agreed with the legal principal enunciated by the majority, but dissented on the factual ground that the information available to the trial judge in *Pate* was not sufficient to require him to explore the competency question sua sponte. It would be as unconstitutional to convict an accused for acts caused by his incompetence as it would be to convict him while he was incompetent to stand trial. Thus, the *Pate* decision requires the conclusion that the failure of a trial judge sua sponte to raise the defense of incompetence when any information indicates that it may be available to the defendant would similarly constitute a denial of due process of law, regardless whether the defendant was represented by competent counsel.

[27] Chief Judge Greene of the District of Columbia Court of General Sessions has ruled that:

> There has been some difference of opinion whether the defense of chronic alcoholism must be raised affirmatively by the defendant to be cognizable by the Court. In my opinion, the sounder view is that the Court has the obligation to inject this issue on its own motion when it appears likely from the evidence that the defense may be available. When the judge recognizes a prima facie case of chronic alcoholism from the defendant's criminal record, he should not close his eyes to the possibility of this defense, particularly when, as is so often the case, the defendant himself lacks both counsel and the intellectual capacity to raise the defense on his own.

District of Columbia v. *Walters*, Crim. No. DC–1850–66, Aug. 16, 1966, reprinted in 112 Congressional Record 22716 (Sept. 22, 1966). This view was subsequently adopted by virtually all trial judges in the Court of General Sessions, and the court today sua sponte reviews the records of every individual who appears before it charged with public intoxication in order to determine whether chronic alcoholism may be available as a defense. Those defendants who may be alcoholics are then interviewed by public health personnel who make a diagnosis and report their findings to the court. The chronic alcoholics are acquitted. The D.C. Crime Commission concluded that this type of court procedure "would appear to be compelled" by the decisions cited above. *D.C. Crime Commission Report* 979 n. 71.

[28] In *Fultz* v. *United States*, 365 F. 2d 404 (6th Cir. 1966), the court reviewed on a petition to vacate sentence the case of an indigent defendant who had pled guilty to a charge of bank robbery and had been sentenced to 10 years imprisonment. The defendant experienced delirium tremens for several days after his arrest, and, upon a mental examination, it was determined that he "had a long history of periodic, severe alcoholism, and prolonged and immoderate use of drugs," but was competent to stand trial. After only 15 minutes consultation his court-appointed attorney pled him guilty, and the trial judge accepted the plea without further inquiry. The sixth circuit held that the trial judge had acted improperly. Noting the relevance of the *Easter* and *Driver* decisions, the court held that a trial judge must not accept a guilty plea without first thoroughly investigating the circumstances under which it is made and determining that the plea is voluntarily made with an understanding of the nature of the charge.

[29] See *Report of the Committee on Prisons, Probation and Parole in the District of Columbia* 84–86, 89–90, 102, 109 (April 1957); *Report of the Subcommittee on Alcoholic Problems*, 23 J. Bar Association of D.C. 428, 430 (1956); *Maryland Mental Health Newsletter* 1 (December 1966); and *D.C. Crime Commission Report*, 477, 483, 485–486. Although there are no precise statistics available on the experience of the District of Columbia Court of General Sessions since the *Easter* decision, officials and observers of that court estimate that at least 90 percent of the defendants charged with public intoxication who are unable to afford the $10 collateral that would obtain their release from the police precinct station, and who therefore must appear in drunk court, are indigent chronic alcoholics.

broad health and welfare problem.[30] If a defendant is found to be eligible for a court alcoholism program, then obviously he should not be convicted in the first place. The *Easter* and *Driver* decisions are fundamentally in conflict with any type of judicially sponsored postconviction program for the treatment of alcoholism. However benevolent such programs may be, constitutionally they are a thing of the past.

The judiciary should be very happy to see the courts step aside in this area and to see public health, welfare, and rehabilitation officials take over problems which they should have taken over many years ago. Courts have not set up programs to treat epileptics, narcotic addicts, the handicapped, or any number of other categories of mentally and physically ill people that regularly come before them. There is no reason why alcoholism should be an exception.

In this connection, one recent decision is apposite. In *Sweeney* v. *United States*,[31] the Seventh Circuit concluded that it is unreasonable and unjust to impose a requirement of sobriety upon an alcoholic as a condition for probation. The court therefore held that an alcoholic's probation may not be revoked when he is later found intoxicated. Thus, probationary control over an alcoholic's drinking has been precluded even in a jurisdiction where the precise *Easter* and *Driver* issues have not yet come before the courts.[32]

This raises the important question as to the jurisdictions in which the *Easter* and *Driver* decisions should properly be implemented by trial judges at the present time. The Supreme Court has denied certiorari in the case of *Budd* v. *California*,[33] the only test case on alcoholism that has yet been presented to it. The very troublesome procedural defects of that case may well have persuaded the Court to defer considering the legal issues presented until a more appropriate case comes along.[34] There are now test cases on alcoholism pending in three State Supreme Courts—Michigan,[35] Massachusetts,[36] and Washington[37]—which could soon be on their way to the Court. And I am firmly convinced that the vigorous dissents from the denial of certiorari in *Budd* make it virtually certain that, when the Supreme Court does decide an alcoholism case,[38] it will concur with the *Easter* and *Driver* results. Nevertheless, the question necessarily arises as to what trial judges may and should properly do in the interim.

Certainly, there can be no question but that the *Easter* decision should immediately be implemented in the District of Columbia courts. And as shall be related in a moment, most of the trial judges in the District of Columbia Court of General Sessions have done a laudable job under very trying circumstances. This will be discussed in some detail below, because it is a case study of what a truly responsible local court can do to lead the way to new procedures for handling chronic inebriates in its community.

The response of the trial courts in the five States that comprise the Fourth Circuit has thus far been disappointing. A few courts have accepted the *Driver* decision as the controlling law, and have implemented it. The vast majority of the courts, however, have not applied it.[39]

Those courts in the fourth circuit which have chosen not to apply the *Driver* decision have apparently done so on two bases. First, some have concluded simply that a decision by a U.S. court of appeals—even on an issue of Federal constitutional law—is not binding upon State courts until the State supreme court or the U.S. Supreme Court adopts it. This is an erroneous conclusion. It would make the Federal judicial system virtually unworkable. The *Driver* decision is presently the controlling law in every trial court throughout each of the five States which make up that Circuit, and must be enforced.

The second way in which local courts have avoided the *Driver* decision is by refusing to raise the defense of alcoholism *sua sponte* for any defendant, regardless of his record. It requires little imagination to realize that the average skid row derelict does not read the Federal Reports, much less the newspapers, and has no knowledge whatever about his legal rights. Even if he did think, in some vague way, that he might have a defense to the charge of intoxication, he probably could not begin to understand the ramifications of raising that defense. And of course, many of these derelict defendants appear before the court in only a semiconscious or confused state, and few are represented by counsel.[40] Thus, unless the trial judge *sua sponte* assumes the obligations of protecting the rights of these men, those rights will never be protected.

In those areas where the judges have not *sua sponte* raised the defense of alcoholism, it has very seldom been raised by the defendants. Joe Driver, himself, has been convicted for public intoxication in Durham on more than one occasion after the Fourth Circuit handed down the decision which bears his name.[41] This perversion of justice is intolerable in a civilized society.

Putting aside the District of Columbia and the Fourth Circuit for a moment, the question arises whether trial judges in jurisdictions where no comparable case has yet

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[30] The programs instituted by these trial courts, in an attempt to stem the tide of alcoholism, should now be transferred to other public agencies which will have available to them far more extensive and more effective resources of the types described later in this paper. The reason for transferring responsibility for rehabilitation from the courts to other public agencies is not because the courts have failed in their attempts in this area, but rather because this is a prerequisite to removing the entire problem of public intoxication from the criminal law system. To the extent that police, court, and probation officials continue to attempt to provide treatment for alcoholism, the entire criminal approach to alcoholism will necessarily remain. On the other hand, it is abundantly clear that the compassion of such judicial leaders as Judge Harrison of Des Moines and Judge Burnett of Denver, who were responsible for early court programs of this type, must be retained in any new programs that are developed if they are to succeed. See, e.g., U.S. Department of Health, Education, and Welfare, *Proceedings of the Conference on the Court and the Chronic Inebriate* (Apr. 23, 1965).

[31] *Sweeney* v. *United States*, 353 F. 2d 10 (7th Cir. 1965).

[32] In the District of Columbia, the probation program conducted by the Court of General Sessions for chronic alcoholics has now been abandoned, because the *Easter* decision precluded placing alcoholic defendants on probation to the program.

[33] *Budd* v. *California*, Calif. Sup. Ct., Jan. 6, 1966 (unreported), cert. denied, 385 U.S. 909 (1966). The Supreme Court has, of course, made clear on several occasions that its refusal to hear a case does not indicate its views on the merits of the question raised. See, e.g., *United States* v. *Carver*, 260 U.S. 482, 490 (1923); *Brown* v. *Allen*, 344 U.S. 443, 451–452 (1953).

[34] Budd was convicted of public intoxication in the Municipal Court for the Oakland-Piedmont Judicial District, County of Alameda, Calif. No written opinion was rendered. The California Superior Court affirmed this conviction, without opinion. When no further appeal within the State was available, instead of seeking direct review in the U.S. Supreme Court, Budd filed a habeas corpus petition in the California Supreme Court, which denied the writ, again without opinion. Budd then sought certiorari from the California Supreme Court ruling. The California Supreme Court decision may well have rested on the ground that Budd had already had an opportunity to litigate his constitutional claim. And it is well-settled that where there may be a valid and independent non-Federal basis for the State court's decision, the Supreme Court will not review it. See, e.g., *Murdock* v. *Memphis*, 87 U.S. (20 Wall.) 590, 636 (1875); *Herb* v. *Pitcairn*, 324 U.S. 117, 125–126 (1945). The Attorney General of California contended in response to Budd's petition for certiorari that the Supreme Court lacked jurisdiction of the case because of his failure to seek direct review. Mr. Justice Fortas, who with Mr. Justice Douglas dissented from the denial of certiorari, took pains to refute this procedural contention, which suggests that it may indeed have been the basis for the majority's refusal to hear the case.

[35] *People* v. *Hoy*, No. 51563.

[36] *Commonwealth* v. *Owens*, Middlesex Superior Court, Docket No. 74393, on certification to the Massachusetts Supreme Judicial Court.

[37] *Seattle* v. *Hill*, No. 39050.

[38] On Apr. 3, 1967 the Travis County Court in Texas convicted Mr. Floyd Powell of public intoxication and fined him $50. The court found Powell a chronic alcoholic but rejected his common law and constitutional arguments that he could not properly be convicted for public intoxication. Under Texas law, no further appeal is possible within the State. A notice of appeal and jurisdictional statement will be filed in the U.S. Supreme Court under 28 U.S.C. § 1257(2), which permits a direct appeal (rather than a petition for a writ of certiorari) where a State statute is challenged on Federal constitutional grounds and the validity of the State statute is upheld.

[39] See New York Times, Apr. 10, 1966, p. 56.

[40] See, e.g., *D.C. Crime Commission Report* 478.

[41] See, e.g., Washington Star, Nov. 25, 1966, p. B-6; "Recorder's Court Cases in Durham," Durham Morning Herald, Oct. 4, 1966.

been decided can or should implement those decisions in their own courts, if they believe them to be a proper statement of law.[42] Some trial judges believe that, until an appellate decision is handed down in their jurisdiction, they are compelled to follow the old view of the law even though they disagree with that view. This is an erroneous concept of a trial judge's responsibility to the community.

A trial judge has an obligation, usually stated in his oath of office, to uphold the Federal and State constitutions. That obligation is far deeper, and far more compelling, than the principle of stare decisis. If a trial judge is convinced that the *Easter* and *Driver* decisions are correct statements of the law, he is obligated to implement them in his own court without waiting for an appellate court to order him to do so. A municipal court judge in California took it upon himself to declare the local intoxication law unconstitutional, and it has not been seriously suggested that he overstepped his judicial authority.[43]

Many of the judges who have chosen not to follow the *Easter* and *Driver* decisions have done so because of a sincere conviction that it would be more inhumane to throw derelict alcoholics back out into the streets, to an uncertain fate, than it would be to throw them into jail, where they will at least be cared for. No one can quarrel with the sincerity of these judges. But what passes for humanity in the short run becomes cruel punishment in the long run.

Judicial acquiescence in the criminal handling of alcoholics virtually precludes ever breaking out of the revolving door method of processing alcoholics through the courts and jails. To the extent that the judiciary permits a community to continue to handle derelict alcoholics as criminals, the community may have little or no incentive to change that procedure. Edmond Burke once wrote that "All that is required for the triumph of evil is that good men remain silent and do nothing." [44] If the good men in the judiciary and the bar remain silent and do nothing, the *Easter* and *Driver* decisions could go down in history as theoretically intriguing, but practically meaningless, judicial aberrations. And the evil of handling alcoholics as criminals could be perpetuated.

One example of what a vigorous and conscientious local court can accomplish may be seen in the work of the District of Columbia Court of General Sessions since the *Easter* decision was handed down on March 31, 1966.[45] A majority of the judges in that court concluded that they were obligated to raise the defense of alcoholism *sua sponte* for virtually all of the defendants who appeared in drunk court charged with public intoxication. As of October 31, 1966, exactly 3,229 individuals had been adjudged chronic alcoholics, and therefore can never again be convicted of public intoxication in the District of Columbia.[46] And only a handful of those 3,229 individuals raised the *Easter* defense by themselves. In virtually all cases the trial judge raised the issue *sua sponte* and referred the defendant to a court psychiatrist for diagnosis.

