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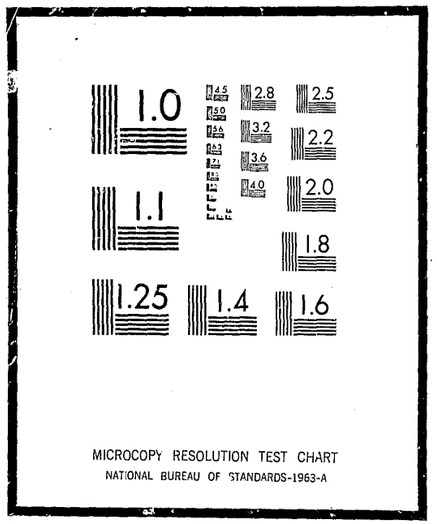

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JOINT CONFERENCE

ON

ALCOHOL ABUSE AND ALCOHOLISM

Sponsored by

National Institute on Alcohol Abuse and Alcoholism
National Institute of Mental Health
Health Services and Mental Health Administration
U. S. Department of Health, Education, and Welfare

Law Enforcement Assistance Administration
U. S. Department of Justice

National Highway Traffic Safety Administration
U. S. Department of Transportation

held at

University of Maryland Adult Education Center
February 21-23, 1972

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JOINT CONFERENCE ON ALCOHOL ABUSE AND ALCOHOLISM

FOREWORD

The Interagency Conference on Alcohol Abuse and Alcoholism, held February 22-23, 1972, at the University of Maryland's Center of Adult Education, College Park, Maryland, marks a major step in a nationwide effort to develop coordinated approaches to alcohol-related problems at all levels of Government.

The Conference was sponsored by the National Institute on Alcohol Abuse and Alcoholism of the National Institute of Mental Health (Department of Health, Education and Welfare), the National Highway Traffic Safety Administration (Department of Transportation) and the Law Enforcement Assistance Administration (Department of Justice).

This cooperative effort manifests our common concern to deal jointly and effectively with a national problem seriously challenging our health care system, our criminal justice system and our traffic safety conditions. In this regard, the Joint Conference attempted to focus on three common problem areas: (1) the alcohol-related offenders -- violent and nonviolent; (2) the public inebriate; and (3) the drinking driver.

It is evident that a successful answer to this challenge will require further efforts at coordination among many agencies and levels of Government. The Joint Conference Workshop has recognized this important need for a coordinated, nationwide approach by recommending that the NIAAA, LEAA, and NHTSA, in the Regional Offices, provide guidelines, strategies and mechanisms for joint planning, programming, funding, and coordination at the regional, State, and local levels. It is hoped that these Proceedings of the Federal Conference will serve as an important source document in the development of such unified efforts in the future.

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PURPOSE AND PLAN OF THE CONFERENCE

Purpose

As noted in the Foreword, problems involving alcohol abuse and alcoholism are now the concern of several Federal agencies, among them the Law Enforcement Assistance Administration (LEAA), the National Highway Traffic Safety Administration (NHTSA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). These three agencies conduct a variety of planning and funding efforts aimed at problems caused by excessive drinking.

Since it is believed that joint planning, programming, and even funding by the three agencies may be the most effective way to reduce the size of these problems, LEAA, NHTSA, and NIAAA jointly sponsored a conference to explore methods and means of working together at the regional, State, and local levels, a conference which is reported in the following pages.

Developments over the preceding two years lent special urgency to joint action by the three agencies. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act signed into law by President Nixon on December 31, 1970 established the NIAAA within the National Institute of Mental Health (NIMH). NHTSA set up its Alcohol Countermeasures program. The Secretary of Health, Education, and Welfare and the Secretary of Transportation initiated a memorandum of understanding between the Federal departments containing NIAAA and NHTSA. LEAA and NIMH set up an interagency Subcommittee on Alcohol. Most recently, the National Conference of Commissioners on Uniform State Laws drafted a Uniform Alcoholism and Intoxication Treatment Act, designed as a non-punitive approach to dealing with alcoholic individuals, which it recommended for passage by State legislatures. At least one legislature has already done so.

Conference Objectives

The major objective of this conference was to assist the development of joint planning, programming, and coordination at the regional, State, and local levels to deal with the alcoholic offender, the drinking driver, and the public inebriate. Law enforcement personnel are usually the first to contact all of these persons, but courts, corrections, and health and mental health systems often enter the picture shortly thereafter. Especially in the light of the Uniform Law that many States will undoubtedly adopt, efforts of the three agencies must focus on developing appropriate

mechanisms for assuring that people with alcohol-related problems receive the necessary assistance. Discussions at this conference would, it was hoped, point out the kind of mechanisms needed and suggest ways of developing them. The conference was intended to serve as a prototype for others to be held at regional, State, and local levels.

A second major objective of the conference was to develop a proceedings consisting of the papers and summaries of discussions. The proceedings were to reflect the problems and recommendations for integrating the planning, programming, and coordinating of services which together would provide better and more effective care for persons with alcohol-related problems.

Plan of the Conference

The conference, held at the University of Maryland Adult Education Center, College Park, Maryland, on February 21-23, 1972, was based on three workshops.

I. The Violent and Non-Violent Alcohol-Related Offender

This population group was defined as persons who have committed violent or non-violent alcohol-related offenses and display alcohol problems.

II. The Public Inebriate

This population is made up of people often referred to as "skid row drunks" or "street men." Their offense is that of being chronic public drinkers.

III. The Drinking Driver

This group was defined as individuals who endanger themselves and others because of consuming alcohol beyond the point that permits safe driving.

Each of the three workshop groups was planned to consist of about 25 persons: 10 from regional offices of the three agencies; nine researchers and program people; and six "consumers" representing those who have been or are affected by alcohol problems and who have taken leadership in helping to mitigate such problems. Papers circulated in advance of the conference served as the take-off point for discussion in each group. Discussion was wide-ranging, but in general it was devoted to defining problems and suggesting cooperative and pragmatic methods for solution.

In the following pages, the papers are presented, each followed by a summary of discussion. Recommendations by the three workshops were presented at the final session.

Conference Responsibilities

The conference was planned and organized by an interagency committee made up of:

John C. Wolfe, Project Officer, NIAAA
John L.F. Slee, NIAAA, coordinator, Asst. Project Officer
Kenneth S. Carpenter, LEAA
Dr. Helen Erskine, LEAA
Elizabeth Kutzke, NIMH
Dr. James Nichols, NHTSA
James Murphy, U.S. Bureau of Prisons

W. Thomas Engram was the University of Maryland's representative in administering the conference. Roma K. McNickle edited the proceedings.

Co-Chairmen

Morris E. Chafetz, M.D., Director
National Institute on Alcohol Abuse and Alcoholism
Department of Health, Education and Welfare

Jerris Leonard, Administrator
Law Enforcement Assistance Administration
Department of Justice

Douglas W. Toms, Administrator
National Highway Traffic Safety Administration
Department of Transportation

Richard W. Velde, Associate Administrator
Law Enforcement Assistance Administration
Department of Justice

Willard Y. Howell, Director
Office of Alcohol Countermeasures
Department of Transportation

Kenneth L. Eaton, Deputy Director
National Institute on Alcohol Abuse and Alcoholism
Department of Health, Education and Welfare

Sub-committee-members

Project Officer, Dr. John C. Wolfe
*Asst. Project Officer & Coordinator, Mr. John L.F. Slee

* Mr. Kenneth S. Carpenter
Dr. Helen Erskine
Mr. William Foulis
* Mrs. Elizabeth Kutzke
Mr. James Murphy
* Dr. James Nichols
Dr. Michael S. Roath
Miss Ruth Sanchez
Dr. Saleem A. Shah
Mr. James Simsarian
Mrs. Judith Wolfson
Dr. Robert Yoerg

* Planning Committee members

WORKSHOP I -- THE VIOLENT AND NON-VIOLENT ALCOHOL-RELATED OFFENDER

Moderator: Kay Tanzola

Recorder: H. Russel Miller

Papers: Youth, Violence, and Alcohol
Steven R. Burkett

Criminality and Psychiatric Illness: The Role of Alcohol
Samuel B. Guze

Exploring Some Common Ground Relative to Alcohol Abuse
Lyle D. Filkins and Rudolph G. Mortimer

The Alcoholic Offender: Manpower Needs for the Future
Frank Ervin

YOUTH, VIOLENCE, AND ALCOHOL

Steven R. Burkett
Department of Sociology
Washington State University

In recent years the American public has, so to speak, become "hung-up" on violence. With the assassination of several prominent political figures, riots, an increase in political demonstrations, and an apparent increase in violent crime, we have in effect undertaken a national self-study program. Perhaps the most significant aspect of this program was the creation and culmination of the National Commission on the Causes and Prevention of Violence, which sought to understand both the nature and causes of violence in America and to propose some possible solutions to this "new" problem. It is heartening to note in the face of recent accusations that the recommendations of such commissions are, more often than not, ignored and discarded--that the conference we are attending is in direct keeping with several recommendations involved in the Violence Commission report.

In any discussion of violence there are, of course, many complex issues involved. Not the least of these is the concern over violence and youth. And this issue is certainly no less conspicuous when we examine the role of alcohol in individual acts of violence. Both violence and alcohol use and abuse among youth are generally viewed as major, but nevertheless distinct, social problems. It is, however, quite easy to arrive at the "obvious" conclusion that the former is somehow causally related to the latter. Unfortunately, obvious conclusions, albeit valid at times, are perhaps more often than not misleading; and it is more than an understatement to suggest that those who plan, make, and implement policy must treat such facile conclusions with utmost caution.

With these comments in mind, and in keeping with the conference objectives, the focus of this paper is essentially twofold: First, we will examine the extent and place of both violence and alcohol use and abuse among today's youth; and the role of alcohol in individual acts of violence.[1] Second, we will examine some policy implications of the evidence presented and pose some suggestions regarding joint program planning and development on the part of the participating agencies. Given limitations of time, space, and available evidence, the following comments will be somewhat superficial in content and scope. Hopefully, however, they will serve as a starting point for fruitful discussion.

1 For purposes of this paper, "violence" is restricted to acts by individuals or small groups which cause damage to persons or property.

Youth, Violence, and Alcohol: A Perspective

In discussions of youth in general, it has become almost fashionable to utilize such concepts as "youth culture," "adolescent society," and "adolescent subculture." And, more often than not, these concepts are accompanied by descriptive accounts which picture today's youth as alienated, rebellious, hedonistic, aggressive, and violent.

The development of the adolescent society is generally viewed as an outcome of rapid social and economic change. The need for an extended period of formal education prior to adult employment and the increase in functions performed by such institutions as the school as opposed to the family have resulted in both a more prolonged period of adolescence and an increasing separation of adolescents from adults. The teenager of today is, in the words of one author, "'cut-off' from the rest of society, forced inward toward his own age group, made to carry out his social life with persons his own age." (7, pp. 3-4) This, combined with the ambiguous norms regarding what is "proper" and "improper" for youth, has, it is argued, led to a conflict of generations. Out of this conflict and its antecedent conditions, have arisen oppositional social systems which are very much "now-oriented" and revolve about values which frequently reward physical aggression.

The concern over violence among youth which both generates and is generated by such a view is not without some apparent basis in fact. Investigations both by the Violence Commission and the earlier President's Commission on Law Enforcement and the Administration of Justice provide ample evidence of this. The Violence Commission, for example, concluded that the "true rate for each of the four major crimes--homicide, rape, assault, and robbery--appears considerably higher for those 18-24 and 15-17 than for other age groups." (32, p. 607) Furthermore, although the Commission "could only be sure of a disproportionate increase in the true rate" for the 10-14 and 15-17 age groups in aggravated assault and robbery, it did note that the "increase in youthful age groups, portends a parallel increase in future violence." (32, p. 607) The facts, then, do suggest reason for concern. And, they would appear to lend at least some credence to a view of youth in conflict with adult society.

Similarly, available data regarding teenage drinking are not entirely inconsistent with such a view. Despite the illegality surrounding the possession and use of alcohol, for example, studies of teenage drinking patterns have consistently indicated that, with the exception of some regional variations, the majority of high school students drink. (17, 18, 26) Furthermore, several studies have noted the social nature of drinking among youth, and the importance of peer support and peer influence with respect to the extent of drinking, the type of beverage consumed, and the setting in which drinking usually takes place. (1, 6, 15, 24, 26, 29) Together, these facts suggest strong subcultural supports for drinking and may, in a limited sense, be taken as an index pointing to the pervasiveness

of an oppositional youth culture in conflict with adult authority.