The response of District of Columbia officials to the *Easter* decision had initially been one of disinterest and disinclination to act.[47] The Court, by making it clear that the decision would be implemented vigorously, soon forced public officials to abandon this posture of indifference.

These public officials then attempted to put into operation wholly inadequate procedures which, in effect, would have done no more than to change the sign over part of the local workhouse to read "Hospital" rather than "Jail." The Court responded by refusing to commit any adjudicated alcoholics to this new so-called health facility for treatment, when testimony proved that it was still essentially a penal institution and that adequate treatment for alcoholics was not available there.[48]

As a result, comprehensive treatment programs and modern facilities are now being developed. These new programs and facilities would not be forthcoming were it not for the courage and sense of community responsibility of our local judges. This was judicial integrity at its pinnacle. The District of Columbia, and judges throughout the country can take great pride in these men.

Some might think that the press and the citizens groups in the District of Columbia would have heaped abuse upon the judiciary for releasing this tremendous number of derelict alcoholics upon the community. These derelicts certainly did not present a pleasing sight to the eye, and some undoubtedly died who might have lived had they been sent to jail.[49] But the public did not blame the judiciary. Just the opposite was true. The judiciary has been publicly praised for refusing to continue to punish intoxicated alcoholics, in spite of the community problems this has raised.[50] But the public press, [51] citizens groups,[52]

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[42] It should be noted that, in addition to the District of Columbia and Fourth Circuits, two other circuits have also indicated that they would agree with the *Easter* and *Driver* decisions. See *Fultz* v. *United States*, 365 F. 2d 404 (6th Cir. 1966); *Sweeney* v. *United States*, 353 F. 2d 10 (7th Cir. 1965). Other recent cases have also applied the disease concept of alcoholism to the field of social security law and employment law. *Lewis* v. *Celebrezze*, 359 F. 2d 398 (4th Cir. 1966); *Schompert* v. *Celebrezze*, W.D.N.Y. No. 10,937, May 24, 1966, reprinted in 112 Congressional Record 22718 (Sept. 22, 1966) (daily ed.); *News Syndicate Co.*, 44 L.A. 308 (1964). Thus, it would appear that *Easter* and *Driver* now represent the prevailing view in this country.

[43] *People* v. *Dobney*, Los Angeles Mun. Ct. No. D475555, May 12, 1966, reprinted in 112 Congressional Record 22718 (Sept. 22, 1966) (daily ed.), rev'd on other grounds, Los Angeles Superior Ct. App. Div. No. CRA6963, Oct. 14, 1966.

[44] Burke, letter to Thomas Mercer.

[45] The D.C. Crime Commission has reported on the confusion in court procedures during the first few months after the *Easter* decision. *D.C. Crime Commission Report* 487—488. For the most part, however, this confusion was engendered by the failure of District of Columbia officials to offer any meaningful assistance to the court in handling the problem that arose, coupled with the policy of continuing to arrest known alcoholics. The judiciary was thus caught in a squeeze between the arrest and nontreatment policies, and the confusion that resulted was not of its own making.

[46] As of May 10, 1967, 4,496 individuals had been adjudged chronic alcoholics in the Court of General Sessions.

[47] See Washington Post, Oct. 9, 1966, p. B-3.

[48] See Washington Post, June 21, 1966, pp. A-1 and B-1; Washington Star, June 21, 1966, page A-1; Washington Post, June 22, 1966, pp. A-24 and C-1; Washington Star, June 22, 1966, p. C-16. Under well-settled law, patients committed under civil procedures may not be detained in a penal institution. *Benton* v. *Reid*, 231 F. 2d 780 (D.C. Cir. 1956); *Miller* v. *Overholser*, 206 F. 2d 415 (D.C. Cir. 1953); *White* v. *Reid*, 125 F. Supp. 647 (D.D.C. 1954); *White* v. *Reid*, 126 F. Supp. 867 (D.D.C. 1954; *In re Maddox*, 351 Mich. 358, 88 N.W. 2d 470 (1958). Committed patients are, moreover, entitled to adequate medical treatment under the least restrictive circumstances feasible. *Rouse* v. *Cameron*, D.C. Cir. No. 19863, Oct. 10, 1966; *Creek* v. *Stone*, D.C. Cir. No. 20563, May 1, 1967; *Lake* v. *Cameron*, 364 F. 2d 657 (D.C. Cir. 1966) (en banc); Bassiouni, *The Right of the Mentally Ill to Cure and Treatment: Medical Due Process*, 15 DePaul L. Rev. 291 (1966). Senator Tydings has stated that, "a judge who fails to make certain that adequate treatment is available, and sends an alcoholic to a treatment facility simply because it is there and it is not filled, is not discharging his judicial obligations in a wise and humane way." Tydings, *The Chronic Alcoholic: A Challenge to the Efficient Administration of Justice*, address to the Washington, D.C. Area Council on Alcoholism, reprinted in 113 Congressional Record H6004, H6006 (May 23, 1967).

[49] See, e.g., Washington Post, June 23, 1966, p. A-3.

[50] See *Report of the Ad Hoc Committee on Alcoholism of the District of Columbia Public Health Advisory Council* 9-12, 19-20 (June 24, 1966):

> The Ad Hoc Committee wishes to make clear its position that the responsibility for the unfortunate deaths of alcoholics on the streets, and in the jails awaiting trial, certainly does not rest either with the police or with the judiciary. It rests, instead, with the District of Columbia Commissioners and with the District of Columbia Department of Public Health. P. 10.
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> The Ad Hoc Committee wishes to commend the judiciary for its responsible handling of this matter during the past 2 months. P. 10.

See, also, Tydings, *The Chronic Alcoholic: A Challenge to the Efficient Administration of Justice*, address to the Washington, D.C. Area Council on Alcoholism, reprinted in 113 Congressional Record H6004 (May 23, 1967).

[51] See, e.g., the following editorials: Washington Post, July 19, 1964, p. E-6; Jan. 26, 1966, p. A-20; Mar. 17, 1966, p. A-20; Apr. 3, 1966, p. E-6; Apr. 15, 1966, p. A-20; May 8, 1966, p. E-6; May 30, 1966, p. A-16; June 22, 1966, p. A-24; July 8, 1966, p. A-16; July 21, 1966, p. A-22; Aug. 21, 1966, p. E-6; Dec. 26, 1966, p. A-18; Mar. 25, 1967, p. A-8; Washington Star, Jan. 28, 1966, p. A-12; Mar. 26, 1966, p. A-4; Apr. 5 1966, p. A-12; July 4, 1966, p. A-14; Washington Daily News, Apr. 1, 1966, p. 22; Washington Catholic Standard, Apr. 7, 1966, p. 8; June 16, 1966, p. 8; July 14, 1966, p. 6; Oct. 6, 1966, p. 8.

[52] See *Report of the Ad Hoc Committee on Alcoholism of the District of Columbia Public Health Advisory Council* 13 (June 24, 1966), which criticized the "prevalent opinion within the District of Columbia Government, that the current crisis in the handling of chronic alcoholics should be ignored, or at best treated as a public relations problem, rather than dealt with as a health matter."

and the bar association [53] have severely criticized the District of Columbia officials who have failed to provide public health facilities for derelict alcoholics.[54] And the same attitude would prevail in any community in the United States in which the judiciary and the bar similarly had the courage to lead the way to new, more humane procedures for the handling of its chronic inebriate population.[55]

B. With regard to the police handling of chronic inebriate offenders, it is not a false arrest for a policeman to charge an unknown inebriate with public intoxication, even after the *Easter* and *Driver* decisions. A policeman should not be required, at his peril, to make a judgment on the street as to whether an intoxicated individual is or is not a chronic alcoholic.

When a policeman knows or has reason to believe that an inebriate is a chronic alcoholic, however, a far more difficult legal issue is raised. To some, the availability of the defense of chronic alcoholism still seems more properly an issue for the courts than for the police.[56] But to a growing number of responsible lawyers in the District of Columbia who have watched daily arrests of men who have been adjudged chronic alcoholics after the *Easter* decision, any police detention of a known chronic alcoholic for his public intoxication should be condemned as illegal, as well as unconscionable.[57] This is, therefore, still an uresolved issue.

But more important than the technical legal question of false arrest is the broad community policy involving the handling of derelict alcoholics. There is no reason why the police should be burdened with the ignominious task of daily sweeping chronic inebriates off the public streets and into the courts. I was called upon in the District of Columbia to assist a man who had been arrested 39 times during the period March 31 through September 6, 1966. When the amount of time he spent incarcerated in jail and in various hospitals was considered, this amounted to one arrest for every 2 days he appeared on the public streets.[58] Certainly, the answer to the *Easter* and *Driver* decisions is not simply to arrest derelict alcoholics, duly bring them to trial, and then immediately return them to the streets without assistance, only to repeat the process the very next day. This only speeds up the revolving door, and furthers persecution, degradation, and deterioration of chronic inebriates. It cannot contribute to the elimination of these abuses, as the *Easter* and *Driver* decisions demand.

As a result, judges in the District of Columbia have ordered that no known chronic alcoholic should be brought before the court again on charges of mere public intoxication.[59] The courts should go even further. Lists of people previously adjudicated as alcoholics should be sent to every police precinct within the community, with instructions that these people cannot properly be held on charges of mere public intoxication.[60]

But even more basic, the police can and should take two immediate steps on their own to end the revolving door process, pending development of a broader community program that will be discussed below. First, they should assist any drunken person to his home, whenever that is possible. Second, if an individual is unable to take care of himself, the police should assist him to an appropriate public health facility where he can receive the necessary attention.[61] Under no circumstances should the police arrest known alcoholics time and time again.

The question arises, of course, whether the police may properly assume responsibility for intoxicated individuals and escort them to an appropriate public health facility to receive proper medical attention. If the inebriate does not give informed consent, would the police incur liability for a false arrest?

The police have duties of a civil nature, in addition to their responsibility for enforcing the criminal law. When a policeman escorts a heart attack victim to the hospital, he certainly is not arresting him. Thus, the police have both a right and a duty to take unwilling intoxicated citizens, who appear to be incapacitated or unable to take care of themselves, whether or not they are alcoholics, to appropriate public health facilities.[62]

Nevertheless, law enforcement officers have expressed considerable apprehension about the possible liability of policemen for false arrest under these circumstances. Certainly, this question should be resolved immediately, preferably by enactment of a statute,[63] in order to lay the necessary legal foundation for the proper medical handling of intoxicated alcoholics.

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[53] See *Report of the Committee on Mental Health on Facilities for Treatment of Alcoholics in the District of Columbia* (Sept. 28, 1966), approved and transmitted by the Bar Association of the District of Columbia to the District of Columbia Board of Commissioners on Oct. 7, 1966.

[54] The *D.C. Crime Commission Report* found the response of the District of Columbia government to the *Easter* decision "totally inadequate," reflecting "a basic lack of planning by the city government." Pp. 486, 488. It stated that "responsibility for the gross inadequacy of treatment services for alcoholics rests with the Board of Commissioners and the Department of Public Health," since "although the unanimous holding in *Easter* was widely anticipated throughout the community, no effective steps were taken to prepare for it." Pp. 488–489. The Commission characterized this failure to care for derelict inebriates as "a callous disregard for human life." P. 491. The report stated that based on the responses of District officials to the *Easter* ruling, the "Commission has substantial doubts that they have the requisite determination or expertise to execute a comprehensive treatment program for alcoholics." P. 492.

[55] See, generally, Abbott, *Citizen Attitudes and Public Responsibility*, North American Association of Alcoholism Programs Rep. No. 34 (Nov. 1, 1966).

[56] See Judge McGowan's concurring opinion in *Easter*, 361 F. 2d at 60 n. 1.

[57] On Oct. 14, 1966, D.C. Court of General Sessions Judge Hyde commented from the bench in drunk court that District policemen may face false arrest suits if they continue to arrest for public intoxication persons known to have previously been adjudged chronic alcoholics. See Washington Star, Oct. 14, 1966, p. A–1; Washington Post, Oct. 15, 1966, p. B–1. In conceding during the *Easter* litigation that determination of alcoholism would properly be made at trial rather than at the time of arrest, defense counsel did not anticipate the pattern of daily arrests of known alcoholics, resulting in virtual persecution of chronic inebriates, that followed. See e.g., n. 58 infra and accompanying text.

[58] See Memorandum in Support of Motion to Reopen Proceedings, *District of Columbia v. Strother*, D.C. Ct. Gen. Sess. Crim. No. DC–25861–66 (Sept. 14, 1966).

[59] Judge Hyde ordered, beginning Oct. 15, 1966, that the names of defendants charged with public intoxication shall be checked against the court's master list of chronic alcoholics when they are transferred from the police precinct stations to the cellblock in the basement of the court. Those already adjudged chronic alcoholics were released immediately, without coming before the court. See Washington Star, Oct. 16, 1966, p. B–2.

[60] This recommended procedure has not been instituted in the District of Columbia or elsewhere. Beginning in January 1967, however, the D.C. Court of General Sessions instituted a new procedure for handling public intoxication defendants under which, as the D.C. Crime Commission recommended, virtually no one is convicted for public intoxication. Under this procedure, previously adjudicated alcoholics are referred for treatment or are released without appearing before the court. A public health nurse reviews the records of those not previously adjudicated alcoholics and interviews those whose records show some indication of a drinking problem. Of the defendants interviewed, those who are diagnosed as alcoholics and so adjudged by the court are either referred for treatment or released. Those not interviewed, or interviewed but not adjudged alcoholics, are nolle prossed and are referred to a new court program, the Citizens Information Service (CIS), funded under the Law Enforcement Assistance Act. CIS attempts to determine what type of problem led to the appearance in court, and then channels the individual into appropriate community resources. In this way, incipient alcoholism problems may be headed off before they can become serious.