There is, of course, always a danger in overgeneralizing. Although there is little doubt that youth today are more peer-oriented, and perhaps more assertive, than youth of previous generations, there is little, if any, evidence to suggest that all youth--or even the majority of youth--are totally alienated from adult society. (10, 11) Nor is it apparent that the "typical" adolescent is caught up in a pattern of overt rebellion and violence. Despite differences in music, hair styles, and modes of speech and dress, it would appear that much youthful behavior is quite consistent with adult values and expectations. More youth today than ever before, for example, aspire to the completion of college in preparation for white-collar occupations. And, there is more than sufficient evidence to suggest that parents strongly influence youth in these areas. (9, 12)

Wherein, then, lies the conflict? For many youth there apparently is none, or at least very little. Many, perhaps most, adjust quite readily to the demands of adolescence and future adulthood, and experience little difficulty in coping with the frustrations of "incidental" differences in attitudes, values, and behavior. Others, however, do experience difficulties in meeting the demands placed upon them, many of which can be viewed as outcomes of the changes noted above. It is these youth who are likely to "drift" into what may be referred to as a "rebellious" dimension of the youth culture in which the dominant themes of that culture are most strongly expressed, e.g., an emphasis on immediate rather than long-term goals and an emphasis on physical aggression as a means of gaining status in the eyes of their peers. (13, 20, 22)

Given the above, it is useful to re-examine in somewhat greater detail the "facts" of both violence and alcohol use among youth. First, with respect to violence, it is clear that, despite the relatively high rates of violent offenses among youth, it is nevertheless the case that only a very small proportion of all youth engage in such acts. While it may be true that one in six male youth makes an appearance before juvenile court (32), the vast majority of these youth will be one-time offenders who have been referred there for offenses illegal for children only; e.g., minor in possession of liquor. Those youth who are arrested and referred to court for acts involving physical aggression, on the other hand, are generally those with a history of previous contact with the police and juvenile court. (32)

The relationship between youthful violence and recidivism cannot be over-emphasized. Although available evidence suggests that violence among youth is predominantly, though certainly not exclusively, centered among black male youth in our urban ghettos, the differences in rates between whites and non-whites and in socioeconomic status levels appear to be substantially reduced when recidivism is taken into account. Recognition of this fact points us toward a consideration of other characteristics common to delinquents regardless of race or social status.[2]

Involvement in delinquency appears to be related to a general pattern of withdrawal from the major socializing institutions, principally the family and the school. The family, of course, has traditionally been linked to delinquency in terms of "deviant," imperfect, or inadequate socialization, and/or terms of general absence of parental control which, in effect, frees some youth to become involved in "deviant" or delinquent peer groups. The school, however, has recently been the subject of great interest among delinquency researchers. (23, 25) Several studies have noted that underachievement and low involvement in school are sources of stress for some youth (8) and that withdrawal from school is strongly related to involvement in a wider pattern of alienation and rebellion. The fact of "exclusion" from full participation in "conventional" activities is heightened with the application of the delinquent label, and this in turn serves to make continued involvement in progressively more serious delinquent conduct all the more rewarding.

The facts of drinking among youth, though in some respects less well researched, are quite consistent with the evidence concerning violence. While it may be true that a majority of young people drink, their drinking is nevertheless infrequent and generally involves rather small quantities of alcohol--usually beer. It is in a general sense, then, "controlled." Most of those who drink have had their first experience with alcohol in the home, and although much youthful drinking takes place apart from immediate parental or other adult supervision and control--in part, due to legal restrictions on its possession and use--youthful drinking nevertheless tends to reflect local adult drinking practices and adult attitudes toward alcohol. (2, 27) Only a small proportion of those youth who drink do so frequently, and relatively few experience any social, psychological, or physiological complications as a result. (17, 18)

In a recent study of drinking among high school students, Polk and Burkett found that those students involved in a pattern of withdrawal from the "success stream" through high school, that is, were not planning to attend college, received low grades, and participated in few, if any, school activities were more likely to be involved in a pattern of aliena-

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2 Throughout this paper little attention has been directed toward social class and racial variables. Although it is clear that rates of violence are much higher among lower socioeconomic status groups, particularly among male black youth, there appear to be factors which are more important in terms of explanation; e.g., school performance and attachment to school and family. Lower-class black youth, like other lower socioeconomic status youth, are among those least likely to be "held into" the "system." This accounts for their relatively high delinquency rates. Second, there is very little information on the drinking patterns of various racial groups, let alone on the relationship between that drinking and violent delinquent conduct.

tion and peer rebellion, including official delinquency, a tendency toward aggressive behavior, and "problem" drinking than were those students who were very much "tied into" the school system. (21) Furthermore, these findings could not be explained away by the social class backgrounds of the youth despite the fact that the rates of drinking and delinquency were somewhat higher among youth from lower socioeconomic status families than among youth from white-collar homes. A few other studies have noted a somewhat similar association between school performance and attachment to the school and "serious" drinking (22, 33), while others have noted a similar association between delinquency and "problem" drinking. (3, 16, 19, 31)

Unfortunately, research directed specifically at the role of alcohol in individual acts of violence by youth is almost nonexistent. (19) At best, then, available evidence suggests an association between "problem" drinking and involvement in delinquency. Both, however, appear to be "outcomes" of the same general process of withdrawal and exclusion from the conventional stream of adolescent adjustment, and involvement in a wider pattern of alienation and peer rebellion. There is no evidence to suggest that alcohol "causes" violent behavior among youth.

Some Recommendations

From the above discussion it is clear that there is an association between delinquency, both violent and non-violent, and teenage drinking. Beyond this, however, it is difficult to be very explicit. The research on teenage drinking, some of which has been cited here, is extremely limited both in terms of time and space. Research directed toward the nature of the relationship between alcohol use and delinquency is limited both in terms of quantity and quality. Research directed specifically at the relationship between alcohol use and individual acts of violence by youth (or, for that matter, delinquent acts in general) is virtually nonexistent. There is, to put it quite simply and frankly, too little information upon which to base recommendations for sweeping solutions specific to alcohol-related offenses and youthful offenders.

Need for Basic Research

At the risk of sounding like the proverbial broken record, it should be clear that basic research directed toward the issues just noted must receive high priority on the the list of things to do. In addition, there is a critical need for epidemiological research on alcohol-related offenses and offenders. Such research would be greatly enhanced through the collection of national, State, and local statistics designed to determine where and when alcohol is, in fact, involved in criminal and delinquent offenses, and by whom such offenses are committed. Statistics such as these would prove extremely useful, both in furthering the cause of basic research and understanding and in the detection and prevention of alcohol-related offenses committed by young and old alike.

Diversion from the Justice System

Despite the general lack of information, we are not, of course, totally ignorant. We do know that a relationship, however tenuous, exists between alcohol use and delinquency among youth. Furthermore, there is no doubt that some youth have problems with alcohol, and whether or not this leads to or is involved in individual acts of violence, these youth are in need of assistance. We also know that current laws designed to prevent teenage drinking do little to deter the use and abuse of alcohol. At best, more stringent enforcement of liquor-possession laws appears to reduce the number of non-problem users, while the number of problem users remains relatively constant. (30, 31, 33) These facts combined with the further "fact" that early and frequent contact with the juvenile justice system appears to be related to progressively more serious delinquent conduct, suggest some possibilities for experimental program development and implementation in the areas of law enforcement and education.

With respect to law enforcement, Blum has suggested that the first arrest for an offense involving alcohol may be taken as a "warning signal" of the possibility of future alcohol-related offenses. He goes on to note that "the most modern methods of juvenile police work and of juvenile corrections may bear fruit if applied in these early stages." (4, p. 43) Along with this general suggestion it might be noted that there has been a recent trend, both in legislation and in practice, to divert youthful offenders--principally first-time offenders and/or those engaged in "status offenses" such as minor in possession of liquor--from the juvenile justice system.

Without going into any great detail, a fruitful area for experimental program development, both in connection with and apart from the juvenile court, would be the provision of intensive alcohol education programs for those involved in alcohol-related offenses in lieu of juvenile court or incarceration. Since alcohol use may be associated with other problems-e.g., poor school performance and family problems-such programs could include various other services such as work-study and tutoring services and family group therapy, as well as medical assistance where necessary.

This suggestion is in keeping with a general concern that more attention be directed toward the first-time offender than is currently the case. The principle of diversion has as its ultimate goals both withholding the delinquent label, and the development of a more positive attitude toward and understanding of the legal system on the part of youth. The programs I have suggested do, of course, assume police, court personnel, and community service workers who are trained to deal with specific types of children with particular types of problems. The coordinated effort of the various participating agencies would be helpful in the development of such programs and the training of necessary personnel.

Alcohol Education

Alcohol education has, of course, traditionally been pointed to as the principal preventive measure with respect to teenage alcohol use and abuse. Unfortunately, it would appear that the list of recommendations for such programs is at least as long as the list of actual programs in operation. And that same list is without doubt far more lengthy than a list of serious attempts to evaluate the effectiveness of such programs once implemented.

Given the perspective on youth outlined in the first part of this paper, some questions can be raised regarding the "typical" alcohol education program.[3] First, such programs are usually conducted as part of the general curriculum of public high schools. If "problem" drinking is centered among those who have withdrawn from school in a psychological sense, then the impact of the usual lecture and film program on those most in need is no doubt minimal. Second, in-school programs obviously miss those youth who have dropped out of school unless, of course, the programs are directed, as they should be, toward the early school years.[4] Third, it is apparent that few alcohol education programs involve parents, teachers, and other adults as well as students. Thus, such programs may at times have a generally negative impact if what is presented is inconsistent with or in conflict with local attitudes and values relating to alcohol. Fourth, it is my impression that alcohol education programs are, more often than not, generally negative in their approach to alcohol and its use. Again, such programs apparently "turn-off" many of those for whom they would be most beneficial. Finally, it seems to be a rare instance when the recipients of alcohol education programs become actively involved in the planning and operation stages. More often they are passive subjects who have the miseries of alcohol use explained <u>to</u> them.

Young people need and thrive on involvement. In fact, if the analysis in the first half of this paper is even close to understanding the processes underlying alcohol use and violence among youth, it is the lack of involvement which necessitates the development of programs to "combat" teenage vices. Active involvement and participation in discussions of their problems and their lives would seem to make some sense. With respect to alcohol and drug education programs there is an obvious need for innovative new programs based on a firm understanding of the place of alcohol in the lives of youth. Such programs might do well to begin on the premise of not

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3 The following comments are based in large part on the results of a recent survey by the author of all high schools in the State of Washington.

4 It should be noted that we know very little about the drinking practices of school dropouts. This suggests another crucial area for future research.

attempting to prevent youth from drinking but to show them how to drink. In fact, it might be useful in a very general sense to quit "preventing" use altogether, either through educational means or the use of the legal machinery.

Moreover, there is room for all of the participating agencies to enter into the development of sound and comprehensive alcohol education programs. Such programs should not be viewed as the sole "property" of the schools but should be undertaken in a variety of settings in which alcohol and its various social, psychological, physiological, and legal aspects can be explored and discussed by all of those affected by its use.

Concluding Comment

Given limitations of time and space, any attempt to deal with a subject as complex as the one addressed in this paper will, of necessity, be limited in scope. There are certainly related issues and facts which I have ignored or given only passing attention. I have chosen, in one sense, to focus largely on what we do not know. I have taken this approach for two related reasons: first, to point to the urgent need for further knowledge; and second, to suggest that we be extremely careful before plunging into development of programs which may in the short run appear to be "successful" but which will in the long run prove to be mere exercises in symptomatology.

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DISCUSSION:

Dr. Burkett provided additional information on the relation of youthful drinking to class and school performance. The findings of the Polk-Brunett study, showing that drinking youth were apt to be those who were not doing well in high school, was made in a largely suburban area, but when replicated in a large city (Seattle) the findings were the same. The Seattle study included the use of marihuana. Middle-class youth who were not doing well in school were more likely to be using pot than blue-collar youth who were doing well. This suggests, it was remarked, that youthful drinking may be a coping mechanism.

There was consensus that almost no information is available on the relationship between drinking and acts of violence in youth. Predictive measures need to be developed. It is known, for example, that alcoholism is a familial disorder; hence children of alcoholics are a high-risk population.

Are there successful programs for treating youthful alcoholics or problem drinkers? AA is not suited to this group. The ASAP retraining programs should yield information on this point if carried out over a considerable period and carefully evaluated. The need for careful research on countermeasures was repeatedly brought up. We may be expecting solutions to problems much faster than our knowledge of the problems permits.