[61] Delerium tremens, the severe withdrawal symptoms suffered by chronic alcoholics when they stop drinking, range from convulsions to hallucinations, and require medical care. They are more dangerous to the life of the individual than are any of the manifestations of withdrawal of morphine. World Health Organization Expert Committee on Alcohol and Alcoholism, *Report*, Tech. Rep. Ser. No. 94, at 6–7, 11 (June 1955); Johnson, *The Alcohol Withdrawal Syndromes*, Q.J. Stud. Alcohol, Supp. No. 1, at 66 (November 1961). The *D.C. Crime Commission Report* at 476 noted that 16 persons arrested for intoxication died while in police custody in 1964–1965. See, generally, the Correctional Association of New York and the International Association of Chiefs of Police, *Alcohol and Alcoholism: A Police Handbook* (1965).

[62] A person would be deemed incapacitated or unable to take care of himself if he is unable to make a rational decision about accepting treatment. People not incapacitated could be offered treatment or might voluntarily request it, but could not be taken into protective custody. The *D.C. Crime Commission Report* at 497 concluded that the common law permits this type of protective custody, relying upon *Orvis* v. *Brickman*, 196 F. 2d 762 (D.C. Cir. 1952) and long-standing custom, but nevertheless recommended enactment of a protective custody statute to dispel any doubts. The police have discretion to act upon reasonable grounds and cannot be required to make a difficult diagnosis on the street, but neither the common law nor a protective custody statute could properly be construed to permit indiscriminate street-sweeping of all derelict inebriates. See *Plancich* v. *Williamson*, 57 Wash. 367, 357 F. 2d 693 (1963); *Forsythe* v. *Ivey*, 162 Miss. 471, 139 So. 615 (1932); *Christiansen* v. *Weston*, 36 Ariz. 200, 284 p. 149 (1930).

[63] Legislation has been introduced in Congress to accomplish this objective for the District of Columbia. H.R. 6143, Title VIII of H.R. 7327, S. 1515, and S. 1740, 90th Cong., 1st Sess. (1967).

Once new procedures are instituted for handling the chronic court inebriate as a public health problem, the police will be happy to cooperate. The police have long suffered under the public's command that they daily sweep this human refuse from the streets, a task which provides no redeeming benefit either for their unfortunate victims or for the community. They will be delighted to see the old system replaced by procedures that will allow them to help these people back on the road to recovery, rather than just to push them further down into their sodden skid row environment.[64] The failure of our society in the past to handle the chronic drunkenness offender in a humane way rests not with the police, but rather with State and local government officials who have directed that this problem be handled under the criminal law rather than as a public health and welfare matter.

C. With regard to the handling of chronic alcoholics by prosecuting attorneys, it is instructive to refer to the Canons of Ethics of the American Bar Association. Canon 5 provides that "the primary duty of the lawyer engaged in public prosecution is not to convict, but to see that justice is done." [65]

This does not mean, of course, that a prosecutor is obligated to defend the very man that he is prosecuting. It does mean, however, that he is obligated to make certain that an innocent man is not convicted. And in the context of the *Easter* and *Driver* decisions, this means that a prosecuting attorney is obligated either to drop the charges, or at the very least to inform the judge of the relevant facts, whenever he has reason to believe that a defendant may have available to him the defense of chronic alcoholism.[66] It is then up to the judge to protect the defendant's rights.

A truly responsible prosecutor, moreover, would take it upon himself to review a defendant's record prior to any court proceeding, and to make appropriate recommendations to the court on his own motion. The prosecutor is, after all, an arm of the court, and a representative of the community. As such, he cannot properly remain indifferent. He should instead take affirmative steps to make recommendations for the noncriminal handling of any chronic alcoholic he is assigned to prosecute.

Of course, prosecutors are not qualified to diagnose alcoholism. In most instances, however, the alcoholic defendant's past record will readily demonstrate a drinking problem, and will be quite sufficient to lead a prosecutor to recommend to the court that an appropriate medical examination be made. In short, there are any number of ways in which prosecutors may responsibly exercise their public duty to assist the alcoholics with whom they come in contact in their daily work.

In the District of Columbia and Fourth Circuits, the prosecuting attorneys in the drunk courts have chosen to take no position whatever with regard to the applicability of the *Easter* and *Driver* decisions to individual defendants. Hopefully, this attitude will change voluntarily.[67] If it does not, however, the courts have an obligation to require these prosecuting attorneys to live up to their responsibilities. Trial judges have the power to enforce standards of professional conduct by all attorneys who appear in their courts. Any attorney who fails to live up to the Canons of Ethics should not be permitted in the courtroom, whether he is a prosecuting attorney or counsel for the defense.

D. Similarly, correctional officials should have little or no responsibility for the treatment of chronic alcoholism. If prosecuting attorneys and the judiciary adequately perform their functions, chronic alcoholics will no longer populate the country's prisons, as they currently do.[68] And it is quite clear that a prison setting is hardly the atmosphere in which to attempt to rehabilitate a chronic inebriate offender.

There will remain in the prisons, nevertheless, some who have been properly convicted of more serious crimes, who have a drinking problem unrelated to those crimes. It would obviously be wise for public health, welfare, and rehabilitation personnel to work with correctional officials to provide appropriate treatment for these people while they are still in jail, in order to head off future alcoholism problems.

E. The primary responsibility for developing practical programs for helping chronic inebriates necessarily rests, however, with doctors, nurses, social workers, and other health and welfare personnel working in the area of alcoholic rehabilitation. A judge can find an alcoholic not guilty of a given crime with which he is charged and release him, but he cannot order State or Federal officials to build health facilities and develop adequate rehabilitation programs. A prosecutor can, similarly, only exercise his discretion to prosecute or to drop charges. And a lawyer can defend a chronic alcoholic charged with crime, but cannot offer him the treatment necessary to prevent similar court appearances day after day after day. In the last analysis, we must all rely upon the health, welfare, and rehabilitation professions to initiate humane new civil procedures and programs to replace the present criminal procedures.

These personnel will readily find that, if new procedures for handling chronic inebriates are presented, the police, the courts and the local attorneys will offer their full cooperation. But the disconcerting point is that up to now the health and welfare professions have not greeted the *Easter* and *Driver* decisions with the sense of challenge and responsibility that had been hoped for. Now is the time for them to step forward with imagination and dedication, to present new procedures for handling inebriates, new treatment programs designed to rehabilitate alcoholics, and new legislative proposals to develop an appropriate legal structure under which these objectives may be properly pursued.

One would hope that these new procedures will come voluntarily from the health and welfare professions. If they do not, however, then the legal profession as a whole—the judiciary, the prosecutors, and the local bar—should take every step possible to force these new programs into existence. The legal profession has long assumed the duty of a public protector of the rights and liberties of all citizens. It must be as zealous in protect-

[64] See, e.g., the testimony of Col. Edward L. Dowd, President of the St. Louis Board of Police Commissioners, before Subcommittee No. 3 of the U.S. House of Representatives on the District of Columbia on H.R. 6143 (Apr. 10, 1967).

[65] See also *Berger* v. *United States*, 295 U.S. 78, 88 (1935); Jackson, *The Federal Prosecutor*, 24 J. Am. Jud. Soc'y 18 (1940).

[66] The *D.C. Crime Commission Report* at 488 concluded that "the Corporation Counsel had at the very least an obligation to call the court's attention to facts such as prior record or adjudication which suggested chronic alcoholism."

[67] Since the *D.C. Crime Commission Report*, prosecutors in the District of Columbia Court of General Sessions have worked closely with public health personnel and the judges in carrying out the *Easter* mandate.

[68] See *D.C. Crime Commission Report* 481–483.

ing the rights of derelicts as it is in protecting the rights of those citizens who are more fortunate in life. Humane results can be obtained in any community which is fortunate enough to have a wise and compassionate judiciary and bar.

IV

This necessarily raises the question as to what type of new noncriminal procedures might be adopted for handling chronic inebriates.

For purposes of analysis, one can properly separate the derelict, or skid row, or homeless inebriates, on the one hand, from the inebriates who do have homes, families, and personal resources upon which they can rely. Although the derelict inebriates represent a relatively small portion of the total alcoholic population—ranging from 3 to 15 percent, depending upon the statistics on which one chooses to rely—they obviously represent virtually the entire chronic inebriate problem in the courts and jails.

As already discussed, any inebriate who has a home and family to take care of him should promptly be escorted to that home by the police, rather than arrested. Of course, if it appears to the policeman that the inebriate is in medical danger, he should either take the man directly to a medical facility or inform his family that medical help would appear to be required.

Perhaps at some future time, when the problem of handling drunken derelicts has been solved, communities will be able to provide public facilities and programs for inebriates who are not direct public charges. But at this time, when communities cannot even begin to handle their drunken derelict population, there is no reason why they should also attempt to take charge of those who do have resources of their own, beyond making certain that they get back home safely. Thus, public resources should be concentrated almost completely upon the derelict chronic inebriate.

The question must then be squarely faced whether the traditional criminal method of handling inebriates who have no home or other resources should be retained or discarded. It should be recognized that not all of the derelict inebriates found on the streets will have available to them the defense of chronic alcoholism provided by the *Easter* and *Driver* decisions. Some do drink voluntarily and therefore, under current statutes and case law, are subject to arrest and conviction until they become alcoholics.[69]

Is there any valid public policy reason why a legislature should brand an intoxicated person, who is causing no public disturbance, as a criminal? We must face reality. The public intoxication laws in the District of Columbia never have been, and never will be, enforced uniformly upon the public as a whole.[70] And the situation throughout the rest of the country is no different. Police do not pick up intoxicated party-goers emerging from elegant dinner parties or suburban country clubs. There are as many intoxicated people in the streets of the exclusive residential areas in the cities as there are in the skid row areas, and very few of the prosperous and respectable drunks are arrested. Public intoxication statutes typically are enforced against the poor and, in particular, the homeless man.[71]

Should this country, as a civilized nation, enact criminal laws aimed solely at a very small, virtually defenseless, esthetically unacceptable segment of our population, with the intent of simply sweeping them off the streets and into oblivion? The public intoxication statutes now on the books have no redeeming social purpose, regardless of the issue of alcoholism, and they should not be retained.[72]

Even worse, by substituting criminal sanctions for public health measures, these statutes preclude the use of preventive techniques to head off incipient alcoholism problems. Common sense demands that public health and welfare programs be brought to bear on the incipient alcoholic as early as possible, when he first publicly exhibits a problem and has a good prognosis for recovery, rather than utilizing criminal sanctions and ignoring the problem until he reaches the stage of full blown alcoholism where his prognosis for recovery is much poorer. The present criminal procedures guarantee perpetuation of the derelict inebriate problem throughout the country.[73]

Nor can public intoxication statutes be defended as necessary to maintain the public safety. Disorderly conduct statutes are quite sufficient to protect the public from physical harm. These statutes should be retained and fully enforced.

What, then, should be done with derelict inebriates found intoxicated on the streets? A new three-part program should be instituted.

First, an inebriate who, in the judgment of the police, is unable to take care of himself, should be brought to a detoxification center that is staffed with public health personnel, to receive whatever medical help for his acute intoxication may be necessary.[74] This should be a voluntary facility. The individual might be required to remain there for some specified period of time in order to make certain that he will again be able to take care of himself when he leaves. But he will not have been arrested, and could not be detained for a longer period against his will.

Second, an inebriate who has a drinking problem should be encouraged to remain for perhaps 1 or 2 weeks in an inpatient diagnostic center, where a complete work-up can be prepared on his medical, social, occupational, family, and other personal history. This should also be a

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[69] But see the writings of Judge Murtagh supra, n. 6 who persuasively argues that public intoxication cannot constitutionally be designated a crime because only activity that substantially interferes with the rights of others can be considered criminal in nature. Judge Murtagh's thesis has not been tested in the courts.

[70] See *D.C. Crime Commission Report* 475–476:

> Members of the Department were encouraged not to make an arrest if the inebriated person was accompanied by someone who could take care of him, if he was close to his home and could get there safely, or if he would take a taxicab and go home.

[71] See, generally, Kleiboemer & Schneider, *The Law on Skid Row*, 38 Chicago-Kent L. Rev. 22 (1964).

[72] U.S. Attorney General Katzenbach, in testifying on July 22, 1965, before an ad hoc subcommittee of the Senate Judiciary Committee on the Law Enforcement Assistance Act of 1965, stated that "of the approximately 6 million arrests in the United States in 1964, fully one-third were for drunkenness." He suggested that "Better ways to handle drunks than tossing them in jail should be considered." Later, in appointing the members of the D.C. Crime Commission, the President specifically suggested as one area of special study:

> (5) diagnosis and noncriminal treatment of sociomedical problem offenders (e.g. alcoholics * * *). *1 Weekly Compilation of Presidential Documents 5 (Aug. 2, 1965).*

The *D.C. Crime Commission Report* at 495 concluded that public intoxication should no longer be a criminal offense:

> The Commission believes that public intoxication alone should not be a crime in the District of Columbia. Criminal sanctions should be restricted to individuals who, in addition to being intoxicated, behave in a disorderly manner so that they substantially disturb other citizens.

The report noted that "disorderly conduct" would not include "Persons who are simply noisy, unable to walk properly, or unconscious." Id. at 496.

[73] The *D.C. Crime Commission Report* at 486 concluded:

> The resort to criminal sanctions has completely failed. Periodic commitments to a penal institution were a misguided solution, failing to meet either the alcoholic's immediate health needs or the more basic problems underlying his illness. Reliance on short-term criminal remedies allowed health authorities in the District of Columbia to neglect their responsibilities to deal effectively with the problem of chronic alcoholism. To this extent, therefore, the use of the criminal law to punish alcoholics was responsible for helping to perpetuate the chronic drunkenness offender problem in the District.