Considerable time was spent in discussing alcohol education courses in high school, which were felt to be generally ineffective. They come too late, typically in the 12th grade, when drinking patterns have already been established. Information on alcohol as a health hazard should be given much earlier and without the moral tone that characterizes many alcohol education programs. Most of these programs, indeed, turn youth off because either overtly or by implication they preach total abstinence. Moreover, parents are not involved in school programs. In developing an alcohol education program for Maryland schools, it was found that teacher's attitudes and behavior were highly important.

It was recognized that it might be better to divert from the criminal justice system youth who come into juvenile court charged with drinking or alcohol-related offenses -- e.g., minor in possession of alcohol, which is the charge for 20 percent of youth brought before King County (Seattle) juvenile court. Such diversion has become fairly general in recent years. But perhaps we should regard the first apprehension as a warning signal of future offenses.

There was some concern with the focus on violence in connection with drinking by youth, or by anyone else. In other illnesses that have violence --delirium, etc. -- you don't concentrate on the violence but on the disease itself. The focus in dealing with drinking should be on attitudes, causes, and related issues.

CRIMINALITY AND PSYCHIATRIC ILLNESS: THE ROLE OF ALCOHOLISM

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Since 1959, we have been studying convicted felons "to determine the prevalence and kinds of psychiatric disorders present in such a population, and to note any possible associations ... between psychiatric illness, family history, parental home experience, delinquency and crime history, and school, job, military, and marital histories." (1) This study was supported in part by a U.S. Public Health Service grant.

STUDY OF CONVICTED MALE FELONS

We began this long-term study with a systematic psychiatric and social investigation of a consecutive series of convicted male felons. The psychiatirc results of this first phase are summarized as follows. A sociopathic personality disorder (antisocial personality) was found in 78 percent of the sample; alcoholism was found in 43 percent; drug dependency in 5 percent; anxiety neurosis in 12 percent; homosexuality, schizophrenia, and epilepsy in 1 percent each; mental deficiency, dementia, and undiagnosed psychiatric illness in less than 1 percent each. Alcoholism was shown to be associated with an increased family history of alcoholism and suicide and an increased personal history of suicide attempts, wanderlust, military service difficulties, fighting, job troubles, and arrests. (1,2,3,4)

First Follow-up Study

Three years later, a follow-up investigation was carried out to determine criminal recidivism rates and relate such rates to various clinical and social variables. Detailed and systematic reports of the subsequent arrests, convictions, and prison experiences of our sample were obtained through the help of the Missouri Board of Probation and Parole. These reports furnished the data for determining recidivism rates. Recidivism was shown to be associated with the extent of the prior criminal careers, with a certain category of crime, with race, with age, perhaps with educational level, and with the presence of alcoholism. (5)

To examine further the possible association between alcoholism and recidivism, the parole office records of the parolees were studied. (6) Detailed reports concerning criminal recidivism were available for 116 of the 121 parolees: 48 alcoholics, 13 questionable alcoholics, and 55 non-alcoholics. During the summer of 1963, we were permitted to abstract the parole office record for each of the parolees. At this time 12 men were

still being followed by the parole office. The others had been discharged from the jurisdiction of the parole board (parole either completed or revoked). The average period of supervision up to the time of our study was 22 months. The range was from one to 53 months. All comments concerning problem drinking were noted and recorded.

Such comments were found in nearly half of the records. The frequency of such notations varied from 71 percent for the men diagnosed as alcoholics to 20 percent for the men diagnosed as non-alcoholics, with the figure being 54 percent for those diagnosed as questionable alcoholics. The differences between the alcoholics and non-alcoholics were statistically significant. They indicated that the criteria for the diagnosis of alcoholism were valid, because the frequency of notations about excessive drinking paralleled the certainty of the alcoholism diagnosis, and the observations leading to these notations were independent of the criteria used for the original diagnosis of alcoholism. Furthermore, the notations were made by parole officers who had no knowledge of the alcoholism diagnoses. A detailed analysis of the parole records of the 116 parolees indicated that the men who had originally received the diagnosis of alcoholism had significantly more trouble while on parole than had the non-alcoholics.

Study of First-Degree Relatives

The next phase of the study was carried out between 1962 and 1965. (7, 8) This consisted of a systematic psychiatric investigation of 519 first-degree relatives of the convicted felons (260 by personal interview plus other information and 259 by other information only). The results of this study were as follows. Most of the relatives were free of psychiatric illness. The only psychiatric disorders seen more frequently among these relatives than among the general population were antisocial personality, alcoholism, drug dependency, and hysteria. The first three were found chiefly among the male relatives and hysteria was found only among the female relatives. High rates for various forms of delinquency, social maladjustment, and crime were revealed by the study of the first-degree relatives. The alcoholic relatives showed significantly higher rates for these manifestations than did the non-alcoholic relatives. Most importantly, the presence and the severity of the alcoholism were correlated with the felony conviction rate among the relatives.

Second Follow-up Study

Having demonstrated the importance of alcoholism in this population, we proceeded in 1967 with the next phase of the investigation: a psychiatric and social follow-up of the original convicted felons. This has now been completed. (9, 10)

There were 223 men in the original sample. Of these, we were able to locate 209, or 94 percent. Among the 209 located men were five who had died, two who were abroad, 26 who refused to be interviewed or who were so

uncooperative that we considered them as refusals, and 176 who were personally interviewed.

The dead men had died an average of three years after the initial interview. Their average age at death was 48 years, with a range of 21 to 81. Two were married, and one was a widower, having murdered his wife as the index crime. At the original interview, each had received the diagnoses of antisocial personality and alcoholism. Two were definite alcoholics, and three were questionable cases. No other diagnoses had been made. At least two of the men had been involved in another felony subsequent to the original study. The causes of death, obtained from their death certificates, were: cancer of the liver with cirrhosis; bullet wound of the heart; bronchial pneumonia; auto accident; and stab wound of the heart. Thus, three died a violent death and a fourth probably from liver complications of alcoholism.

Of the two men who were abroad, one was with the Army in Vietnam and the other had been deported to Frankfurt, Germany. We were thus not able to interview these men. The 176 men interviewed represented 79 percent of the original sample, or 87 percent of those located alive in the United States.

The interviewers at follow-up were not the same as those who conducted the original interviews. While familiar with the results of the study up to that point, they did not know the individual diagnoses of the men, nor did they consult the original interview record until after the follow-up interview had been completed. The follow-up interviews were conducted in our hospital, in other psychiatric and general hospitals, in private homes, in jails, in places of work, at airports, in hotel rooms, and, in a few cases, via long distance telephone. Men were located and interviewed in nearly one-half of the States from New Hampshire to California and from Florida to Washington. When each subject was contacted, he was reminded of the original interview, and his cooperation was solicited for the follow-up interview. Each individual was reimbursed for his time and travel expenses.

Research assistants kept a detailed log of the search for each individual, noting all contacts with the subject, his friends, relatives, employers, police, etc. Any comments, suggestions, descriptions, or other information obtained from these sources were recorded. All kinds of records were gathered: police, prison, parole, hospital, clinic, private physician, vital statistics, military service, insurance, etc. (Whenever possible, wives of the men were also systematically interviewed. The results of these interviews will be presented below.)

The same structured interview was used as in the original study. It included a history of current and past illnesses and injuries; a description of all hospitalizations and operations; and a detailed symptom inventory designed to elicit the manifestations of anxiety neurosis, hysteria,

obsessional neurosis, schizophrenia, affective disorders, organic brain syndrome, alcoholism, drug dependency, antisocial personality, and homosexuality. These diagnoses were made according to specific check-list criteria. (1, 9) In addition, a detailed family history of psychiatric difficulties and a history of parental home experience were obtained. The interview also included sections dealing with school history, job history, marital history, military experiences, and police troubles. Specific inquiry was also made about suicide attempts. A mental status examination concluded the interview. Specific criteria were provided for scoring individual items. In general, these criteria selected symptoms or features that appeared to be medically significant because they required treatment or interfered with the subject's normal life.

The data obtained at this eight- to nine-year follow-up confirmed the findings of the original investigation and of the study of the first-degree relatives, that the principal psychiatric disorders associated with criminality are antisocial personality, alcoholism, and drug dependency. Schizophrenia, primary affective disorders, organic brain syndromes, the neuroses, and homosexuality are apparently not seen more frequently in male criminals than in the general population. The data also indicated that increased recidivism rates are associated with the following factors: flat-timer status (reflecting a more extensive criminal career), relative youth, and the diagnoses of antisocial personality, alcoholism, and drug dependency. It was also importantly noted that remission of the latter two conditions was correlated with a decline in recidivism.

Wives of Felons Studies

The study of the wives (11) may be summarized as follows. Of the 176 men interviewed at follow-up, 33 had never married, 21 were divorced, 21 were separated, one was a widower, and 100 were married and living with their spouses. The wives of 109 men were interviewed. Eight wives refused to be interviewed; the husband refused to permit us to interview his wife in four cases; two wives were dead (one following divorce from her husband); and 20 wives could not be located (all divorced or separated from their husbands). We interviewed 77 percent of the current or most recent wives of the interviewed men (90 percent of the wives located alive). The same interview was used for the wives that was used in the other phases of the study.

The data indicated that the wives and husbands came from similar family backgrounds characterized by instability, parental discord, broken homes, alcoholism, criminality, frequent suicides and suicide attempts, and frequent psychiatric hospitalizations. A comparison between the wives and the first-degree female relatives indicated great similarity. Antisocial personality, alcoholism, and hysteria were seen frequently in both groups. Fifteen percent of the wives and 11 percent of the female relatives received at least one of these diagnoses. Eleven percent of the wives and 6 percent of the female relatives received the diagnoses of either antisocial personality or alcoholism. The wives, like the female relatives, had a frequent history of police trouble.

To summarize, convicted felons, the great majority of whom come from grossly disturbed families, marry women from similarly disturbed backgrounds. The wives evidence the same psychopathology seen among their husbands' first-degree female relatives. This appears to be an example of assortative or non-random mating in which individuals from similar backgrounds tend to marry more often than would be expected by chance. It suggests that the children of these matings would be exposed to a double dose of factors that predispose to delinquency, antisocial personality, criminality, alcoholism, and drug dependency, whether these factors are genetic, environmental, or both.

Study of Female Criminals

In view of the findings concerning the female first-degree relatives and the wives of the male criminals, we began a study of female criminals parallel to that of male criminals to determine the significance of alcoholism in the pathogenesis and persistence of criminal behavior among women. (12, 13) The entire caseload of female felons under supervision in District 8 of the Missouri State Board of Probation and Parole was selected for study: 71 women as of July 1, 1969, plus seven new cases during July and August. This included parolees from the Missouri State Prison for Women at Tipton and probationers from the St. Louis County Courts, plus a few interstate transfers.

Interviews were arranged by the parole officer in charge of the case. The subjects were told: "a doctor from Washington University is doing a study on the medical and health problems of people who have had trouble with the law." The interviews were usually carried out at the parole office. Occasionally, because of transportation or other difficulties, the interview took place either in the subject's home or at our hospital. Each woman was told that the parole board would make its records available to us but that everything she told us would be kept confidential. The interview, lasting from two to six hours, was the same as that used for the male criminal study. Each woman signed a release of medical information form and was asked to encourage her relatives to cooperate in a family study.

All the women received at least one psychiatric diagnosis. Antisocial personality, alcoholism, drug dependency, hysteria, and homosexuality were encountered more frequently than would be expected in the general female population. Antisocial personality or hysteria was found in 80 percent; a 20 times greater prevalence of hysteria (over 40 percent) than is found in the general population (1 to 2 percent) was the most striking finding.

There may be a question about the validity of the information collected at interview in any study; this is particularly true in a study of criminals. Fortunately, extensive information from other sources was available about each case. Independently and routinely assembled by parole officers, it included court records, police reports, prison records, social

history about the family, and information about schooling, jobs, marriages, military service, and health. These data were recorded in pre-sentencing reports and in progress reports to the court on parole status. In addition, records were obtained from hospitals, clinics, and private physicians. All of these records were reviewed for comments and observations relevant to the following diagnoses: antisocial personality, alcoholism, drug dependency, homosexuality, and hysteria. The findings indicated that there was a very high correlation between the diagnoses made at the time of the research interview and the record information concerning these five diagnoses. Nearly every case with information in her records consistent with any one of these diagnoses was identified by the interview. The interview, in addition, picked up cases not identified by the records.

We have just completed a study of the first-degree relatives of these women, but the data have not yet been fully analyzed. We plan to (1) carry out a five-year follow-up study of the women to verify the diagnoses, (2) study their husbands, and (3) compare recidivism rates with various psychiatric diagnoses, particularly alcoholism.