[74] A detoxification center should, of course, be affiliated with, and constitute an integral part of, the general medical services of a general hospital. Indeed, all aspects of a program for the control of intoxication and alcoholism must be coordinated with, and integrated into, broad community health planning. See, e.g., H.R. 6143 and S. 1740, 90th Cong., 1st Sess. (1967).

completely voluntary facility. A genuine offer of meaningful assistance should be the only inducement used to persuade an inebriate to make use of it. And it is indisputable that never before in this country's history has any community reached out to these unfortunate people with such an offer.

Third, a network of aftercare facilities should be established to provide food, shelter, clothing, vocational rehabilitation, and appropriate treatment, rather than simply dumping the derelict back onto skid row. Perhaps the most important aspect of this part of the program would be residential facilities, to provide an entirely new atmosphere that will, hopefully, reverse the process of degradation that has gradually forced the derelicts down to their present position. Indeed, without residential facilities located in the community, no rehabilitation program has a chance for any significant success. As with the other facilities, this should be entirely voluntary.

A new program of this nature should not contain a long-term residential inpatient treatment facility of the type now used to house the mentally ill. Any such facility must be rejected on both medical and legal grounds.

First, experts in the field of alcoholism rehabilitation state that involuntary commitment for treatment is unnecessary. They say that even the so-called hopeless, hard-core cases will voluntarily respond if only someone will reach out to them, draw them in, and support them in the crises that inevitably accompany their struggle to leave skid row.[75] They blame the gross inadequacies of existing facilities and programs, and the public's traditional hostility toward alcoholism—not any unwillingness of the alcoholic to respond—for the present massive alcoholism problems in this country.

A second reason for opposing involuntary commitment procedures is on constitutional grounds, which will be discussed below. Suffice it to say here that there is no more constitutional basis for depriving a chronic alcoholic of his freedom to choose or reject medical treatment than there is for the involuntary treatment of any other ill person who is suffering from a noncontagious disease.

Of course, the type of program outlined will not eliminate the problems of public intoxication or alcoholism. Nothing ever will. There will undoubtedly remain a number of inebriates who will not significantly change their ways regardless what type of treatment program is either offered voluntarily, or forced involuntarily upon them. The question of how these people should be handled must therefore forthrightly be faced.

Since communities can no longer handle them as criminals, as a result of the *Easter* and *Driver* decisions, only two choices remain. They can either be warehoused involuntarily on some type of an alcoholic farm, or they can be processed through the type of voluntary treatment program described above.

It would be unwise to institute a warehousing system. Those who are close to the treatment of alcoholics state that they are not willing ever to write off the possibility of helping even the most hard-core chronic inebriates. They cannot determine ahead of time who can be helped, or how long it may take. In their judgment, warehousing of alcoholics, regardless how incalcitrant they may seem, is not medically warranted. And a warehousing program would be patently unconstitutional.[76]

Compulsory or involuntary treatment for alcoholism is unjustifiable from a legal standpoint except in three limited areas. First, in a situation where a person is not mentally competent to make a rational decision as to whether he wishes to undergo treatment, a court has a right and a duty to make that decision for him. Thus, if a person is mentally incompetent and also is an alcoholic, involuntary treatment may be appropriate. But this is the very rare case. The vast majority of chronic alcoholics do not suffer from any mental illness that would render them, when sober, unable to make a rational decision about treatment. For most alcoholics, therefore, involuntary treatment is not appropriate.

Some would argue that any person who fails voluntarily to accept treatment for his alcoholism must *ipso facto* be considered incompetent to make a rational choice. This is obviously fallacious.[77] A person who chooses not to undergo surgery for heart disease is not considered mentally incompetent to make that choice. Nor is a person who chooses not to undergo any other form of medical treatment for a noncontagious disease, that might be considered by the majority of the population to be an obviously intelligent step. In a free society, the choice of the individual to accept treatment or to reject it must be respected.

Second, when a derelict alcoholic becomes so debilitated that he is virtually dying on the street he is obviously not competent to make a rational choice about treatment. A court should have the power, under those limited circumstances, to commit him for treatment until he once again is capable of making a rational choice. But this does not mean an indeterminate sentence, or indeed any commitment longer than about 30 days. The unfortunate plight of the derelict inebriate cannot lead society to deprive him of his liberty on humanitarian grounds any more than it should lead society to deprive him of his liberty on criminal grounds. The former is as unconstitutional as the latter.

The third limited area where compulsory or involuntary treatment for alcoholism is justified from a legal standpoint is where the alcoholic exhibits a pattern of behavior caused by his intoxication that directly and substantially endangers the safety of other persons. Communities will not, and need not, tolerate dangerous behavior caused by alcoholics, any more than they must tolerate the public appearance of a person infected with a contagious disease or any other dangerous behavior. The public may properly obtain protection from any such behavior as long as the injury threatened is of a physical rather than an esthetic or other merely irritating or unpleasant nature, and as long as there is a strong likelihood of injury rather than just an imagined, theoretical, or speculative possibility. Even then, however, both humane and legal principles demand that treatment be made available in order to rehabilitate the offender and

[75] See, e.g., *D.C. Crime Commission Report* 499 & n. 123.

[76] See n. 48, supra. The D.C. Crime Commission recognizes that "the constitutionality of a civil commitment law for alcoholics, in the absence of a criminal charge, is far from clear," and recommends that harmless alcoholics (those not charged with disordery conduct) be treated entirely on a voluntary rather than an involuntary basis. *D.C. Crime Commission Report*, 499. See, also, *State* v. *Ryan*, 70 Wis. 676, 36 N.W. 823 (1888). The sole situation in which the Commission concluded that even "short-term" involuntary commitment of harmless alcoholics may be justified is where they are "severely debilitated" and therefore "pose a direct threat of immediate injury to themselves." The Commission recognized that many homeless alcoholics have "poor diagnoses, and may never become self-sufficient," and recommended that:

> For these unfortunate people, simple humanity demands that we stop treating them as criminals and provide voluntary supportive services and residential facilities so that they can survive in a decent manner. *D.C. Crime Commission Report* 501.

See, also, *State* v. *Robards*, 224 La. 588, 70 So. 2d 135 (1953); Hutt, *Recent Forensic Developments In The Field of Alcoholism*, 8 Wm. & Mary L. Rev. 343, 354–358 (1967).

[77] *Cf. United States* v. *MacLeod*, 83 F. Supp. 372 (E.D. Pa. 1949), where the trial judge concluded that a chronic alcoholic who was not suffering from a mental illness was, when sober, mentally competent to stand trial on a criminal charge. If a sober alcoholic is competent to stand trial, or make a contract, or vote, he is also competent to decide whether to accept or reject treatment for his illness.

to avoid further behavior inimicable to the public safety in the future.[78]

From a purely medical viewpoint, it would appear that compulsory treatment is unethical under principles long accepted by the American Medical Association,[79] and reaffirmed at Nuremberg[80] and Helsinki[81] after World War II. The medical profession has traditionally respected the right of the patient to choose treatment or to reject it. No patient who is mentally competent may be treated against his will, regardless of the legal concepts involved. Physicians have no more right to play God than do lawyers or judges. Thus, although the medical profession can and rightly should use every reasonable form of persuasion to convince alcoholics to accept appropriate treatment, those who choose not to accept it must have their decision respected.

Finally, from a wholly practical standpoint, mass commitment of alcoholics for involuntary treatment simply would not work. In the District of Columbia, for example, there are a minimum of 6,000 derelict chronic inebriates, and well over 50,000 chronic alcoholics of all walks of life. There are an additional 50,000 alcoholics in the surrounding suburban areas. At the time of the *Easter* decision, there were less than 50 inpatient beds and a small outpatient clinic in the District of Columbia that could be used to treat this enormous number of alcoholics. At the present time, there are only about 550 inpatient beds, even if facilities are stretched as far as possible, and perhaps slightly improved outpatient facilities, but still no residential facilities located in the community. If compulsory treatment procedures were utilized, how could the District of Columbia handle 6,000 derelicts, or a total of over 50,000 chronic alcoholics of all kinds, with only 550 beds and a small clinic?

And one must recognize that the facilities of the District of Columbia are among the best that exist in any city in the United States today. If there is a problem there, one can imagine the problem that exists in other parts of the country. In many places, there is not a single bed available to treat these people.

Of what use, then, would it be to have mass civil commitment to nonexistent facilities? Communities would be reverting to the dark years when the mentally ill were chained to walls in the basements of hospitals that were medical facilities in name only. Incarceration in a health facility would become no less cruel a form of punishment for alcoholism than incarceration in a prison.[82] This cannot be allowed to happen. If for no other reason, voluntary treatment is a practical necessity.

And even then, there are grave doubts that any community in this country can even remotely begin to handle the alcoholics who would voluntarily flock for useful treatment, if it were available. Certainly, experience in the District of Columbia demonstrates that it will be many years before even those who are begging for help can be provided proper treatment.

This raises the final point that should be considered, the extent of the community resources that should be allocated for the treatment of chronic inebriate derelicts. There are many competing considerations for the social welfare dollar in today's budget. It is difficult to justify neglecting children's health and education, on which the entire future of this country necessarily depends, in order to treat derelict alcoholics a little more humanely. And this obviously is not the solution.

What can be done, however, is to start by taking the resources that have previously been used to handle inebriates on a criminal basis, and to convert them into public health, welfare, and rehabilitation resources. In the District of Columbia, for example, the former women's penal institution has been converted into a modern public health inpatient facility for alcoholics.[83]

At some future time, hopefully, the policemen who ordinarily spend much of their time sweeping the streets of drunken derelicts will be released from that unpleasant and unnecessary chore, in order that they can get back to the business of fighting serious crime. The amount of time spent by police in the District of Columbia Court of General Sessions simply waiting for a drunk to be run through the usual conviction process, before he can once again go out to the community and perform the more valuable functions that the police should be performing, is appalling.

There are no reliable data on the actual increase or decrease in cost that would result in the short and long runs from handling public intoxication as a public health rather than a criminal matter. Some penologists insist that the total cost to the community would be decreased rather than increased, and there are undoubtedly some who believe the opposite. In any event, this is not an area where overwhelming cost must be incurred without demonstrable benefit to the community or substantial savings in other areas. The best of both worlds—humane handling and rehabilitation of the inebriate, and greater protection of the public—can be obtained. Certainly, this must be the goal.

Judges and lawyers are trained in the law. We are not competent to decide exactly what type of noncriminal public health procedures are most likely to result in re-

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[78] *Cf.* Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 Harv. L. Rev. 1288, 1290—1291 (1966).

[79] Section I of the American Medical Association Principles of Medical Ethics states that "the principal objective of the medical profession is to render service to humanity with full respect to the dignity of man." The Judicial Council of the AMA, in interpreting this principle, has stated that:

> The American Medical Association believes that free choice of physicians is the right of every individual and one which he should be free to exercise as he chooses;
>
> Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care, and the American Medical Association vigorously supports the right of the individual to choose between these alternatives * * *.

AMA, *Opinions and Reports of the Judicial Council* 4–5 (1966). The Judicial Council has also ruled that new drugs or procedures may be utilized on a patient only with "the voluntary consent" of the patient. Id. at 9.

[80] The Nuremberg Code for Human Experiment states, as its general principle, that "the voluntary consent of the human subject is absolutely essential."

[81] In 1964 the World Medical Association adopted the "Declaration of Helsinki," consisting of recommended ethical principles to guide physicians in clinical research. Principle II(1) states that where a new therapeutic measure is used, "If at all possible, consistent with patient psychology, the doctor should obtain the patient's freely given consent after the patient has been given a full explanation." Principle III(4a) states that "The investigator must respect the right of each individual to safeguard his personal integrity, especially if the subject is in a dependent relationship to the investigator."

[82] In the Scandanavian countries involuntary treatment was substituted for criminal punishment of derelict inebriates in 1893, on the rationale that "what cannot be inflicted as punishment cannot be objected to when it is done to take care of a person:"

> Special institutions should be created for them, and they would not be called prisoners, but inmates. So medicine became a justification for the kind of sentence that law itself could not justify. In practice, most skid row alcoholics serve in a very severe prison for a much longer period than the great majority of our ordinary prisoners do for ordinary crimes.
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> * * * * *
>
> What is interesting here is the way words, concepts, and even ideals have been taken out of one context (medicine) and used very efficiently in another one (a legal framework) to curb minorities who have little power to fight back.

Christie, *The Scandanavian Hangover*, in Trans-action, January-February 1967, pp. 34, 37.

[83] See Washington Star, Nov. 15, 1966, p. B-1; Washington Post, Dec. 28, 1966, p. B-1. Although this provides an adequate inpatient facility, its usefulness has been virtually nullified by the lack of outpatient aftercare and residential facilities. The *D.C. Crime Commission Report* at 493–494 noted that "chronic alcoholics require community oriented treatment so that they can gradually readjust to urban living," and warned that "Confining them in a rural institution and then suddenly depositing them back in the city without extensive aftercare support is likely to cripple the rehabilitative process."

habilitation of chronic inebriates. But we are competent, and we do have the duty, to make certain that the present criminal procedures are not continued. The public cannot be expected to respect a system of criminal justice that condemns sick people to jail because they are sick.[84] Nor can the public respect a system of public health and welfare care that condemns derelict chronic alcoholics to a lonely death on the streets. Drastic changes in the handling of chronic inebriates in communities throughout the country are long overdue, and trial judges have the responsibility and the power to initiate those changes immediately.

[84] Samuel Butler recounted the cruelty of punishing the sick in ch. XI of *Erewhon*. One victim of the practice was convicted of "pulmonary consumption" and sentenced to "imprisonment, with hard labor, for the rest of your miserable existence." In his oral opinion, the judge reproached him:

> It is intolerable that an example of such terrible enormity should be allowed to go at large unpunished. Your presence in the society of respectable people would lead the less able-bodied to think more lightly of all forms of illness; neither can it be permitted that you should have the chance of corrupting unborn beings who might hereafter pester you.
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> * * * * *
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> But I will enlarge no further upon things that are themselves so obvious. You may say that it is not your fault. * * * I answer that whether your being in a consumption is your fault or not, it is a fault in you, and it is my duty to see that against such faults as this the commonwealth shall be protected. You may say that it is your misfortune to be criminal; I answer that it is your crime to be unfortunate.

SOME MAJOR ISSUES IN DEVELOPING COMMUNITY SERVICES FOR PERSONS WITH DRINKING PROBLEMS [1]

by Thomas F. A. Plaut

Contents

What prompts major American mental health agencies to focus attention on alcohol problems at this time? There is an increasing awareness of the magnitude of these problems and of the very sizable number of persons with drinking problems seen by many agencies—psychiatric as well as nonpsychiatric. In addition there is a growing realization that neither mental health programs nor other helping services have taken a substantial leadership role in providing care and treatment for these patients.

In recent years psychiatry and allied mental health professions have shown signs of overcoming their traditional lack of concern about alcohol problems. Less than two years ago the American Psychiatric Association issued its first position statement in this area, "Concerning Responsibility of Psychiatrists and Other Physicians for Alcohol Problems" (February 1965). The establishment of a national center for the prevention and control of alcoholism within the National Institute of Mental Health indicates both an awareness that additional governmental activity is required and that mental health professions (and agencies) should be in the forefront of such activities. This national center, while administratively part of the National Institute of Mental Health, is to be the focal point for Federal programs in the Public Health Service and within the Department of Health, Education, and Welfare that bear on alcohol problems. In addition, it is likely to be the principal focus for all Federal government activities in this area.

The initial reports of the Cooperative Commission on the Study of Alcoholism will be published in the fall. This major 5-year project, supported by a grant from the National Institute of Mental Health, has undertaken a broad examination of many aspects of American alcohol problems. The policy volume from this Commission will urge that community mental health programs take a major role at the local level in the developing and strengthening of treatment services for persons with drinking problems. Also forthcoming in 1967 is a report by the joint information service (of the American Psychiatric Association and the National Association for Mental Health) on a study of psychiatric treatment services for problem drinkers.

These varied approaches all emphasize that psychiatric personnel and agencies should mobilize their own resources, and those of other agencies, to deal more effectively with alcohol problems. During the recently completed nationwide mental health planning activities, 22 States established separate alcoholism committees or task forces. However, over half of the States did not administratively identify this as a separate area for study. Even among the 22 States singling out this problem, in the majority of instances little or no effort was made to

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[1] Background paper prepared for Surgeon General's conference with the Mental Health authorities, Washington, D.C., December 1966.

integrate the planning of alcoholism services with that of other mental health services. In too many States the alcoholism planning was left to individuals, often narrow in their orientation, who were unable to take advantage of this opportunity to bring the care and treatment of problem drinkers more into the mainstream of psychiatric services and of other community agencies. The recent passage by the 89th Congress of the comprehensive health planning and public health services amendments of 1966 (Public Law 89–749) provides another opportunity to overcome the continued isolation and disregard of alcohol problems. Under these amendments the Federal government will meet 100 percent of the costs of statewide health planning activities during the two fiscal years ending June 30, 1968. This comprehensive health planning is to take advantage of and build upon already existing State plans—including the mental health planning activities referred to above. There then is a challenge for all health medical care agencies to insure that appropriate attention is given to alcohol problems in the development of these State plans—and it is likely that leadership in this regard often will need to be provided by the State mental health authorities.

American attitudes toward drunkenness and toward drinking continue to influence and complicate efforts to develop effective alcoholism programs. These attitudes, including the accompanying ambivalence and residuals of the prohibition controversy, must be understood and dealt with if progress is to be made in mobilizing professional interest and activity in this area.

THE MAGNITUDE AND IMPACT OF PROBLEM DRINKERS ON PSYCHIATRIC AND OTHER AGENCIES

Large numbers of problem drinkers are in contact with various helping agencies. While these persons often are identified as problem drinkers, in many instances they receive little or no treatment for their drinking problems.

The impact of problem drinkers on major American care-giving agencies is illustrated by the following statistics. In 1964 there were slightly under 70,000 first admissions of male patients to the nearly 300 State mental hospitals in the United States. Over 15,000 patients, approximately 22 percent, were given a diagnosis of alcoholism at the time of their admission.[2] Among women patients the proportion with alcoholic diagnoses was much lower—only 5.6 percent. Because problem drinkers generally have a short duration of stay in mental hospitals (in California averaging less than two months), the proportion of resident patients with an alcoholic diagnosis is far lower—generally under 6 percent of all patients.

In nine States, alcoholic disorders lead all other diagnoses in mental hospital admissions. Maryland, for example, reports that 40 percent of all male admissions are for alcoholism.[3] There is substantial variation among States in the proportion of male admissions with an alcoholism diagnosis. Some examples of the percentages for different States are: Louisiana 25 percent, Maine 12 percent, Ohio 19 percent, Oklahoma 5 percent, Pennsylvania 14 percent, Tennessee 21 percent, and Virginia 26 percent.[4] The majority of these patients are not psychotic, and in many States most are admitted on a voluntary rather than a committed basis. Most still have some ties to their families, and the majority are upper lower class or lower middle class.

The number of psychiatric wards in general hospitals is rapidly increasing, and currently more patients are admitted annually to these wards than to the State mental hospitals. The proportion of patients who are alcoholic is virtually identical to the figure for mental hospitals. In 1964, 22 percent of the men and 5.9 percent of the women discharged from community based psychiatric facilities were diagnosed as alcoholic.[5] Here too there was substantial variation from State to State. Some examples of the percent of all patients discharged from the psychiatric wards of general hospitals who had an alcoholic diagnosis are the following: California 34 percent, Illinois 15 percent, Iowa 19 percent, Minnesota 29 percent, Michigan 35 percent, and New York 20 percent. In these facilities too, the duration of stay for alcoholic patients is short—often lasting for only a few days, i.e., until the detoxification is completed.

Over 550,000 adult patients are seen each year in general psychiatric clinics.[6] While the proportion of these patients diagnosed as alcoholics is very small, only 3 to 4 percent, the total number is between 15,000 and 25,000.[7] Here too there is variation between States. In California, for example, where local alcoholism clinics are supported by funds from the State department of mental health, only 1.1 percent of the patients admitted to outpatient mental health clinics were diagnosed as alcoholic.[8] In Maryland the comparable figure was 7 percent—with an additional 10 percent being found to have the symptoms of excessive drinking, but not having been given an alcoholism diagnosis.[9] It is interesting to note that the total number of patients seen annually by the approximately 140 specialized alcoholism clinics probably also is under 25,000.

The impact of problem drinkers on the medical-surgical wards of general hospitals is illustrated by a study in which the extent of drinking problems among 100 consecutive male admissions to a general hospital was determined. No preselection was made in terms of the diagnosis of the patients, and the hospital did not have a psychiatric service. The admitting physicians identified 12 of the 100 men as problem drinkers, and 17 additional cases of probable alcoholism were uncovered by the researcher, making a total of 29 percent.[10] Casefinding of problem drinkers in this population is then relatively easy.

The relation between economic dependency and drinking problems has been much discussed. However, only a few studies have been made of the incidence of drinking problems in welfare caseloads, and there is little information on the causal relation between the problem drinking and dependency. Problem drinking is found

[2] "Patients in Mental Institutions, 1964: State and County Mental Hospitals," U.S. Department of Health, Education, and Welfare. National Clearinghouse for Mental Health Information, Public Health Service Publication No. 1452, pt. II, Washington, D.C., 1966, p. 21.

[3] Statistics Newsletter, State of Maryland, Department of Mental Hygiene, VII–8, Aug. 10, 1965.

[4] "Patients in Mental Institutions, 1964: State and County Mental Hospitals," op. cit.

[5] "Patients in Mental Institutions, 1964: Private Mental Hospitals and General Hospitals with Psychiatric Facilities," U.S. Department of Health, Education, and Welfare. National Clearinghouse for Mental Health Information, Public Health Service Publication No. 1452, pt. III, Washington, D.C., p. 41.

[6] Bahn, A. et al., "Current Services and Trends in Outpatient Psychiatric Clinics, 1963," *Psychiatric Studies and Projects*, Mental Hospital Service of the American Psychiatric Association, vol. 3, no. 7, October 1965.

[7] Ibid., and Bahn, A. K., "Outpatient Psychiatric Clinic Services to Alcoholics, 1959." *Quarterly Journal of Studies on Alcohol*, 24: 213, June 1963.

[8] California Department of Mental Hygiene, "Alcoholic Patients: California State Hospitals for the Mentally Ill, State-operated Outpatient facilities, Short-Doyle Programs," *Biostatistics Section*, Bulletin No. 43, November 1964.

[9] Bahn, A. K., and Chandler, C. A., "Alcoholics in Psychiatric Clinic Patients," *Quarterly Journal of Studies on Alcohol*, 22: 411, September 1961.

[10] Pearson, W. S., "The Hidden Alcoholic in the General Hospital: A Study of 'Hidden Alcoholism' in White Male Patients Admitted for Unrelated Complaints." *North Carolina Medical Journal*, 23: 6, 1962.

in a sizable proportion—estimates range from 10 to 25 percent—of the families of welfare recipients.[11]

Many arrests involve alcohol-related offenses. The impact of problem drinking on the American police-legal system is graphically illustrated by the following figures. In 1965, out of close to 5 million arrests in the United States for all offenses, over 1,535,000 were for public drunkenness (31 percent). In addition, there were over 250,000 arrests for driving while intoxicated. Another 490,000 individuals were charged with disorderly conduct which some communities use in lieu of the public drunkenness charge. Thus at least 40 percent of all arrests are for being drunk in a public place or being under the influence while driving.[12] Two words of caution must be added here. First, many persons arrested for public drunkenness are no more intoxicated than countless other individuals who escape arrest because they are not exposed and vulnerable to police detection as are skid row men. The public is more likely to insist on the police removing the unshaven, toothless, poorly clothed men than an equally drunk visiting business man! Second, it is not known what proportion of persons arrested for public drunkenness would be considered as having chronic drinking problems. In any case, it appears likely that various health agencies—including mental health programs—will in the future be asked to take more responsibility for the care of some of these persons—particularly those defined as suffering from chronic alcoholism.[13]

Professional workers in various helping fields frequently find many problem drinkers among their cases. Public health nurses, social workers in family agencies, welfare workers, physicians in the emergency wards of general hospitals, parole and probation workers, clergymen and lawyers report that problem drinking is one of the most frequent medical-social problems they encounter in their day-to-day work. All—or nearly all—of these problem drinkers need help of one sort or another and most behave in ways that cause concern to others and to some part of the community.

Despite the widespread occurrence of problem drinking, and the substantial contact that most persons in helping positions have with problem drinkers, there has been only very limited provision of adequate assistance to these men and women. The problem drinker often creates bafflement, confusion and other mixed feelings not only in those with whom he is closely associated, but also in those who have some opportunity and responsibility to help him.

LOW PRIORITY OF ASSISTANCE TO PROBLEM DRINKERS

In view of the large numbers of problem drinkers in the United States and the extent to which these people are among the clientele of virtually all helping agencies, there has been strikingly little focus on this area by the major professional associations. Psychiatric, medical, social service, or public welfare agencies generally also have not taken the responsibility for insuring appropriate attention to these patients. For example, despite substantial improvement in recent years, medical care for the acute effects of excessive drinking still leaves much to be desired. The fact that a man's condition is due to the intake of large amounts of alcohol has a great impact on how he is handled by hospitals—or by physicians in private practice. One of the factors influencing the medical care is the appearance and stance of patients as they present themselves to the physician.[14]

However, the neglect of the behavioral aspects, i.e., the drinking problem itself, is even more striking. Few physicians are interested in or feel qualified to help a patient overcome his drinking problem. The same can be said of psychiatrists, who often believe that problem drinkers cannot be helped by the same methods used for other psychiatric patients. Problem drinkers constitute only a tiny fraction of total caseloads in psychiatric clinics. While few clinics have explicit policies excluding problem drinkers, generally the staff felt unable to help these patients, and as a result, most alcoholic patients get screened out. Other community agencies, often aware of the lack of interest in psychiatric clinics, do not make referrals. Psychiatric wards of general hospitals rarely admit and never seek out alcoholic patients who have been treated for acute illness in these same hospitals. Most mental hospitals are ambivalent in their attitude toward the many problem drinkers admitted to their wards. The short duration of stay and frequent absence of any real treatment for these patients are indicative of this attitude.

Let us compare the reaction of mental hospital staff to three patients. The first is a schizophrenic man admitted to the hospital for the third time in a two-year period. The staff will be concerned about him, will wonder how the treatment could be improved this time. Second is a man admitted for the third time in the same period because of a suicide attempt. Again the hospital staff will be concerned, but also puzzled, perhaps a bit disappointed, and they may consider keeping the man in the hospital longer. The third returning patient is a problem drinker. Here, the reaction is more likely to be one of irritation, anger, and even punitiveness. Comparison with the suicidal patient is particularly instructive, because "self-inflicted" elements also are clearly present in that condition. However, the negative reaction to the alcoholic patient is likely to be far stronger—and less sympathetic.