Implications of the Studies

All the work so far indicates that antisocial personality, alcoholism, and drug dependency are the important psychiatric disorders associated with adult criminality. The absence of an increased prevalence of schizophrenia or other psychotic states raises questions about the adequacy or relevance of many discussions concerning psychiatric illness and criminal responsibility, since such discussions usually specifically exclude from consideration antisocial personality, alcoholism, and drug dependency. The study of women criminals will serve as a check on the study of male criminals, since in each investigation first-degree relatives of the opposite sex and spouses will be studied. If all the results prove consistent, our present conclusions will be greatly strengthened, and a major goal of parole practices and other rehabilitation procedures will have to be directed at controlling the alcoholism (and drug dependence).

In addition to this important implication for social psychiatry, the results of the proposed study will contribute to our knowledge about various clinical aspects of chronic alcoholism. We will learn more about the long-term implications of the various manifestations of alcoholism and more about the chronologic development of the various symptoms of alcoholism. We will obtain data about spontaneous remission rates in early alcoholism and of possible associations between various personal and social factors and these remission rates.

The association between antisocial personality and hysteria is also potentially of great significance. The findings described are supported by other data obtained from studies of hysteria. (14, 15, 16) This association is important because, coupled with the observation that hysteria is predominantly a disorder of women while antisocial personality is

predominantly a disorder of men, it offers the interesting possibility that, depending upon the sex of the individual, the same etiologic and pathogenetic factors may lead to different, though sometimes overlapping, clinical pictures. The follow-up and family studies of the women criminals may contribute to our understanding of this association between two apparently different conditions.

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DISCUSSION:

Dr. Guze's paper described a long-term study of convicted felons in Missouri, which revealed three psychiatric conditions occurring among them at significant frequencies: antisocial personality, alcoholism and drug dependency. Only 10 percent had none of these conditions. Antisocial personality tended to be coupled with either alcoholism or drug dependency.

Alcoholism was important not only in itself but also because it was associated with recidivism. Therefore, Dr. Guze believes, any attempt to rehabilitate convicted felons must include an effort to control their alcoholism.

Almost all of the felons had long histories of trouble with society, often dating back to elementary school and going on to police and juvenile court. The only group of which this was not true were rural blacks.

There is no hard evidence that the incidence of alcoholism is or is not about the same in most prison populations, but the Missouri situation is believed to be fairly typical.

A related study found that 24 percent of the males seen in a psychiatric clinic and 20 percent of those on the general wards of a teaching hospital met the medical criteria for a diagnosis of alcoholism used in the study of felons. Dr. Guze estimates that between 5 and 8 percent of the general male population probably would meet such criteria.

It was suggested that a very promising research model would be to identify children who are high risks for alcoholism, beginning at about age 7 or 8. A possible model is a study now being funded by NIMH on children who are high risks for schizophrenia, having schizophrenic parents.

Having identified these children who are high risks for alcoholism, one would give them treatment for about 10 years. The difficulty is that we have no experience in such preventive treatment. New ideas are needed.

There was a general feeling that many, if not most, prison treatment programs for alcoholics are not very effective. We need to know more about how these men and women got into the criminal justice system and how changes in the system affect prisons. For example, the more professional a police force becomes, the more crime will be reported, partly because citizens trust the police more and partly because of the professional emphasis on reporting.

One workshop member reported that alcoholics in programs he ran at a federal prison did well in the institution. AA members did best of all, but the alcoholic group as a whole did better than the the control group.

There was considerable sentiment in the workshop for "doing something

now" with treatment programs without waiting for all the i's to be dotted in research. It was agreed that enough is now known about treatment that seems to work to go ahead on a wider scale. But some reasonable portion of resources must be reserved to research new theories.

The workshop strongly favored the implementation of a model plan for diagnosing and treating alcoholics in several correctional settings - prison, probation, and parole -- over a long enough period to gain meaningful results. Evaluation should be a part of this program from the start.

Wider public support will be needed to deal with the problem of alcoholism in the general population. Much more money is going into drug abuse programs than into alcohol abuse programs, even though drug abuse affects far fewer individuals. Part of this disparity is due to the relative newness of widespread drug abuse, particularly among middle-class youth. It will require genuine public commitment to deal with alcohol problems, both in terms of money and in destigmatizing the alcoholic and making personal efforts to help him.

A practical approach would be to bring pressure to bear on Congress to include treatment for alcoholism under national health insurance legislation that seems destined for passage in the near future.

EXPLORING SOME COMMON GROUND RELATIVE TO ALCOHOL ABUSE

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Alcohol abuse, in terms of a metaphor that we have found descriptively useful, is the body of an octopus. Hanging from this body are several dangerous tentacles to be avoided by the individuals and organizations of our society. Among these are: self-destruction of the problem drinker in social, psychological, and physical terms; broken marriages with the misery that is visited on the alcoholic, his spouse, and his children; welfare rolls swollen by families without an adequate provider; overloaded courts and jails devoting a significant portion of their resources to problem drinkers; hospitals occupied in part with patients being treated only for symptoms of alcoholism, albeit serious ones in many cases, rather than for the underlying causes; a variety of criminal activities so correlated with alcohol use that one suspects a causal link between the two; long-term caretaking facilities for alcoholics, such as State and veterans' hospitals, that are a drain on society's resources and probably aren't a great deal of joy to the residents; a tremendous amount of highway violence, with resulting death, injury and economic loss to the alcohol abuser, to other highway users, and to the society generally.

We could probably go on and list even more of these tentacles hanging from the alcohol abuse body, such as large business losses deriving from absenteeism and reduced job performance. But that would destroy the metaphor, so we will stop here.

Those of us in the highway safety field, of course, are concerned primarily with the highway unsafety tentacle. But just as you might think that treatment for a severe case of alcoholic gastritis without treating the underlying alcoholism would be a shallow "solution" for a medical problem, you might equally well believe that a group working only on the highway unsafety tentacle is taking a rather shallow approach to a far more general problem. We would be inclined to agree. Although the nature and extent of safety specialists' contributions to amelioration of the larger issue are far from clear, we are encouraged that traffic safety officialdom--at all levels of government and across many segments of society--are increasingly aware of the much larger social context in which their particular interest is imbedded.

This conference, and the legislative and interagency activities preceding it, are concrete evidence of the recognition of the common interests of those in attendance. The purpose of this paper is to explore some of this common ground and to suggest some specific topics for consideration in activating further our shared interests.

ALCOHOL ABUSE AS SEEN IN THE TRAFFIC ENVIRONMENT

It is now commonly accepted that the abusive use of alcohol is by far the largest single contributing factor to the occurrence of highway crashes, particularly fatal crashes. The frequently cited statistics associated with the national toll need not be belabored here. In this section, however, we will note some historical aspects of the problem and emphasize some recent findings that more clearly delineate the association between alcohol and highway crashes.

The opening remarks of an editorial entitled "Motor Wagons" in a 1904 issue of The Quarterly Journal of Inebriety are enlightening:

> We have received a communication containing the history of twenty-five fatal accidents occurring to automobile wagons. Fifteen persons occupying these wagons were killed outright, five more died two days later, and three died a few weeks after the accident, making twenty-three persons killed. Fourteen persons were injured, some seriously. A careful inquiry showed that in nineteen of these accidents the drivers had used spirits within an hour or more of the disaster.

The point is that alcohol abuse and traffic crashes have been deeply intertwined from the earliest automotive days. Notwithstanding society's considerable efforts to deal with this situation in the intervening 58 years, Borkenstein et al. were able to show, from their classic study in Grand Rapids, Michigan (1) in 1962, that the relative probability of crash occurrence at a blood alcohol concentration (BAC) of 0.10 percent W/V (100 mg.percent [1] is six times that at zero blood alcohol, rises to 25 times at 0.15 BAC, and rises even more sharply thereafter. It cannot be plotted above a BAC of 0.25 (because there were no drivers in the control population above 0.25), a concentration which will be cited later.

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1 Blood alcohol concentrations in percent weight by volume will hereafter be referred to by the decimal portion only; e.g., "0.10" will indicate "0.10 percent W/V."

Findings from research conducted by the Highway Safety Research Institute (4) under a grant from the National Highway Traffic Safety Administration (NHSTA) rather clearly point to the fact that many of the people of concern to any one of the sponsors of this conference are, with reasonable probability, likely to be of concern to either or both of the other two. The Wayne County (Detroit and environs) Traffic Fatality Study (4) included 309 drivers, 140 passengers, and 167 pedestrians killed from July 15, 1967 to August 31, 1969. The study population included all traffic fatalities 16 years of age and older who, with minor exceptions, died within 24 hours of the crash. Some of the more significant findings follow:

1. Fifty-five percent of the 309 drivers died with BAC's of 0.10 or higher and 36 percent died with 0.15 or higher. Fourteen percent died with a BAC of 0.25 or higher, a concentration so far in excess of that reached by social drinkers that this single fact is probably diagnostic of severe problem drinking. Even a BAC of 0.15 is highly suggestive of problem drinking.

2. A breakdown by age group and BAC, as shown in Table 1, more clearly indicates the high degree of alcohol abuse among the driver fatalities.

Table 1. Distribution of 308 Wayne County driver fatalities by age and BAC

Age	Number	percent at or above given BAC			
		0.01	0.10	0.15	0.25
16-19	34	50	29	18	9
20-25	76	75	63	42	7
26-35	57	82	81	68	21
36-45	44	80	73	66	34
46-55	45	67	51	38	13
56-65	32	44	31	31	9
66+	20	20	5	5	-0-
	308*	66	55	43	14

*Age missing on one zero BAC fatality.

3. Twenty-two percent of all pedestrians died with BAC's of 0.25 or higher, with 44 percent of those between 35 and 55 years of age in this range. BAC's above 0.40 are not uncommon.

4. Criminal records were sought for all 616 fatalities, and a statistically significant relationship ($p \leq 0.01$) was found between one or more criminal convictions and BAC at death as shown in Table 2.

Table 2. Association between criminal convictions and BAC of 616 Wayne County traffic fatalities

		percent at given BAC		
Conviction status	Number	-0-	0.01-0.09	0.10+
No criminal convictions	533	41	18	41
Had criminal convictions	83	16	11	73

5. Twenty-nine fatalities had convictions for drunkenness offenses not associated with driving, such as drunk and disorderly conduct or drunk in a public place. All but seven had BAC's of 0.10 or higher at the time of death.

6. One hundred forty-three fatalities, or 23 percent of the population, evidenced one or more of the following problem drinker criteria: BAC of 0.25 or higher; conviction for drinking-related offense; cirrhosis of the liver; diagnosis of alcoholism or problem drinking on a social or medical agency record; or report of alcoholism by the witness who identified the body of the fatality at the morgue.

The results from an analysis of persons admitted to a general hospital in Michigan for various reasons and subsequently diagnosed as alcoholic are also significant in showing the over-lap in caseloads.

1. The 6-year crash rate for the 1,247 driving alcoholics was about twice that of a random sample of Michigan drivers of the same age.

2. The hypothesis that there is a direct correlation between a high rate of driving convictions and behavioral deviancy (in terms of criminal convictions, drunkenness convictions not associated with driving, and mental illness diagnoses) was substantiated.

3. Behavioral instability (as reflected in family problems, or in the three marital statuses of single, separated, or divorced) was associated with a high crash rate.

In summary, alcohol abuse is a characteristic feature of fatal traffic crashes. Problem drinkers are highly overrepresented among drivers who are killed after drinking, and high BAC's at time of death are correlated with prior criminal convictions. Driving alcoholics, moreover, have higher crash rates than non-alcoholics.

TOWARD COOPERATIVE EFFORTS

It is obvious that university traffic safety researchers are ill-prepared to suggest highly specific ways and mechanisms by which various Federal agencies can interact effectively to further their common interests and goals. Rather we shall outline some general goals and describe some tools whose use we believe will help to further the several common purposes.

Before turning to these, let us raise a general issue whose continued lack of resolution almost surely will get in the way of effective inter-agency cooperation. The issue turns in part on various ways of identifying the alcohol abuser, depending on the specific environment in which the alcohol abuse occurs, and the methods by which society chooses to deal with him, once identified.

We have argued metaphorically that alcohol abuse is not a neat, well-behaved entity which can be simplistically defined and dealt with as such, but rather a somewhat amorphous, generalized concept from which many undesirable behavioral manifestations derive. Similarly, we believe it would be a serious mistake to assume casually that the "violent and non-violent alcohol-related offender," the "public inebriate," and the "drinking driver" labels will prove useful in classifying individuals for subsequent processing through a remedial production line. Such labels are probably necessary for organizing conferences in some coherent fashion and for communicating ideas among concerned individuals, but it would indeed be a statistically rare alcohol abuser who conveniently placed himself once and for all in only one of these neat pigeonholes.

Suppose we have a problem drinker--an alcoholic, if you prefer--who occasionally gets drunk and beats his spouse, who frequently gets drunk and drives, who occasionally gets drunk in a public place, and who frequently misses work on Monday morning because of a hangover. Are we to assume that the best way of dealing with this individual--from either the perspective of humane and effective treatment for him as an individual or from the perspective of society's need to curb his drunken behavior--is a function of the specific behavior by which his abusive use of alcohol becomes known? We think not, and we urge all personnel in agencies which may have a mandate to deal with only one of the alcohol abuse tentacles at least to be aware

of the possibilities of others and respond accordingly. Government may of necessity have to be compartmentalized, but let us try to insure that the response of government need not be.

Having argued the idealistic side of the coin, let us take a look at the practical way of it, particularly in the context of drunk driving. Drunk driving, whether done once a year by a social drinker on New Year's Eve or weekly by a chronic alcoholic, is a crime. It has long been thus, and the rather severe penalties attendant to conviction suggest that its seriousness has been recognized by society. Although we claim no gifts of prophecy, we see nothing on the legislative or constitutional horizons to suggest that drunk alcoholic drivers caught in the legal net will not be subject to the processing and sanctions of the criminal law. Mr. Justice Fortas' footnote in his minority opinion in Powell v. Texas (392 U.S. 514, 1968) seems particularly cogent:

> It is not forseeable that findings such as those which are decisive here--namely that the defendant's being intoxicated in public was a part of the pattern of his disease and due to a compulsion symptomatic of that disease--could or would be made in the case of offenses such as driving a car while intoxicated, assault, theft, or robbery. Such offenses require independent acts or conduct and do not typically flow from and are not part of the syndrome of the disease of chronic alcoholism. If an alcoholic should be convicted for criminal conduct which is not a characteristic and involuntary part of the pattern of the disease as it afflicts him, nothing herein would prevent his punishment.

From a practical point of view then, it seems that those people and agencies whose instincts lead them to emphasize the individual with the police and judicial agencies that are likely to be serving as casefinders, in a criminal context, of alcoholic clients. On the other hand, criminal justice system personnel and agencies will probably have to admit that the traditional legal tools at their command are not likely to be effective deterrents for the alcoholic criminals whom they process. This is the crux of the rationale which has led one of the authors to advocate a combined health-legal approach to control of the problem drinking driver. (5) Whether one buys that approach or not is irrelevant at the moment. The point is that a working resolution of the potentially profound philosophical differences between the two camps must be achieved at all levels if effective interaction is to follow.

Once resolution is achieved, traffic safety, public health, and law enforcement agencies can clearly benefit from combining certain of their efforts relative to the nation's problems of excessive alcohol consumption. By combining their programs concerned with the problem drinker, it should be possible that an overall reduction in the cost of their administration

could be achieved. In addition, an improvement in information flow between these agencies could result in more rapid and appropriate treatment being received by the problem drinker.

Common Records Systems

It would be useful to improve the collation of records of an individual's past history related to traffic accidents and violations, criminal background, and admissions to hospitals or clinics dealing with alcoholism problems. Access to these types of records would be useful because of the known syndrome of alcoholism which typically involves elevated frequency of traffic accidents and certain types of traffic violations, such as driving under the influence of liquor or while impaired, reckless driving, arrests for criminal acts involving the use of alcohol, and charges of drunk and disorderly. For these reasons such data could be used as means of indicating the likelihood of the existence of a drinking problem for a given individual who comes before the traffic or criminal courts or is admitted to an alcohol treatment agency.

Background history information of this type would also be of assistance in the more enlightened disposition of criminal cases. By using information that strongly suggests that the individual is suffering from a drinking problem, the courts would be in a better position to impose sentences that incorporate remedial treatments for this disease.

Improved record-keeping would also be of great assistance for the conduct of research involved in determining the factors leading to alcohol abuse and the effectiveness of various treatments. Since the type of information about an individual that is needed by researchers is concerned with both traffic and criminal records as well as social and medical history, it can be difficult and costly to conduct such work. The record-keeping systems of different States differ in this regard and those of police agencies in specific communities are even more variable. Data concerning social background history are extremely difficult to find because they may be located in a variety of public and private agencies; and it is difficult to obtain release for them for confidential reasons. Consideration should be given to providing improved access to such data for bona fide reasons, and this is a matter that could be expedited by joint efforts among the agencies involved.

The issue of invasion of an individual's privacy needs careful consideration on philosophical, legal, and practical grounds. Miller has investigated this topic extensively, particularly in reference to electronic data-processing technology. (8) His balanced account is highly recommended.

Early Identification of Problem Drinkers Among Agency Case Loads

Although the etiology of alcoholism and problem drinking is not well understood, it is evident that numerous factors are involved. Whether the disease is dependent on physiological or psychosocial factors can still be debated, but the need to provide early detection should be self-evident. Early detection may enable treatment to begin before the detrimental effects of the disease have an influence upon society, halt further deterioration in the individual's health and behavior, and improve the prognosis for recovery. As shown in Table 1, a high BAC is often found in young drivers and is strong evidence of the existence of an early drinking problem. There appear to be obvious benefits if it is possible to identify these individuals before they become involved in highway collisions or in criminal acts involving alcohol. The ability to identify young persons as problem drinkers is made relatively more difficult, as compared with older persons, because of their shorter past history with consequently less exposure to agencies dealing with alcohol problems, employers, wives, their families, and the police.

Development of Techniques to Identify the Problem Drinker

In view of the present difficulty in accumulating satisfactory background data on an individual, the availability of other identification techniques appears appropriate. Such techniques could be used jointly with data available in current record-keeping systems and subsequently in improved systems that may be developed.

Under NHTSA sponsorship, a study has been recently completed whose objective was to develop a method by which court probation officers or similar personnel could determine whether an individual convicted of a drinking-driver offense was a problem drinker. Since the objective of this technique was that it be usable by individuals who had received little specialized training, it was essential that the procedure be simple to administer. Further criteria were that it not be too time-consuming, in view of the already large demands being made upon court staff, and that it be low in cost in terms of materials and overall procedures. For these reasons it was considered necessary that the procedure be fairly tightly structured and be objectively scored.

A paper-and-pencil questionnaire and an interview were developed. These instruments ask simple questions related to the individual's past social, marital, health, employment, criminal, driving, and drinking habits.

The preliminary format of the questionnaire and interview was validated by administering them to samples of problem drinkers at alcoholism treatment agencies and to samples of social drinkers. The responses of two groups of persons to each of the questions were compared, and those questionnaire or interview items which did not discriminate between the groups were discarded. A scoring syster was then devised, using the

remaining questions, which provided high discrimination between these two groups. This scoring system was then used on further samples of problem drinkers and controls (i.e., social drinker subjects), using the same scoring format as had originally been developed. When the subjects had been scored, it was determined how well the responses on the questionnaire and interview discriminated between them by allocating them to their appropriate groups. This procedure, known as cross-validation, is used to reduce the effects of chance factors that enter into initial validation methods. The results of this analysis indicated that the final group of questions used in the questionnaire and interview were highly effective in differentiating between the problem drinker and social drinker groups. A high concurrent validity coefficient of $r = 0.92$ was obtained by use of both questionnaire and interview.

Another way of looking at the effectiveness of the procedures in discriminating between the problem and social drinkers is to determine the percentage correctly identified as problem drinkers as compared to the percentage of control subjects misclassified as problem drinkers. Figure 1 shows that it is possible to identify about 75 percent of the problem drinkers correctly when none of the control subjects are misclassified. If a false positive rate of about 1 percent is accepted, then about 91 percent of the problem drinkers would be identified. All of the problem drinkers would be correctly identified if a false positive rate of 7 percent were acceptable. Since it is likely that some of the presumed social drinkers were, in fact, problem drinkers, it would appear reasonable that a percentage rate of 3-5 percent of false positives would be acceptable.

While these procedures were found to be highly effective in discriminating between the types of persons used in the validation studies, it is necessary that further work be conducted to provide an estimate of the effectiveness of the questionnaire and interview when used in the courts or in other settings. Preliminary evaluations of individuals convicted of a drinking-driving offense (9) have been conducted in six Michigan traffic courts, apparently with a high degree of validity.

A procedure of this type, or others (11), would appear to be useful to effect early identification of problem drinkers. Needless to say, the validity of such procedures must be carefully determined. This will involve considerable analysis of field tests in the types of environments in which such procedures are to be used. If these techniques are found to be accurate, feasible, and reasonable in cost, then emphasis should be placed on the continued development of appropriate means of treatment and rehabilitation.

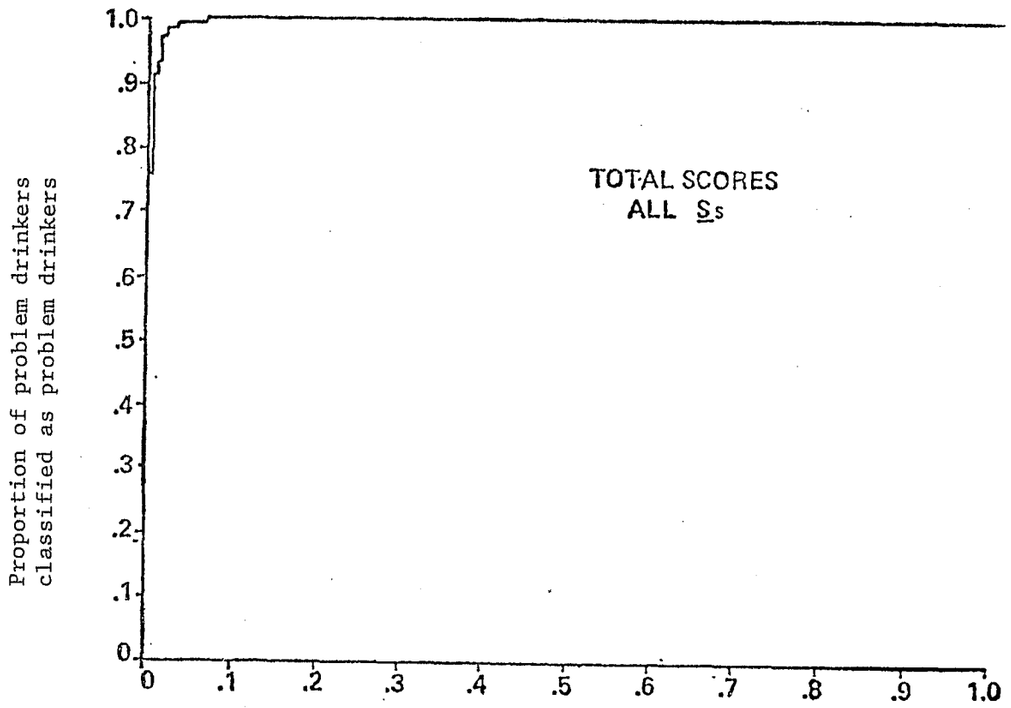

Figure 1. Discrimination of questionnaire and interview between control and problem drinker subjects in validation study

Effective Rehabilitation Networks

The traditional role of police agencies has been enforcement of laws, and that of the courts has been fair and effective administration of justice for those accused of violating such laws. We do not foresee any fundamental shifts in either role with respect to the alcohol abuser who commits, and is apprehended in, criminal behavior.

However, the police and judicial activities may be viewed in a somewhat different light in the following sequence of events which we believe should be initiated for alcohol abusers: casefinding of potential problem drinkers; determination of the existence and seriousness of a drinking problem; determination of the most effective means of dealing with the problem drinker, both in terms of his individual needs and those of the public at large; and carrying out the treatment that has been prescribed.

In this simplified flow process, the police are discharging the case-finding function when they arrest persons engaged in alcohol-related criminal activity. This function could presently be strengthened by increased police alertness for evidence of alcohol abuse during criminal investigations. Further extensions of this concept might take the form of statutes analogous to implied-consent laws now applicable to arrested drinking drivers. It could also be strengthened by increased vigilance for problem-drinking drivers at the times and places they are most likely to be found. Studies have shown that alcohol-related crashes occur most frequently in the late night and early morning hours and on weekend nights more often than on weekday nights. In addition, a survey of drivers in Washtenaw County, Michigan (2) showed that, of the drivers who had been drinking and had BAC's of 0.10 or above, 47 percent had done their drinking in bars or clubs; 33 percent had been drinking at home; with the remaining 20 percent scattered among various places. Therefore, intensified enforcement around drinking establishments may apprehend a large proportion of individuals who have consumed substantial volumes of alcohol and may also detect them early in their driving after leaving such establishments, thereby reducing crashes. It was also found that drivers who drink to impaired BAC levels could be more easily detected on medium-traffic-volume roads than on high-traffic volume roads.