Until very recently—and it is still substantially true—there were three major stepchildren of the mental health field. Many persons are affected by these three problems and all are areas where psychosocial understanding is needed in care and treatment. The three conditions are (1) mental retardation; (2) problems of old age; and (3) problem drinkers. And there probably is more potential for interrupting destructive life styles and improving social functioning among problem drinkers than with either of the other two conditions. Thus it is all the more striking that mental health professionals and mental health agencies generally have shied away from giving leadership in the care and treatment of these patients.

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[11] See: a. "Monthly Report Bulletin," County of Westchester (New York), Department of Public Welfare, vol. 4, No. 10, October 1964.
b. "Public Assistance Cases Where Alcohol is a Factor Contributing to Need," 1965. Wyoming State Department of Public Welfare.
c. "Massachusetts Mental Health Planning Project Report, Task Forces on Alcoholism," Department of Mental Health, 1965.
d. Wass, D. K., "Public Welfare and the Drinking Problem," *Progress*, The Alcoholism Foundation of Alberta, vol. VI, no. 4, pp. 64–68, June 1964.

[12] All figures from: "Crime in the United States—Uniform Crime Reports—1965." Federal Bureau of Investigation, U.S. Department of Justice, Washington, D.C., 1966.

[13] Two recent court decisions are of particular importance in relation to this question. *Driver* v. *Hinnant, N.C.* (U.S. Fourth Circuit Court of Appeals), Jan. 23, 1966; and *Easter* v. *The District of Columbia* (U.S. Court of Appeals for the District of Columbia), Mar. 30, 1966, bar the criminal punishment of alcoholics for the offense of public drunkenness.

[14] Wolf, I., Chafetz, M. E., Blane, H. T., and Hill, M. J., "Social Factors in the Diagnosis of Alcoholism: II. Attitudes of Physicians," *Quarterly Journal of Studies on Alcohol*, vol. 26, no. 1, March 1965.

Individual and institutional responses to problem drinking cannot be understood without examining certain characteristics of normal American drinking practices. Alcohol use in our society is surrounded with many ambivalent attitudes and ambiguous norms. Serving drinks is an intrinsic part of being a good host—in contemporary hospitality patterns. Yet it is unclear how much one should drink, and considerable guilt and discomfort may accompany overdrinking. Drinking is associated with pleasure, with indulgence of impulses in a culture that still retains strong elements of an older ethic stressing the importance of hard work, of self-control, and of personal responsibility. Drunkenness generally is disapproved. Many people react with disgust to it—especially in situations where they feel it is entirely inappropriate. Because most Americans get pleasure from their drinking, and are able to control it adequately, there is a tendency to feel that the problem drinker should also be able to control his drinking. The uncertain reactions to drunkenness point up the lack of clearly defined standards in relation to the use of alcoholic beverages. Less dramatic, but in some ways more significant, are signs of this uncertainty evidenced by the frequent jokes about drinking. Expressions such as "sneak a quick one" and "have a blast" suggest an immaturity or mild guilt feeling which rarely accompanies socially accepted behavior.

The complicated feelings that most Americans have about their own and other persons' use of beverage alcohol probably have delayed the development of more adequate services for problem drinkers. Despite the increasing awareness that problem drinkers need help, there remains a strong belief that the condition is self-inflicted, i.e. that the man could stop his destructive drinking if he really wanted to. The heritage of prohibition and the long history of moral and religious controversy about drinking have contributed to the mixed attitudes of laymen as well as professionals toward persons with drinking problems. The polarity between "wet" and "dry" positions still exerts a major influence. Both problem drinkers and those responsible for their care participate to some extent in the deeply based confusion of feelings about drinking and problem drinking that is characteristic of our culture as a whole.

Further difficulty has been created by the confusion of the medical and behavioral aspects of the condition. Because problem drinkers may require medical attention for immediate (or long-term) consequences of drinking, there is a tendency to stress the importance of medical management to the exclusion of psychosocial management. This is demonstrated in the almost universal isolation, at least in the United States, of detoxification services from services of a psychosocial nature. Some physicians, as well as laymen, have sought to define alcoholism as a disease or illness in the classical medical sense rather than a psychiatric problem or behavior disorder. Many members of Alcoholics Anonymous, at least in the past, have been quite reluctant to focus on the emotional and psychosocial aspects of problem drinking.

For many years it was believed that problem drinkers could not be helped; that their recovery was impossible. While there is increasing evidence that this negative view is not justified, strong pessimism still remains about helping problem drinkers. The residual feelings that problem drinking is a self-inflicted condition, that inability to control one's drinking is a sign of moral weakness or inadequacy also influences reactions to successful and unsuccessful cases. The latter are vividly recalled and the former may be quickly forgotten. The "slips" of problem drinkers are far more likely to be considered evidence of failure than are comparable setbacks of other patients. The setting of unrealistic goals, i.e. expecting almost immediate total abstinence, has added to feelings of pessimism about helping these patients. Further, the cultural ambivalence undoubtedly often has made it more difficult for therapists to develop appropriate helping relationships with these patients and this has increased the number of failures. Finally, many problem drinkers do present difficult therapeutic challenges—this, however, is true also of other psychiatric patients, especially those generally referred to as character disorders. Some psychiatric workers with experience in treating problem drinkers feel that viewing the drinking problem primarily as a symptom of other underlying psychological difficulties has made more difficult the treatment of these patients. There is, however, no unanimity in this view.

Large numbers of problem drinkers have, of course, been helped by professional agencies, by psychiatrists, by other physicians and by Alcoholics Anonymous. In addition, there are persons who had serious drinking problems for a number of years and then stopped having difficulty with alcohol, even in the absence of assistance from either AA or any professional source of help. Such spontaneous recoveries, of course, are not unknown in the field of general psychiatry either. The continued persistence of pessimistic views about the treatment of problem drinkers, in the face of considerable evidence to the contrary, demonstrates the tenacity of public and professional ambivalence about alcohol use and abuse.

CURRENT SERVICES FOR PERSONS WITH DRINKING PROBLEMS

EMERGENCY MEDICAL CARE

There are six principal settings in which the acute consequences of excessive alcohol intake are managed: (1) Medical and emergency services of general hospitals; (2) psychiatric wards of general hospitals; (3) special detoxification facilities; (4) mental hospitals; (5) patients' homes or doctors' offices by private physicians; and (6) jails or other holding facilities. The avoidance of delirium tremens and the treatment of lesser withdrawal symptoms is the objective of such care. Because this emergency medical care is now rather well understood it is all the more shocking that preventable deaths of severely intoxicated persons still occur.

Large numbers of acutely intoxicated persons appear at or are brought to the emergency services of voluntary and municipal general hospitals. Here they may wait long periods of time before receiving care; accident victims and other patients often receive priority. Many hospitals are reluctant to admit intoxicated persons, particularly if they are medically indigent, to the general medical wards unless this is required as a lifesaving measure. The treatment provided in general hospitals usually is very limited; rarely are any attempts made to deal with the drinking problems or to develop a plan for the patient's continuing treatment. Referrals to psychiatry or social service departments or to other community agencies—including AA—are infrequent.

Patients with alcohol intoxication account for close to 20 percent of all male admissions in the psychiatric services of many general hospitals. The average duration of stay is extremely short—less than 1 week. A few patients are transferred to State mental hospitals, but most are released directly to the community without any plans for aftercare or continuing treatment. Patient care usually consists exclusively of sedation and drugs to manage the detoxification and to handle any agitated behavior that might occur. Psychiatric care directed at the underlying drinking problem rarely is provided.

State mental hospitals often admit patients with alcohol intoxication as the major diagnosis. In some hospitals such patients account for over 20 percent of all male first admissions. However, there is great variation both between States and within States in the policy of mental hospitals regarding the admission of intoxicated patients. Some hospital superintendents feel that detoxification is primarily a nonpsychiatric responsibility and should be undertaken by general hospitals rather than psychiatric institutions; others view the mental hospital as the patient's last resource and are more open in their admissions policy. Duration of stay in mental hospitals for these patients is relatively short, except in hospitals with special alcoholism units (see below). Generally little effort is made to involve the patient in any kind of a continuing treatment program and many leave the hospital almost as soon as the medical crisis has passed. Planning for aftercare and referral to community agencies occurs only very rarely.

More men are "dried out" in jails than in all other kinds of facilities combined. While not all men arrested for drunkenness require medical care, even superficial screening is only rarely provided. Each year most large cities have several deaths of intoxicated persons in the jail. Even if the recent Circuit Court decisions on public drunkenness are applied on a nationwide basis, there will still be an urgent need to provide alternative means of caring for indigent intoxicated persons. The street-cleaning function in relation to public drunkenness is likely to remain in police hands for years to come.

The actual medical management of alcohol intoxication, while requiring experience and skill, is not a task of overwhelming difficulty. Some hospitals have treated thousands of cases without any deaths that can be attributed to the alcohol intoxication itself. Most of the deaths occurring in jails and hospitals are preventable: That they nevertheless occur is a severe indictment of both the medical profession and community leaders who permit these conditions to persist. The lack is not in medical or technical knowledge, but in necessary organizational skills and institutional arrangements.

All detoxification services should undertake diagnostic assessment of their patients. Treatment of drinking problems or referral to appropriate community resources should be an integral part of such services. It may be preferable for this type of acute medical care to be offered through general hospitals, but in any case, the care should be closely tied in with these hospitals and with community based psychiatric services, i.e. community mental health centers.

INPATIENT CARE

State mental hospitals are the major setting providing residential treatment directed at altering the patient's drinking behavior. Very large numbers of men and women with drinking problems are admitted annually to State mental hospitals. Approximately five times as many men as women patients have such a diagnosis. Nearly half of the patients are between the ages of 45 and 64, and almost half are admitted on a voluntary rather than a committed basis.

While most of the State mental hospitals still provide only minimal treatment, other than medical detoxification, for patients with drinking problems, over 10 percent of these hospitals now have special alcoholism wards or programs. Some of these programs provide very good care and treatment for problem drinkers. The stimulus for the development of such special programs has been varied—usually the interest of one member of the hospital staff has provided the original incentive; State mental health departments have only rarely taken the leadership role in initiating the alcoholism programs. The three most frequently used therapeutic approaches are: (1) Didactic lectures, discussions, and movies; (2) group psychotherapy; and (3) AA meetings. On most wards the staff encourage patients to continue informal discussions about their drinking problems outside of these group meetings. The widespread use of didactic procedures is based on the belief that a problem drinker needs to have an intellectual understanding of the condition from which he suffers: that with such an understanding the patient can consciously exert substantial control over his drinking. These approaches also are seen as a means of increasing the patient's motivation for help.

Therapeutic community and milieu therapy concepts are applied in many alcoholism wards. The morale of both patient and staff often is high—there is a spirit of mutual cooperation and a belief that patients can receive help from the staff and from one another. As is true in most general mental hospital wards, intensive individual psychotherapy is not regularly used. In part this is because of the shortage of personnel, but, in addition, it

reflects the professional opinion that individual psychotherapy is not appropriate for many of these patients.

Many of the alcoholism wards use sedatives and tranquilizers during the first days or week of the patient's stay in the unit. Vitamin injections also often are given to help build up the patients physically. Generally, however, the hospital staff seeks to have the patients entirely free of medication long before release from the hospital.

A most serious shortcoming of the mental hospital alcoholism programs is the almost total absence of aftercare and followup activities. Rarely are arrangements made for patients to continue treatment with a community agency after their release from the hospital. The hospital staff does not have time for this type of work; it may not even be familiar with the few community resources that do exist. Collaboration with public welfare (and vocational rehabilitation) agencies is increasing. Some units also try to place patients in contact with AA groups in their home community prior to release from the hospital.

In many hospitals with alcoholism programs only minimal use is made of the other hospital services—psychology, social service, vocational rehabilitation, occupational therapy, recreational therapy, religious counseling, etc. In addition, psychiatric residents, psychology interns, social work students and nursing trainees often are not assigned to the alcoholism wards. This reflects both the isolation of the alcoholism programs from the rest of the hospital and the relatively low status that these programs have within the total hospital system.

In summary, the alcoholism programs in State mental hospitals represent a significant and major effort to provide inpatient treatment for problem drinkers. However, such programs exist only in a minority of all mental hospitals and even in these hospitals they often serve only a minority of the problem drinkers admitted to the hospital. Despite many shortcomings, such as understaffing, inadequacy of aftercare arrangements, isolation from the rest of the hospital, possible overemphasis on didactic approaches to the exclusion of others, and some instances of rigidity in treatment ideology, there is much that other mental hospitals and community mental health centers can learn from these programs.

In many respects similar to mental hospital programs, are the small number of special alcoholism treatment units run under the auspices of State alcoholism programs. While some of these units are better staffed and more adequately funded than the mental hospital programs, they serve only a fraction as many patients as do the mental hospital wards. They are most highly developed in the southeastern part of the United States, and it is only in this region that further expansion appears likely.

OUTPATIENT (CLINIC) CARE

The number of alcoholism clinics has greatly increased in recent years. At present there are over 130 such clinics in the United States, most of which, however, do not operate on a full-time basis. The vast majority of these clinics are psychodynamically oriented and the bulk of the actual treatment usually is provided by social workers. Although most alcoholism clinics use group therapy—both for patients and for relatives—the primary therapeutic modality continues to be individual psychotherapy, casework, and counseling. This therapy is in many ways similar to that of psychiatric clinics, although alcoholism clinic personnel often are more active and directive in their work with patients.