The courts, in effect, would be carrying out the initial steps of a diagnostic process to determine whether a drinking problem exists and its nature and extent. A pre-sentence investigation is appropriate for carrying out this function. This is necessary both to provide effective disposition of the case in a short-term sense and also to refer problem drinkers to those rehabilitation agencies which can address themselves to the alcohol abuser's more general needs and provide the required services. The "constructive coercion" concept, in which the prestige and authority of the court are used to motivate problem drinkers to enter and remain in treatment, is a potentially powerful tool in linking the health and legal systems.

These ideas are neither new nor particularly innovative.[2] They are, however, now receiving great emphasis in many locations as part of NHTSA's Alcohol Safety Action Program. The unsuccessful elements of this experience should be captured as fully as possible and publicized extensively throughout all levels of criminal justice and health care systems.

Two parts of this process particularly merit continued NIAAA attention. The need for more effective treatment of alcoholism is widely recognized. In addition, the courts will require a good deal of specific guidance on how to deal most effectively with the individual cases in front of them. It simply is not enough that they know that a defendant is a problem drinker. They must also know what treatment resources are available in their community and, most important, which of these are individually appropriate.

PREVENTIVE EFFORTS

Some remarks regarding the need for efforts directed to the prevention of alcohol abuse are included here, not because of any significant substance which we can offer but because we strongly endorse the need for such efforts. Further, we wish to guard against the inference that we believe the earlier material represents anything like a comprehensive response to the problems of alcohol abuse.

The criminal justice system largely reacts to behavior associated with alcohol abuse after the fact rather than before. Its police officers investigate alcohol-related assault and battery crimes after they occur, and its traffic-oriented components are called on to handle the human and physical wreckage of alcohol-related crashes only after the damage is done. It seems obvious that such activities, however necessary they may be, one continuing evidence of failure rather than of success in combating alcohol abuse.

One can justifiably argue that the arrest and prosecution of drinking drivers should prevent alcohol-related crashes. But unless these activities are suitably coupled with appropriate educational or rehabilitative networks, one must acknowledge that they are preventive only in the sense that they are directed to the highway unsafety tentacle rather than to the central alcohol abuse body.

Moreover, one must question reliance solely on law enforcement techniques because of the sheer size of the drinking driver problem. Table 3 presents data from three roadside surveys: the March, 1971 survey

2 See Filkins et al., (4) for a review of 10 similar programs conducted throughout the country over the last 20 years.

in Washtenaw County, Michigan (2); the October, 1970 survey in Mecklenburg County, North Carolina (6); and the previously cited Grand Rapids study in 1962-63. (1)

Table 3. Percent of drivers at given BAC's

Location	Sample size	Percent of drivers at BAC 0.10-0.14	0.15+	Ratio
Washtenaw County	748	2.94	1.07	2.7
Mecklenburg County	778	2.96	1.16	2.6
Grand Rapids	7,590	0.58	0.18	3.2

These data indicate that there are at least 2.5 times as many drivers on the road in the 0.10-0.14 range as there are in the 0.15 and higher range.

Compare these data with the BAC's of arrested and tested drinking drivers. Little (1971) surveyed 39 different cities, one per State. (7) The Michigan State Police data also displayed in Table 4, cover January 1969-June 1971.

Table 4. Percent of arrested drivers at given BAC's

Location	Sample size	Percent of arrestees at BAC 0.10-0.14	0.15+	Ratio
39 States	15,000+	12.8	82.3	1/6.4
Michigan	46,000+	13.4	83.0	1/6.2

These data show a complete reversal, with over six times as many arrestees in the higher 0.15+ BAC range as in the lower 0.10-0.14 range.

Thus we can infer that for every arrested drunk driver there are another 15 or 16 drivers on the road above 0.10 who should not be there. If we further speculate that there are probably at most 1 percent of the drivers at these impaired concentrations who are subsequently arrested--and it may be much lower--then we are forced to conclude that there is indeed a very large reservoir of drinking drivers who will not be touched

by current law enforcement practices. Furthermore, the reservoir would seem to be so large that even greatly increased enforcement, at economically and operationally feasible levels, probably would not begin to drain it significantly by the special deterrent effect of the law.[3]

This is not to say, of course, that law enforcement should be abandoned as a strategy in controlling drinking drivers. Rather it is to suggest that the Federal agencies and their State and local counterparts should fully explore the possibilities of enhancing the general deterrent effect of existing law enforcement by creating high visibility for it. Credible publicity might be one approach, including information about new legal tools, such as pre-arrest breath screening devices and procedures. If this suggestion is to be followed, then particular care will have to be given to assure that the themes and messages of one agency or vested interest are not in conflict with those of another. Close coordination is clearly in order in the planning and execution of such a strategy.

An obvious but perhaps not fully appreciated fact is that, if the body of the alcohol abuse octupus is generally shrunk in size, then there should be a concurrent reduction in the size of all of the tentacles, including that of the alcohol-related crash phenomenon. For this reason alone, we strongly endorse the general efforts, which are among the NIAAA's top priorities, to prevent problem drinking. In the long run, however, the payoffs to society of effective preventive efforts will far transcend those of just reducing alcohol-related crashes, and we hope that all conferees will keep the general societal goals in mind as each pursues his special interest.

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3 See, e.g., Cramton (3) for a discussion of the special and general deterrent effects of legal sanctions.

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DISCUSSION:

Among the issues emerging in the discussion of Mr. Filkins' paper were these:

Drinking drivers are not a homogeneous group. Each case has to be treated individually. Hence, Mr. Filkins feels, public records should be kept and made available for collation by agencies--courts, treatment--agencies that badly need to know the history of the individuals coming to them. If the Uniform Act really prevents such record-keeping, it may be unfortunate. Some members of the workshop had misgivings about such record-keeping as an invasion of privacy. This problem was studied by Miller in a book referenced in the paper. The subject came up again in the final session of the workshop.

Information on penalties for drunk driving and the likelihood of getting caught can be publicized by police and/or courts in such a way as to deter many drivers. The Scandinavian experience seems to suggest that drunk driving laws are effective partly because citizens feel they are going to get caught.

Technological devices to prevent drunk driving have some potential but certainly cannot be relied on to cut the amount of drunk-driving substantially or to cut fatalities in drunk-driving crashes. Safety interlocking devices used by court order are not likely to gain public acceptance and many alcoholics are manually proficient. "Packaging" safety devices appear to work well at moderate speeds, but many alcohol-related accidents are high-speed crashes.

License suspension or revocation apparently is not a real answer either. A California study showed that two-thirds of persons under these sanctions were driving within the proscribed period, and many of them got into a second crash. You don't need a license to drive, just a key.

Antabuse has not made great inroads on the alcoholic population, largely because it requires voluntary participation that must be kept up. Legal sanctions have been applied spottily and only in recent years. In the Washtenaw County program, use of antabuse is voluntary. Drinking drivers are referred to an alcohol council. It was pointed out in a workshop that referral is not enough. Someone has to take the responsibility to see that the subject goes to the agency or to AA.

Great interest was shown in the Michigan Alcoholism Screening Test. MAST is a yes-no test consisting of 26 questions, all related to the subject's drinking, which have proved discriminatory in other tests. MAST is now used in many places. Some investigators are trying to shorten the

instrument and others to made it self-administered. There have been complaints that it is too sensitive, that it catches people who are social rather than problem drinkers. But, it was maintained, it is better to err on that side.

At intervals in the discussion, it was emphasized that agencies dealing with alcohol have a common constituency. A man may surface as a drunk driver or felon or a public inebriate, but his needs must be treated regardless of where he is encountered.

THE ALCOHOLIC OFFENDER: MANPOWER NEEDS FOR THE FUTURE

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In reviewing the published literature, including the previous papers given at this symposium, there is one most striking conclusion regarding manpower needs in this field. We need more people like Walsh and Shandler who deal with real human beings, as well as some really good social statisticians to provide hard data for realistic social planning. Given the difficult choice, I would opt for more of the people who work with human beings, since it does not seem to me that there is any great mystery about the nature of the alcoholic and his behavior in social terms. The great mystery, presumably not relevant to this meeting, has to do with the psychobiologic processes which underlie problem drinking. Until these processes are clarified, we have no generally applicable therapeutic or preventive measure to offer, and we must deal with the alcoholic as we do with other chronically impaired individuals, such as the blind, the crippled, the mentally retarded, and the diabetic.

Hopefully, we can move society to act, if not with compassion, at least with the sense of social utility and cost-effectiveness which for the other disabilities has led to the development of sheltered workshops, improved environmental design, and special education. Therefore, we probably need to add to our manpower list some sensible publicists to communicate that alcoholics, even public inebriates, are members of the same species as the rest of us. In a society that honors the biological maxim for species survival as little as does our own, that may not help much, but it seems worth trying. Fortunately, we have reduced the moralistic search for public vengeance that was prominent only a few decades ago. If we could also reduce the number of policemen who, in lieu of better prey, are willing to settle for beating a drunk, we could also drop the emergency medical manpower needs in the field. This alone, quite aside from either logic or cost-effectiveness, would probably justify removing alcoholism per se from the criminal justice system.

THE NON-VIOLENT MINOR OFFENDER

I would suggest that in our discussion we try to agree first on the characteristics of the non-violent alcoholic offender and his needs. I suggest the following outline:

1. High probability of recurrent symptoms.

2. High rate of medical problems -- both alcohol-related and incidental.

3. Best prognosis in highly structured, supportive setting.

4. Relatively infrequent (or ineffectual) self-help efforts.

5. With time, increasing probability of brain damage (from trauma, malnutrition, toxicosis) with consequent further impairment of adaptive capacity.

6. "Criminal activity," if any, likely to be related to alcoholic needs -- e.g., stealing, prostitution, check-passing.

For this group of individuals the manpower needs are for fewer policemen, fewer psychotherapeutic psychiatrists, fewer jailers, and for more halfway houses, sheltered workshops, mutual support groups, and good medical care. The evidence to date is that the most effective "helping personnel" are distinguished by personal rather than professional characteristics. They should therefore be recruited not from graduate schools but from unemployed mothers with grown children, retired men, and similar groups. Everybody in the mental health movement seems to talk of this use of "non-professionals" in primary "delivery of service" but tries to implement it by starting new training programs modeled on diluted professional ones. I would suggest apprenticeship, and training, "by contagion" (to use Toch's felicitous phrase), using the several identifiable, viable programs which exist in nearly every urban area as model points.

Since I do have a professional bias and assume that human process can be at least described, I would also want good professional outcome evaluation and description of such centers. Probably good social psychology or perhaps anthropology is the descriptive discipline. At any rate, I'm sure it's not contemporary psychiatry. This participant observer, however, is not to be the implementor nor administrator of the program.

THE ALCOHOLIC FELON

Next, let us turn to the "criminal," independently ascertained for performance of a socially onerous act presumably independent of alcohol consumption. I should like to include in this category the "dangerous driver," who in any society without the automobile as a graven image would be adjudged "criminal." Further, I think that many of the same logical problems arise in consideration of the two groups.

Many sources have called attention to the frequency with which crimes (and accidents) are perpetrated by individuals with significant blood alcohol concentrations. Three logical, not mutually exclusive, possibilities arise:

1. The ingestion of alcohol was antecedent to, and necessary for, the act.

2. The alcohol ingestion was incidental to and irrelevant to the act -- that is, it was independently motivated by the same state leading to the act.

3. That 2. is true, ab initio, but that the presence of alcohol reinforces the "criminogenic state." That is, it increases the probability of the act (or of getting caught at the act!).

I find the available data not clarifying in regard to these possibilities. But I suggest that it might be possible to assign some individuals to each category with an improvement in understanding and management.

Estimates of 20-45 percent incidence of alcoholism in prison populations have been made. (The rate in a socioeconomic matched population is not clear.) Guze in his paper today and elsewhere has documented the higher recidivism rate for this group than for non-alcoholics, although Roth[1] has pointed out that they make better prison adjustments, are more likely for parole, and generally are serving shorter sentences. Guze has also emphasized that the initial criminal behavior began before the heavy drinking did in his group.

All of these data suggest that the felon who is a chronic alcoholic poses some special problems in management. The evidence that he makes a good institutional adjustment to prison, has a high recidivism rate that can be ameliorated by close parole supervision, and that his crimes (when not "alcohol-related") are often for property is suggestive of the minor offender. That is, these individuals are least likely to repeat offenses if they are in a continuing, supportive, supervised community. Manpower needs replicate those of the minor offender except that these individuals now "belong to" the criminal justice system, their programs are funded by LEAA rather than NIMH, and they are on legal rather than social parole. Within the correctional system they could probably be managed with fewer constraints than the non-alcoholic population; unfortunately, most correction systems are so bad that this is a marginal consideration in planning. In Massachusetts a common occurrence is the transfer of a new parolee to a halfway house for drying out. Prison "hooch" is powerful stuff!

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1 Loren H. Roth, Robert Levinson, and Nathan Rosenberg, "The Alcoholic Felon", Quarterly Journal of Studies On Alcohol, 32, #2, 1971.

THE VIOLENT OFFENDER

There are two subgroups of alcoholic offenders whom I find of particular interest. Both are likely to have records of violent behavior and often of violent offenses. The first includes individuals who, for whatever complex sociobiologic reasons, have periods of increased tension and restlessness, drink in a misdirected attempt at self-medication, exacerbate the dysphoric state as well as impair cognition, and finally erupt in a "criminal" act or a self-injurious one.

The other, less common group includes the cases early described as "pathological intoxication" and are characterized by episodic destructive behavior, seen only with alcohol, and often with only a small amount. These latter individuals are rarely "chronic" alcoholics, although they would be included as alcoholics by certain of Jellinek's criteria.[2] The former are often "binge drinkers," the binges associated with the rising tension states.

These two subgroups include individuals who have intrinsic brain disease, and it may be that, with better diagnostic tools, many of them would be so diagnosed. In any case they require a good medical workup not now routinely available.

The existence of these identifiable subgroups, probably a fraction of the alcoholic felon population, points up a more important issue to me. I suggest that the concept of the "alcoholic" is as useless -- or worse, as misleading -- as the concept of the "schizophrenic" or even the "criminal."

The role of man's oldest and most favored brain toxin in the total syndrome of social failure which leads some men and women into the clutches of the mental health system and others into the criminal justice non-system is varied. That variety has a finite set of subdivisions, but until they are recognized and weighed (and their mechanisms understood) we might as well light candles as to do systems analysis on "The Alcohol Problem."

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[2] See E. M. Jellinek, The Disease Concept of Alcoholism, New Haven: Hill House, 1960.

DISCUSSION:

If we are talking about working with large numbers of subjects in viable, community-oriented programs, Dr. Ervin said, a great deal more manpower will be needed to staff the programs. More professionals will of course be needed. But heavy emphasis must be placed on the use of non-professionals. By that term he means not the paraprofessional, who has been given some kind of diluted professional course, but people who come from the community, perhaps the ex-con or the ex-addict who has learned to survive. Such people can best help alcoholics coming from prison or from community treatment because they have been through the mill too. Alumni of Daytop or other successful community programs (carefully screened) can be trained through apprenticeship, learning by contagion to become change agents.

Some of these non-professionals may well be the "therapeutic personalities" to whom attention has been given in recent years, people who have special ability, perhaps inborn, to help others. Research is now seeking to determine the elements that go to make up the therapeutic personality.

The Maryland program for training alcoholism counselors gives ex-alcoholics training for six months for placement in general hospitals. Here they handle drunks who come to emergency wards, offering counseling and suggesting treatment. Strange to say, the physicians have learned from the counselors something about treatment of alcoholics, even that alcoholism can be treated. Some general hospitals have begun to request counselor training for nurses and other staff members.

CONCLUDING DISCUSSION:

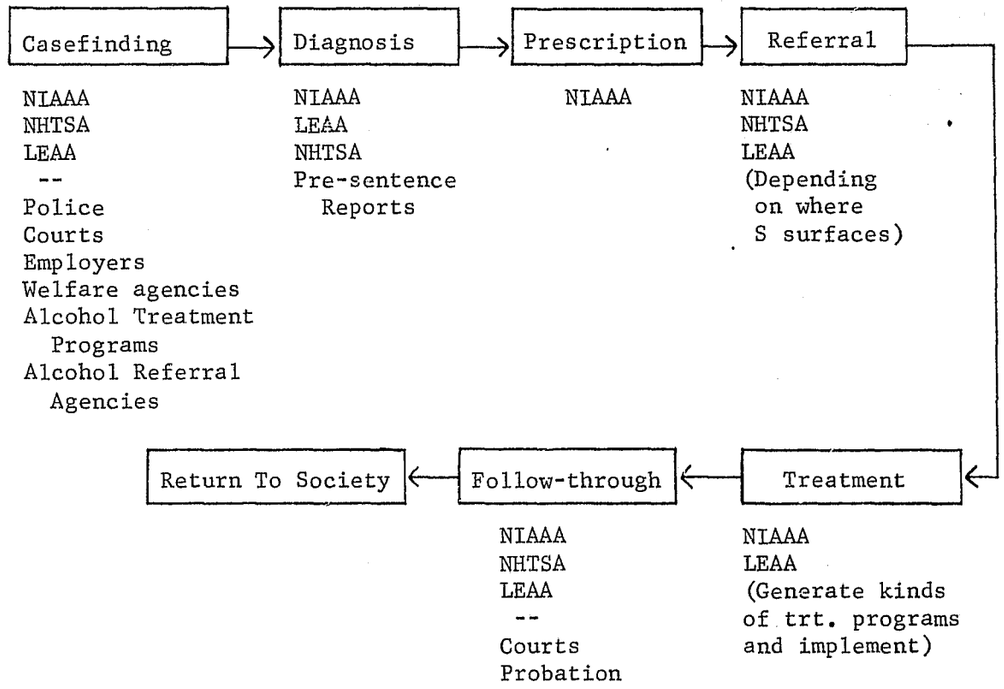
Much of the discussion immediately following Mr. Filkins' and Dr. Ervin's papers was devoted to the conclusions and recommendation that this workshop might make to the conveners of the conference. Points made in both periods are melded into the following narrative.

It was suggested that both State and local programs would benefit if representatives of the three Federal agencies met at least quarterly at the regional level to check on programs in operation, determine how they might be made more viable (as by reallocation of funds), and see what the gaps in service are. Alternatively, regional representatives and State people might meet around a single issue -- e.g., drunk driving.

As a practical matter, communities interested in having an alcoholism program should get the interest and endorsement of top State officials -- the head of the public health department, of the State police, a prominent judge. Just to have these people talking together would be an advance over the present situation.

The proposition was advanced that social action should be the outcome of this conference. We know what can be done to minimize social costs of alcohol abuse, at least to some extent. Why not identify one or two specific areas for intensive cooperative effort, to try out several different program models so that we can get decent records and ascertain what works best under a given set of circumstances? For example, the drunken driver is a social concern, attempts at control are politically viable, and some money is already in the field. The three agencies might work on this problem, using different models.

A flow chart was developed for successful treatment of the alcoholic, no matter where he surfaces. Casefinding is being done now by programs linked to all three agencies or by State and local agencies without help from the Federal agencies, such as police, courts, employers, welfare agencies, and alcohol referral and treatment groups.



Diagnosis -- medical and psychosocial -- is the interest of NIAAA. LEAA is concerned here too, with pre-sentence reports that can be done by a trained alcohol problems counselor instead of an overworked probation officer.

The prescription function is the interest of NIAAA.

Referral is the interest of all three agencies, depending on where the subject surfaces. Referral is the point where the process often breaks down. Too many subjects fall through the cracks.

Treatment is the interest of NIAAA, which generates modes of treatment and methods of implementing them, and LEAA through the alcohol programs of jails and prisons.

Follow-through is the interest of NIAAA in treatment and LEAA and NHSTA through courts and probation officers.

The flow should conclude with the return of the subject to society.

It was emphasized that the community is the place where needs must be perceived, staff recruited, funds secured, and programs given public support.

The consumers -- in the form of drinkers and their families -- must be involved in planning programs.

WORKSHOP II -- THE PUBLIC INEBRIATE

Moderator: Donald Ottenberg

Recorder: Anne L. Twomey

Papers: The Housing and Treatment of the Public Inebriate
Irving W. Shandler

The Public Inebriate and the Highway Transportation System
Kent B. Joscelyn and Victor L. Streib

2,000,000 Unnecessary Arrests
Raymond Nimmer

Meaningful Employment of the Public Inebriate
Joseph L. Walsh

THE HOUSING AND TREATMENT OF THE PUBLIC INEBRIATE

Irving W. Shandler
Diagnostic and Rehabilitation Center
Philadelphia

Several thoughts occurred to me when I received the title of the paper I was asked to prepare for this Joint Conference.

First, the emphasis on housing struck a familiar and almost embarrassing note. Several years ago our Diagnostic and Rehabilitation Center (DRC) was actively engaged in a program of rehabilitating and relocating men from Philadelphia's skid row. The Center had the primary responsibility for the rehabilitation program, and a local urban renewal agency arranged for the relocation. Even though rehousing was not the Center's responsibility, I realize in retrospect that we had taken the position that, if we were successful in our efforts to get a man sober and help him to leave the row, his adaptation to his new housing was almost assured.

Like many professionals from the social sciences, public and mental health fields, we were enamoured by the mystique of therapy and its ability to equip any person to handle everyday problems. While we were sensitive to the bread-and-butter issue involved in getting men to and holding them at the Center, we were ready to allow clients to leave the program -- heavily therapized, medically able to function, with some type of economic subsistance, tied into some type of community agency -- but little if any emphasis on their housing.

It did not take too long or too many follow-up reports to realize that the program's lack of emphasis on housing was creating a revolving door. Placing a man in a specialized housing program was not a guarantee of successful rehabilitation and relocation. If the man was <u>not</u> in a good housing program it was a guarantee of failure. For the DRC now, housing is and will continue to be an integral part of our rehabilitation program.

Another thought triggered the re-reading of the Williamsburg Papers(4) which contain a talk prepared for that conference held in February 1969. In that paper, I reported on Philadelphia's progress in moving toward a comprehensive alcoholism program and made the prediction that within two years the program would be developed. Now, <u>three</u> years later, Philadelphia still lacks a well-defined, well-coordinated city-wide program. Although there had been some legal precedent for action there was neither the political commitment from City Hall nor the moral concern by the public mental health leadership.

In a more positive sense I realize that not too many years ago the answer to the question of both housing and treatment of the public inebriate would have been very simple - the jail. Now there is an atmosphere of change, a sense of concern, and an apparent willingness to attack this problem with the interest and support of three Federal departments. It is an impressive beginning.

THE PROBLEM

This discussion of "the problem" is based on certain premises. The public inebriate is essentially the skid row man. The problem of the public inebriate is one of increasingly critical importance to most urban areas. It is essentially not a police matter. It should be the responsibility of health officials.

While statistics will vary from city to city, the number and percent of individuals arrested as public inebriates (and on related charges) is impressive. The President's Commission on Law Enforcement and Administration of Justice (1) reported in 1967 that one out of three arrests in the U.S. were for simple public intoxication. In Philadelphia the percentage of alcohol-related arrests usually runs between 40 and 50 percent. These arrest reports do give us some information, but they do not answer certain key questions. Specifically, how many individuals are repeaters and help to increase the large number of arrests? If there is evidence that the public inebriate is really the person picked up primarily on skid row, the problem then is related to the entire issue of skid row and its continued existence. This decision involves public policy toward skid row; the law regarding intoxication on the row; the system of involving the inebriate in some type of rehabilitation/rehousing program; and the resources necessary to effectively offer help to those individuals for whom alcohol is a problem.

It should be noted that the system, program, and resources developed in the next pages are being recommended as a common denominator for a total community alcoholism program. Each part of the program will be required in different degrees by each alcoholic at a different point in time. No group, however, is more in need of that total program than the skid row alcoholic.

PUBLIC POLICY

You can't win without City Hall. Any attempt to develop a program dealing with the public inebriate that does not have the support of the community's political leadership is both naive and impossible. As will be suggested later, an effective program will require a plan to control and prevent skid row; and it must have the support of the police, the cooperation of the hospitals, the understanding of housing agencies, etc. All of these will require the stamp of approval from the powers that be. Not every

agency will view the public inebriate as deserving of its attention when compared with the many other legitimate (or more vocal) problems it faces.

The waste of the money and hours of police time, the jammed courtrooms, crowded prisons, and tragic deaths in cells may not be enough to warrant change. These are already well-known facts. Nor can we charge the entire criminal justice system with the poor results of their efforts to rehabilitate the alcoholic. What then does it take to initiate changes? There is no single answer.

Of prime importance is the focus placed on the problem at the national level. Here great strides appear to have been made. State programs -- particularly in health, welfare, highways, and justice -- need to join forces in recognizing the problem and then agreeing on how they can support a course of action. If the situation were not so serious, the bureaucratic games played by competitive public agencies would be worthy of Gilbert and Sullivan.