A striking feature of many alcoholism clinics is their willingness to make at least some provisional contact with the patient right away. Although there often are waiting lists for admission to actual treatment, a clinic staff member almost always is available to see the patient at least briefly within a day or two. This type of "crisis-intervention" philosophy is more widespread than in psychiatric clinics. However, only a very small proportion of patients making contact with alcoholism clinics remain for as many as five visits, but this is equally true of general psychatric clinics. There is a tendency for the less educated, more socially disabled and less motivated patients to drop out before a real treatment relationship is established. Alcoholism clinics, like mental health clinics, tend in a variety of ways, to screen out those patients who appear unable to avail themselves of the particular types of therapy being offered by the clinic. Patients labeled as being poorly motivated and not sincere in their desire to do something about their drinking problem often are not accepted for treatment.

Although the alcoholism clinics usually stress to patients that they will have to give up alcohol, many therapists have other goals besides abstinence in mind for their patients. There is concern about overall psychological and social functioning. The drinking problem is viewed in the context of the total personality and attention is directed at helping patients improve their functioning in familial and occupational roles. Most clinics will refer some patients to Alcoholics Anonymous. It is rare, however, for an alcoholism clinic to associate itself directly with AA, i.e. to provide space for group meetings on its own premises. Also, in contrast to the mental hospital alcoholism units, very few of the clinics have recovered problem drinkers as members of their staff.

Some of the strengths of alcoholism clinics are their ready availability to patients, their work with families, their flexibility in combining traditional psychotherapy with more "reality oriented" approaches, and their increased use of group methods. Among the major weaknesses are the failure to provide any real treatment for a substantial proportion of the patients making at least an initial contact with the clinic; lack of experimentation in developing new approaches in working with less verbal, lower class patients; the continuing isolation from other agencies, particularly general psychiatric services, mental hospitals and medical detoxification facilities; and the lack of relationship to basic professional training institutions. Probably the most serious shortcoming of all is the very small number of such clinics.

Despite the relatively large number of persons with drinking problems receiving some treatment in general psychiatric clinics these clinics usually prefer not to work

with such patients. Some even have explicit policies excluding them. Often the clinic staff does not feel qualified to work with these patients or they question whether psychosocial types of treatment can be effective. Psychiatric clinics are even less likely to receive problem drinkers from emergency medical services or from mental hospitals. As psychiatric clinics become integrated with community mental health programs they will probably be in a better position to work with these patients and to develop collobarative relationships with existing alcoholism clinics.

HALFWAY HOUSES

Recent years have seen the expansion of halfway houses (or recovery homes) for problem drinkers. Residents in these facilities are expected to obtain a job as soon as possible and to pay a certain amount weekly for their room and board. The majority of these houses have been developed through the efforts of AA members and (a much smaller number) through the efforts of church organizations. Most of the facilities are small, providing care for less than 30 persons.

Although some halfway houses are beginning to work with professional agencies, the only treatment program usually is AA meetings. The staff of the houses generally are recovered problem drinkers who work for very little salary beyond room and board. The financial situation of the houses often is quite precarious and a significant proportion of such homes have eventually been forced to close. Despite the name (halfway houses) most residents come directly from the community rather than from a mental hospital or correctional institution. There are strict rules about abstinence in the homes and maintenance of a mutually supportive antialcohol culture is an essential character of these houses. The residents often are not skid row men, although many have had uneven employment histories and are separated from their families.

The future of halfway houses is still uncertain. They have arisen to fill a critical void in community services for problem drinkers. Existing and future halfway houses should establish better working relationships with other helping agencies and adequate means must be found to place the houses on a sounder financial basis.

SHORTCOMINGS OF TREATMENT SERVICES FOR PROBLEM DRINKERS

(1) Medical care facilities, psychiatric agencies, social agencies, public welfare departments, etc., often are reluctant to provide care and treatment for problem drinkers; they tend to neglect and reject these patients.

(2) Certain services, generally available to patients with other disorders, often are denied to problem drinkers by policy or practice. These include hospital insurance coverage, admission to general hospitals, assistance by public welfare agencies, voluntary admission to mental hospitals, and participation in most mental hospital aftercare programs.

(3) The understanding of the nature of problem drinking and of its management is often very limited in general helping agencies.

(4) Where care and treatment is provided for problem drinkers it may be narrow and segmented. That is, adequate assessment of the patient's total problems and potentialities is lacking. Only limited aspects of the patient's life situation and various problems are dealt with. Continuity of care, especially between inpatient and outpatient services and between medical services and behaviorally oriented ones, usually is absent.

(5) Agencies serving problem drinkers generally prefer to work with the most motivated, the best educated and the most socially intact patients. Little care and treatment usually is provided to those who do not meet these criteria.

(6) The specialized alcoholism services—mental hospital programs, alcoholism clinics, and halfway houses—often are isolated from the other community helping agencies.

PROVIDING ADEQUATE COMMUNITY SERVICES FOR PROBLEM DRINKERS

Below are listed some essential characteristics of services for problem drinkers:

(1) A range of different services must be provided—emergency, inpatient, outpatient, and intermediate. These services must be interrelated to insure continuity of care and optimal utilization. It is not necessary that all such services be under a single administrative auspice. However, they do need to be properly coordinated and linked with one another.

(2) The services must be of sufficient magnitude to meet the need. For example, 10 halfway house beds in a city of 500,000 are totally inadequate to the needs for this type of care.

(3) Services for problem drinkers should be staffed primarily by personnel skilled in assisting patients with psychological and social problems.

(4) Medical facilities serving problem drinkers should be equipped to deal with behavioral as well as medical aspects. Medical treatment of the acute and chronic effects of excessive drinking only rarely influences basic drinking problems.

(5) Facilities must serve a wide range of problem drinkers. Different agencies will have to offer services to different types of problem drinkers. Since many agencies currently prefer clients from higher socioeconomic groupings,[15] there should be services of equal quality for different social class groups—and each will have to be attuned to the particular characteristics of that subculture.

(6) Services for problem drinkers must be coordinated with the major care-giving services in the community—mental health, public health, medical care, public welfare, etc. Large numbers of problem drinkers are known to these agencies and it is they who will have to provide much of the help and treatment for these patients.

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[15] Pittman, D. J., and Sterne, M. W., "Alcoholism: Community Agency Attitudes and Their Impact on Treatment Services." National Clearinghouse for Mental Health Information, National Institute of Mental Health, U.S. Department of Health, Education, and Welfare, U.S. Government Printing Office, Washington, D.C., Public Health Service Publication No. 1273.

THE ISSUE OF MOTIVATION

In virtually all facilities providing treatment for problem drinkers, much importance is attached to the issue of motivation.[16] Often the key screening criterion is the patient's motivation (or sincerity) in relation to stopping drinking. Few facilities are interested in working with patients whom they define as inadequately motivated. It is assumed that motivation is an all-or-none phenomenon. If present, then the patient can be worked with; if absent, nothing can be done until the patent really wants to stop his drinking. It is almost as though the motivated patient is seen as worthy of assistance and the nonmotivated one as not. The earlier attitude of rejecting all problem drinkers has been shifted to an acceptance of those who fit a certain image and a rejection of the remainder. Many workers believe there are clear-cut stages through which problem drinkers pass before becoming true alcoholics.[17] In some clinics considerable staff time is spent in determining whether patients are true alcoholics—even though the treatment implications of such labeling are unclear.

The tendency to place the onus on the patient when treatment fails needs to be replaced by the view that each such occurrence is a challenge for the therapist and the agency to develop better and more effective techniques. If current approaches and techniques are effective with only a certain proportion of the target group, then further study and the development of new methods and approaches are required. Evidence is accumulating that changes in the organization, operation, and treatment philosophy of an agency can have a substantial effect on its ability to work with the supposedly unmotivated patient. For example, recent work at the Massachusetts General Hospital [18] has demonstrated that such changes can radically increase the proportion of the referred patients who come into an alcoholism clinic for treatment and who remain in treatment. A similar experiment has been reported in improving the utilization of alcoholism clinic services by women released from a correctional institution.[19] Too frequently the use of motivation as a criterion for the screening of patients functions as a way of excluding those from variant cultural backgrounds, particularly persons from lower socioeconomic strata who are not comfortable with the whole style of operation of most clinics which are geared to middle-class clients. These clinics usually emphasize talking about one's problems, involving other family members in the treatment, and coming in a fixed time every week—all of which amay be alien concepts for many lower class persons.

The necessity of overcoming excessive reliance on a certain type of therapeutic approach is not, of course, restricted to alcoholism clinics. It applies equally to general psychiatric agencies and many other helping services. If mental health centers are to live up to their expectations as true community agencies, they will have to modify and expand the approaches used in the past by most psychiatric clinics and mental hospitals.

IS IT DESIRABLE TO ESTABLISH SEPARATE SERVICES FOR PROBLEM DRINKERS?

It has often been suggested that adequate treatment for problem drinkers can only be provided if a special network of services is established. However, there is increasing agreement that establishing any substantial number of specialized services is neither feasible nor desirable. Many of the services needed by problem drinkers already exist in American communities. The objective should be to insure that these services are strengthened, supported, and made available to problem drinkers on an equal basis with other patients. The establishment of specialized services could weaken rather than strengthen the activities of the key care-givers in assisting problem drinkers. There is evidence that some general care-giving agencies will dump problem drinkers on such specialized services. Or, if there is a specialized inpatient unit in a city, general hospitals are even less likely to admit patients with drinking problems.

There is a danger that specialized services will operate is isolation from the community helping services—thus weakening the effectiveness of these agencies with problem drinkers and reenforcing the belief that alcoholic patients are very, very different from other patients. The presence of even limited special alcoholism facilities may also create the erroneous impression that much is being done for this patient group, that the problem is being handled.

There also is a danger that persons with drinking problems are seen as having difficulties only in relation to their use of alcoholic beverages. It is unusual to find a person who has only a drinking problem—almost always there are also other problems—physical health, social, psychological, or economic. There is a striking tendency for problems to "come in bunches." In some instances these other problems can be viewed as antecedents of the drinking problem—perhaps even as causes. In other cases they have arisen subsequent to the drinking problems, i.e. they may be consequences.

In the organization of services for problem drinkers there must be an awareness that other problems frequently coexist with the drinking problem. These "other problems" often determine where in the community the person with a drinking problem is seen and what types of immediate and long-term treatment he requires. Persons with drinking problems may be hungry or obese, may suffer from diabetes or cancer, may be unemployed, have a fractured leg, be pregnant, or psychotic. Sometimes these nonalcohol problems will need immediate and even continuing attention before the drinking problem can be dealt with; in other instances these problems and the drinking problem will have to be tackled simultaneously. In still other cases no substantial programs can be made until the drinking problem has been dealt with.

There are three major reasons why treatment for problem drinkers should be provided through the basic "helping" services: (1) Drinking problems are of such magnitude that sufficient funds and manpower probably

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[16] Pittman, D. J., and Sterne, M., "Concept of Motivation: Sources of Institutional and Professional Blockage in the Treatment of Alcoholics", *Quarterly Journal of Studies on Alcohol.* 26: 41, January 1965.

[17] See Jellinek, E. M., "The Disease Concept of Alcoholism," College and University Press, New Haven, Conn., 1960.

[18] Chafetz, M., et al., "Establishing Treatment Relations with Alcoholics," *Journal of Nervous and Mental Diseases.* 134: 395, 1962. Prior to the initiation of the new approach very few of the patients referred from the emergency services of the general hospital ever appeared at the alcoholism clinic, and none of those appearing remained in treatment for as long as five sessions. The almost universally held belief was that the kinds of patients receiving assistance at the emergency service were not sufficiently motivated to make use of the clinic. Under the new arrangement, members of the alcoholism clinic staff were assigned to the emergency service and made contact with the patients at this time. This increased the percentage of patients later appearing for an interview at the clinic to 65 percent, and the number staying for at least five visits to 42 percent.

[19] Demone, H. W., Jr., "Experiments in Referral to Alcoholism Clinics," *Quarterly Journal of Studies on Alcohol,* 24: 495, September 1963.

could not be mobilized for a special network except by robbing other needed programs; (2) drinking problems do not exist in isolation from other social, psychological, and health problems. It is inconceivable that any system of specialized facilities could be established to deal adequately with all these associated problems; (3) large numbers of problem drinkers are already known to major care-giving agencies, and often are obtaining some kinds of help from these agencies. The separation of this type of help from assistance for the problem drinking would be unfortunate and possibly even disastrous.

INSURING APPROPRIATE ATTENTION TO PROBLEM DRINKERS—THE ROLE OF SPECIALIZED PERSONNEL AND PROGRAMS

Until work with problem drinkers becomes fully assimilated into the activities of agencies such as mental hospitals, community mental health centers, general hospitals, welfare agencies, health departments, etc., there will be an important role for special alcoholism staffs. However, such specialists should work primarily in educational, catalytic, supervisory, and consultative capacities, rather than solely in direct treatment relationships with alcoholic patients. These specialists can (1) provide consultation to community care-giving services, and (2) stimulate the development of needed mechanisms for the planning and coordination of programs for insuring continuity of care.

There must be some means of insuring proper emphasis in alcohol-related services, lest problem drinkers become lost or "buried" within the larger structure of the agency and the neglect of alcoholic patients continue. The alcoholism specialists seek to bring about social change, to influence agency operations and policy. Their knowledge of the needs of problem drinkers, and about existing services, their understanding of the complex attitudes and feelings about drinking, and their skills in community organization should enable them to assist agencies in providing better services to problem drinkers.

Specialized services for problem drinkers will be needed for certain purposes; to demonstrate that problem drinkers can be helped, to provide a training opportunity for personnel who subsequently will work in other generalized agencies, and to undertake research studies.

THE ROLE OF GENERAL HELPING AGENCIES

While it is a basic thesis of this paper that mental health agencies, especially community mental health centers, can and should have major roles in dealing with alcohol problems they alone cannot provide more than a small fraction of all the care and treatment that is needed. As has already been indicated, a wide range of other community care-giving agencies need to be actively involved in community alcoholism programs. There is increasing awareness that psychiatric agencies alone cannot meet the treatment needs in relation to traditional mental health problems—and this is equally true in relation to drinking problems.

Large numbers of problem drinkers are known to different helping agencies. The personnel of these agencies are in an excellent position to provide varying kinds of assistance to problem drinkers. In addition to case finding and referral (where indicated) they can support and supplement the more specialized help provided to problem drinkers and their families by mental health or specialized alcoholism facilities. In providing assistance to persons with drinking problems such general helping agencies will often need the assistance of the specialized alcoholism personnel referred to in the previous section.

Public health nurses, for example, often are well situated to assist problem drinkers in obtaining help from various agencies. In addition they can work collaboratively with such agencies after the patient has made contact with the more specialized facility. A demonstration program in Boston (at the Massachusetts General Hospital) indicates that public health nurses can supplement the work of an acute psychiatric service by making home visits on cases where the patient has failed to maintain his contact with the service or where other problems are found in the home situation.

Vocational rehabilitation agencies increasingly have expanded their work beyond the traditional areas of physical rehabilitation. Public welfare departments are attempting to shift from an exclusive emphasis on financial support to a greater stress on casework and other social services directed at the numerous social, psychological, and health problems frequently found among welfare recipients. Both rehabilitation and welfare agencies can participate actively in community programs directed at drinking problems.

Medical care, emergency as well as other, obviously is required for some problem drinkers. Mental health agencies, including community mental health centers, will not be equipped to provide such care. This makes urgent the development of far more active collaboration between mental health programs and medical facilities, particularly general hospitals, various outpatient medical programs and nursing homes.

Even aside from public drunkenness offenders a very large number of persons convicted of various crimes are known to have serious drinking problems. Correctional agencies—penal institutions, probation and parole departments—need assistance from mental health agencies, as well as from others, in developing programs and training special staff to provide a broad range of services to the men and women who are their responsibility. These programs and this training should include a major emphasis on problem drinking. The drinking problems of skid row men—and these persons account for the bulk of arrests for public drunkenness—particularly require the collaborative participation of traditional agencies such as welfare departments, medical care facilities, vocational rehabilitation agencies, mental health agencies and the Salvation Army, and also the involvement of newer programs such as economic opportunity and urban development. It is likely that the police-penal system of handling public inebriates will soon be at least partially replaced by other

approaches—especially those of a medical and social welfare nature. Some mental hospitals and medical institutions are already beginning to feel the impact of judges' unwillingness to sentence chronic alcoholics to penal institutions for the offense of public drunkenness. The interrelated medical, psychological, social, and economic problems found among these persons makes essential cooperation and collaborative planning by numerous agencies—some of which may never before have actively working together!

Substantial progress will occur only when the numerous general helping agencies begin to take on responsibilities in relation to problem drinkers that they have failed to assume for far too long. Mental health agencies cannot take on this task themselves. They do, however, have unique contributions to make because of resources at their disposal, particularly trained persons in dealing with psychological and social problems. In addition community mental health programs frequently should be able to provide badly needed leadership for the initiation of comprehensive alcoholism activities at the local level.

THE ROLE OF COMMUNITY MENTAL HEALTH PROGRAMS

There are two related but distinct approaches to community mental health. The first emphasizes that mental health services should be community based, i.e. that patients do not have to go long distances to obtain psychiatric care and that various types of services should be located close to their homes. In this approach the emphasis is still essentially clinical, i.e. in the provision of the best possible care and treatment to patients who see such assistance. The second approach, far more radical in its nature, is heavily imbued with general public health philosophy, i.e. it adds to the clinical dimension a substantially different concern. This view stresses the importance for mental health workers to look beyond individual patients and to ask themselves (and the community) searching questions about mental health problems generally within their area. What are the priority mental health problems of the community? Are there segments of the population in need of treatment who currently are not getting this treatment? Why is such treatment not available to them—or utilized by them? Are there particular points of stress in the community that seem to be accompanied by higher rates of psychiatric disorder? Can anything be done to mitigate and reduce these apparently pathogenic stresses? As is well known this view also stresses the key role of nonpsychiatric agencies and institutions in a broad community mental health program. The community mental health program is seen as the focal point, as a kind of catalyst or "conscience" for the community in relation to psychosocial problems.

Understandably only a minority of psychiatric specialists are familiar with and trained to work effectively along the lines of the second approach to community mental health that is summarized above. Many mental healtht workers remain very skeptical of the scientific bases for this approach—and consequently prefer to function principally as clinicians. Much additional experience is needed with this approach and perhaps quite differently trained personnel will be required before it can be put to an adequate test.

Community programs for dealing with drinking problems require (1) services that are readily accessible to patients and well-coordinated with one another, and (2) a public health-mental health orientation that calls attention to unmet needs, to the role of general helping agencies, to early intervention, to the importance of preventive activities, to the importance of overcoming community resistance to needed action on alcohol problems, and to the relation between drinking problems and other social and phychological difficulties. That is, both elements of community mental health programs are applicable to drinking problems. For this reason mental health programs now have a potential for work in the area of alcohol problems that did not previously exist. Locally based services, a community view of drinking problems, and understanding of the psychological and social issues involved in this area are three prerequisities for comprehensive alcoholism programs. Community mental health programs may be alone in meeting these three criteria.

Community mental health programs can use a variety of different administrative and organizational arrangements in developing alcoholism programs. Many of these probably should be tried on an experimental basis in order to learn more about the strengths and weaknesses of each. Certainly no single model can be proposed at this time. Below are listed some examples of how alcoholism services and programs can be integrated into community mental health activities.

(1) Complete integration of alcoholism services with other activities. Under such an arrangement all services of the program would be open to problem drinkers on an equal basis with other patients. Many psychiatric services state that this is their present policy but, for a variety of reasons, only a few such patients are in treatment with most of these agencies. This arrangement presupposes that staff are sufficiently motivated to work with problem drinkers and that the residual attitudes and prejudices have been overcome. It also assumes that personnel are sufficiently informed and experienced to work effectively with these patients. Such total integration may, however, be quite feasible at some future time.

(2) Special alcoholism services or units within community mental health centers. Under this arrangement, already in operation in certain centers (and planned for others), the services for persons with drinking problems would be physically located within the center and the staff administratively responsible to the director of the center. But these services would have their own personnel, except perhaps in specialized areas such as vocational rehabilitation, occupational and physical therapy. For example, there might be a separate ward for prob-

lem drinkers and/or a special outpatient clinic or day hospital. Ideally trainees from the major mental health professions would rotate through the various services in the center—alcoholic as well as nonalcoholic. Referral of patients and consultation should be relatively easy under such an arrangement.

(3) Special alcoholism services or units as parts of community mental health programs, but not physically located in a center. This arrangement is similar to the one just described except for the physical distance between major mental health services and those for problem drinkers. Administratively the special services would be responsible to the director of the center. Referral and consultation—as well as sharing of trainees—could occur in much the same fashion as under No. 2, but might be slightly more difficult to work out because of the lack of spatial proximity.

(4) Special alcoholism programs not administratively part of the community mental health programs but well coordinated with them. In communities where well-established and adequately staffed alcoholism services already exist, formal administrative integration with the mental health program may not be either possible or desirable. However, such separate alcoholism services should work collaboratively with the mental health services. Only in this way can appropriate referral and consultation arrangements be developed and implemented. Some sharing of staff, or regular joint conferences might also be instituted to insure better cooperation between the two agencies.

(5) Specialized treatment personnel in the mental health program, but no separate alcoholism units. Under this arrangement certain staff—with particular interest and training—would be designated as alcoholism specialists. They would be available to work with problem drinkers, but might also treat other patients. There would be no separately identifiable alcoholism services but the bulk of persons with drinking problems might be treated by these workers. In addition they could function as consultants to others on the staff who were giving treatment to problem drinkers. These specialists would also establish liaison with those other community agencies who work with problem drinkers. As such they would be important linkage persons for the community mental health center and its generic staff.

(6) No alcoholism units in mental health programs, but special personnel to function primarily in nonclinical roles. This arrangement differs from No. 5 in that the special personnel would themselves do little or no treatment with problem drinkers. Rather their work would consist primarily of insuring that problem drinkers received appropriate attention in all the activities of the community mental health programs. In this capacity they might function not only as consultants but also as a kind of conscience for both the mental health program and the community in relation to alcohol problems. They could help to stimulate and encourage various activities within the community that bear on alcohol problems. Thus they would act principally as catalysts, as community organization experts and "change agents" rather than as clinicians or therapists. Overcoming resistance, dealing with stigmatizing attitudes, and taking advantage of opportunities to secure greater attention to alcohol problems would be major elements of their work. In line with the second approach of community mental health mentioned earlier, these alcoholism workers would be using the mental health programs as an operating base from which to develop broad and comprehensive alcoholism activities within the mental health program, in other agencies, and in the community generally.

The type of coordinating activity described above is a relatively new innovation in mental health, public health, and medical care. There is, however, a growing realization that the complexity of American helping agencies requires some such radical steps to insure better utilization and coordination of various services. Continuity of care, joint planning of programs, and agreement on areas of responsibility are examples of the objectives of such coordination. New York City has sought to achieve better cooperation between its health and welfare agencies by assigning a top administrator from the health department to be in charge of medical care activities within the city welfare department. A similar arrangement has just been developed in Michigan at the State level between the public health and welfare agencies. Vocational rehabilitation counselors working in mental hospitals, on a full- or part-time basis are examples of efforts to overcome the barriers to interagency cooperation that frequently arise at the clinical level. The newly established National Center for Prevention and Control of Alcoholism plans to strengthen coordination within the Department of Health, Education, and Welfare by having key personnel from other parts of the Department, such as the Welfare Administration, the Vocational Rehabilitation Administration, and the Office of Education assigned to the center. These individuals would then be channels of communication in relation to alcohol problems between their agencies and the alcoholism center. This clearly should be a two-way street with the alcoholism staff thereby obtaining a far better picture of the work of the other agencies than would occur in the absence of such an arrangement. Several States have had some limited experience with jobs designated as alcoholism coordinators—usually, however, such persons have been attached to State alcoholism programs rather than to general helping agencies. The latter approach might well be equally, if not more effective, in having an impact on general care givers.

A major difficulty in implementing some of the suggestions made in this paper is the lack of trained personnel. While major professional training institutions undoubtedly should expand their educational activities relating to drinking problems it is likely that many personnel of the type described above will need to have special additional training. Until more programs are developed in which persons can learn from the example of others who are dealing with problem drinking in clinical, consultative, and community organization roles, it probably will be necessary for agencies to send such trainees for varying periods of time to the few settings in the United States where alcoholism specialists currently are functioning in roles such as those that have been described. Formally organized short-term training programs as well as brief (or longer) field placements or internships are one means whereby some progress might be made in overcoming this manpower bottleneck. Perhaps the National Alcoholism Center should consider greatly expanding its financial support for such special training programs.

SUMMARY COMMENTS

The magnitude of drinking problems, while not known precisely, is obviously very great and problem drinkers have a significant impact on the work of many helping agencies. There also can be no question about the relative neglect of the needs of problem drinkers by most helping agencies and professions. Neither mental health agencies, nor others, have provided leadership in this regard. However, the last few years have seen increased concern about this problem on the part of many persons, laymen as well as professionals—both inside and outside the mental health field.

Because of the large number of problem drinkers and because other health, psychological, vocational, and social problems frequently are found among persons with drinking problems, it probably is not reasonable to establish a large separate network of treatment services for these patients. Logistically it would be virtually impossible to do without robbing numerous other agencies of the bulk of their trained and experienced personnel. The need rather is to develop means of ensuring appropriate attention to alcohol problems by a broad range of helping agencies.

There is an urgent need for someone to take on responsibility for this major problem area. Such responsibility obviously would not entail provision of all the needed services by any single agency or administrative unit. Leadership of an organizational and catalytic nature is perhaps of primary importance. A recent report to the House of Representatives on comprehensive health planning and services [20] listed the following principal shortcomings of American health services:

- ☐ Fragmentation in programs and organizations.
- ☐ Gaps in service coverage.
- ☐ Lack of rational comprehensive national planning.
- ☐ Lack of coordination at State and local levels.
- ☐ Undue rigidity in financing of federally assisted programs.
- ☐ Inability to use effectively scarce professional personnel.

These criticisms apply with equal, if not greater, force to alcoholism program activities. In the forthcoming national comprehensive health planning activities—with their new emphasis on noncategorical approaches—mental health authorities and community mental health programs will need to take a major leadership role in insuring appropriate attention to the area of alcohol problems. The aforementioned congressional report refers to the role of mental health programs in relation to the "special problem area" of alcoholism.[21]

The staff of the National Center for the Prevention and Control of Alcoholism, with the support of the Secretary's Intradepartmental Committee on Alcoholism and the recently appointed National Advisory Committee on Alcoholism should provide consultative and other assistance to Federal, State, and local personnel in the intensive and comprehensive health planning activities that will take place during the next 2 years. Such collaboration between alcoholism program personnel and general mental health workers can help to insure that future community health—and mental health—programs deal effectively with alcohol problems.

[20] House of Representatives, 89th Cong., 2d sess., "Comprehensive Health Planning and Public Health Services Amendments of 1966," report from the Committee on Interstate and Foreign Commerce, report No. 2271, Oct. 13, 1966, p. 3.

[21] Ibid., p. 10.

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