Most critical is the local level. Here responsible people in the public and private area need to convince City Hall that a program that is good for the public inebriate is good for the city. This may involve techniques that are personal, professional, or political. These men have no militancy and no advocate. Yet concern for them translated into programs benefits all parts of the community.

Related to support, of course, is funding. Here again the Federal level appears to be leading the way. But without the realistic financial support at the State and local levels, programs simply cannot operate.

One brief comment about other drugs. It is almost a bad joke that our society has created a sense of panic about the misuse of certain drugs -- marihuana, the amphetamines, barbiturates, the psychedelics, and the narcotics -- and concurrently has not recognized the country's major drug problem - alcoholism. It should not be an either-or, but responsible officials should be helped to judge the drug problems with legitimate perspective.

THE LAW

The most effective way to create a frame of reference within which a program can successfully operate is to have the full support of the law. Many hoped that the decision on Powell v. Texas would give the country a mandate from the highest court. It did not, but there was considerable evidence that something had to be done to sensitize communities to the problems of the public inebriate.

A major step was taken with the development of the Uniform Alcoholism and Intoxication Treatment Act drafted by the National Conference of Commissioners on Uniform State Laws and approved by that body at its

annual conference in August, 1971. As of this writing the District of Columbia and the State of Washington have new legislation, and the Uniform Act is being considered by five State legislatures. A new law is critical, not only to give legal guidelines, but to remove the incredible sense of confusion that has existed regarding the public inebriate. For example --

In Pennsylvania, since 1794, laws relating to intoxicated offenders have been added which overlap and confuse the judges who must attempt to be guided by them. An offender might be convicted under a 1794 law and jailed by a provision of 1871 or 1895; or under a 1953 Act committed to a hospital in lieu of sentence; or hospitalized under the Mental Health Act of 1966. (2) Still more legislation under current consideration only adds to the sense of confusion. Clearly the cry for legislation that presents new approaches and clarifies the old should have people from the criminal justice system and the health field joining in chorus.

Changes in the law or legislation create conditions for change but are not sufficient in and of themselves. They need to be implemented, and adequate funding must be provided for implementation.

In 1967, the Philadelphia Court of Common Pleas ruled in the case of Commonwealth ex rel. Lee v. Hendricks that "habitual intoxication is an illness, and as such may not constitutionally be made a criminal offense." It would suggest that the public inebriate in Philadelphia would be free of police involvement and instead be handled by health personnel. That was the theory. In fact, little changed. The police were more than willing to cooperate with any public or private program that would relieve them of the burdensome responsibility of picking up the inebriate and either taking him to the drunk tank or trying to get him into a hospital. Nor were the magistrates' courts eager to continue the charade of justice as crowds of skid row men were herded in before the bench and disposed of in a manner that at best was capricious and at worst punitive. But the law was not enough. There was little action from the Health Department and no support from either the City Council or the Mayor.

As a consequence the police continue to pick up the public inebriate, the vagrant, and at times any skid row man. Most are held until the next shift comes on duty and then released. A few may be held for court if in the judgment of the police they need to be sent away. The police recognize their medical limitations and the prejudices of individual officers, but there are still no alternatives. So a gentleman's agreement has developed that satisfies neither the police nor the health officials. Hopefully, that situation may be nearing an end. There is a new city administration and there is some evidence of their interest in supporting the long-awaited program.

Even though Philadelphia has its ruling regarding the public inebriate steps are being taken to persuade the State leadership of the importance of statewide change in the law.

THE SYSTEM

Given legislation that provides a condition for operations, the support of the public officials, and appropriate funding - what then is the system of services that are needed to provide housing and treatment for the public inebriate?

The system should include the following:

1. Emergency screening and referral centers
2. Detoxification units
3. Sub-acute detoxification housing
4. Psychosocial evaluation and referral program
5. Treatment modalities - outpatient
6. Treatment modalities - inpatient
7. Housing - temporary
8. Housing - transitional
9. Housing - supervised boarding homes/hotels
10. Housing - domiciliary

Emergency Screening and Referral Center

The most vital element in the system of working with the public inebriate is to get the man to a place where his medical condition can be judged. Here the extent of his intoxication can be evaluated - whether he is drunk or staggering for other reasons.

These screening and referral units should be available on a full-time basis and geographically located in a way that services the entire community. To this unit the inebriate could be brought, referred, or come on his own. Here he would be examined by physicians and interviewed by alcoholism counselors. As a result the man might be:

- sent or transferred to a cooperating general hospital for detoxification.

- sent to a non-hospital, sub-acute detoxification unit.
- held for a brief time and then discharged to a responsible member of the family or friend.
- taken or sent home.
- transferred to a special protective unit within a local psychiatric setting.

Irrespective of how the inebriate gets to the center, he should become a health facility responsibility and not that of the police. This is not to deny the realistic role the police will have to play in picking up the man and bringing him to the center. There have been recommendations that special emergency patrols handle this responsibility. I can see some limited value in specially trained and deputized health personnel patrolling those areas of known high incidence but not as a city-wide function. Just as the police have been trained to handle other medical emergencies, there is no reason why they cannot be helped to work more effectively with the public inebriate. Appendix A of this paper presents material prepared by the DRC's medical department which can be used as a basis for police instruction.

Not all persons coming to the screening unit will require hospitalization. In 1967 our Center conducted a study at Philadelphia's 6th Police District (which serves most of Center City, including skid row). The results of that study were published in a report, Alternatives to Arrest. (3) The study involved 190 cases. After clinical examination the following results were noted:

- Hospitalization was an urgent need for about 10 percent of the men and required for about one-third.
- Sub-acute detoxification, with minimal medical supervision, was recommended in about 20 percent of the cases.
- Almost half of the clients could, after a short period of time, be discharged to their own custody.

In the study, Breathalyzer tests were given, and about 70 percent of those picked up had readings high enough to be considered intoxicated. About 10 percent had readings low enough to be presumed legally sober. Some had been arrested and brought in because of an unsteady gait or general appearance. Some were not drunk but ill and required hospitalization.

The question raised most often of our medical department concerns the criteria for referral to a hospital for detoxification as against referral to a sub-acute detoxification unit.

The medical department prepared the special guidelines that may be found in Appendix B.

Detoxification Units

Our experience has indicated that not every person brought to the screening unit requires detoxification. For those who do, the detoxification units are really sub-acute detoxification programs and if a man suddenly becomes critically ill, he is transferred to a medical unit. Efforts should be made to be consistent in our terminology.

The length of time needed for detoxification tends to be about five days, but there should be some flexibility for more time if necessary.

Recently, we undertook a small study of 50 consecutive referrals for detoxification to one of our cooperating hospitals. All had been screened by our medical department, and all were accepted by the hospital for treatment. The analysis of the data has not been completed but some of the early results may be of interest.

1. All patients were either acutely intoxicated or in acute withdrawal from alcohol. All were malnourished.
2. All were adults - five female. Thirty-nine were hospitalized for alcohol detoxification alone. Eleven had other medical problems.
3. Their pre-hospitalization diagnosis included 9 additional medical problems, of which these were considered major: cirrhosis, chronic degenerative lung disease (emphysema, bronchiectasis, chronic bronchitis).
4. Discharge diagnosis included 38 additional medical conditions, of which 30 were of major importance:

Chronic degenerative lung disease	10
Diabetes, other abnormal blood sugar	4
Urinary tract infections	4
Cardiovascular disorders	7
Tuberculosis, inactive or active	3
Gastrointestinal disease (cirrhosis, ulcer)	2

5. Three patients left the program against medical advice.

The small number of pre-hospital medical diagnoses is a reflection of the attitude and practice at DRC regarding the acute withdrawal syndrome; i.e. hospitalization is generally considered to be indicated for the syndrome, and therefore time is not spent on extensive medical history and physical examination, leaving this to be done in the hospital.

While detoxification is essentially a medical problem, this is also the time when alcoholism counselors should begin to visit and work with the patient. They should focus on what will happen to him after discharge, with special emphasis on housing, food, money, etc. With this emphasis, the effort to "plug him into" a treatment facility is very natural and usually successful.

A note on the involvement of general hospitals. We have found increasing ease in gaining hospital beds available for detoxification. While no single cause alone dominates, several factors are involved:

- increased number of vacant beds in some hospitals.
- third-party payment for almost all clients via Medicaid.
- referral to hospitals by DRC physicians after screening.
- availability of DRC counselors who "follow" patient into hospital.
- support of DRC to work with patient following discharge.

Sub-Acute Detoxification Housing

This unit is designed to serve patients whose condition is not severe enough to warrant hospitalization but who, in the clinical judgment of the physician, should not be discharged. The man needs a place to sleep it off, and he needs to be watched in the event that severe medical problems do emerge.

Our experience indicated that about 20 percent of those coming to a screening unit may require these services. A great deal will depend, of course, on the experience and clinical judgment of the examining physician, availability of hospital beds, the man's personal resources, etc.

Units need not be heavily staffed, but they need to have people on the premises who can be emotionally very supportive and trained to recognize symptoms that require medical attention, as a former military hospital corpsman is trained. A physician should make daily rounds and back-up hospital facilities must be readily available. The general program should have not only supportive activities but the beginnings of a plan for what happens next. Formal counseling around specific situations should be mixed

with informal group activity. The length of stay should be highly individualized, but every caution should be taken to make certain that the operation is not viewed as a free-load mission or as a dumping ground for other agencies.

Small hotels, a floor of a "Y," or some other property convenient to the screening unit might be considered. The per diem cost will be considerably less than that of a hospital, but special funding will have to be arranged. This could be done through the mental health program as a day-night hospital; perhaps via "intermediate care" category of public welfare; or best of all, financed as an integral part of a comprehensive alcoholism program whereby a central authority assumes all funding responsibility.

Medical-Psycho-Social Evaluation and Referral Program

If the first major component of an alcoholism program is to keep the man alive, the next is to obtain a good evaluation of his condition. This includes the classic medical-social-psychological work-up, but it should be done so as to have meaning to the man and in an atmosphere that is conducive to his participation.

In other papers (4) we have reported on our Center's approach to working with clients: warm, supportive atmosphere; responsible staff; minimum of red tape; emphasis on tangibles, etc. I can only restate here the absolute importance of such an approach if clients are going to be attracted to and involved in the program.

After the evaluation is completed, the case should be reviewed and alternatives prepared for and with the client. Here again, individualization of treatment must be more than a slogan if the program is to work. It means consideration of a total style of life. Abstinence from alcohol is only a partial answer. At the same time rehabilitation goals must be realistic in terms of each man's potential.

This program should be prepared to serve clients from all types of referral: from the detoxification or sub-detox unit; from the courts, prison, clergy, AA, industry, self, etc.

Treatment Modality: Outpatient

Where possible, we place emphasis on treating the client in the community through outpatient facilities. Even if an inpatient program is the client's first rehabilitation step, at some point he returns to his community and should be involved in some form of continued support. No one program can successfully bring the man to a sense of new style of life. The formal individual or group activity will be for a limited time. The client needs to be involved in activities that relate not only to his physical and mental health, but to housing, vocation, or source of income

and use of leisure time. For example, it need not be outpatient therapy vs. AA but outpatient therapy and AA.

It is important to recognize that some people do better in individual counseling and others in group activities. Some respond to depth therapy, while others "make it" best with supportive, non-confronting programs.

Our experience indicates that for most skid row men confrontive or any intensive form of therapy is ineffective and frightening. Emphasis on helping with activities of daily living and developing alternatives to alcohol and learning to have fun have proved to be far more effective in changing their style and leading to sobriety. This does not suggest that formal therapy has no place in programs for skid row alcoholics but rather that comparatively few can really make use of these specialized techniques and then only after significant preparation.

Some termination of formal individual and group activities should also be built into the program for the benefit of both client and staff. Too often, clients simply get over-programmed and quit. Frequently staff are reluctant to let go. If moving out is an objective, it should be encouraged in a structured but flexible way. The open door needs to be there and participation in informal programs may be permitted, but let us avoid the sloppy break of contacts and arrange for specific goals within given time periods.

Treatment Modality: Inpatient Care

Many alcoholics and most skid row alcoholics will require some time in an inpatient setting. For the skid row man, program flexibility from 6 to perhaps 12 or 15 months is not an inappropriate anticipated length of stay. The early stages of his care need to focus on his physical rehabilitation and psychic "cleaning up." It may take many months before he can be worked with in a rational way. While inpatient programs tend to have more control in protecting the fragile patient, we still feel quite strongly that efforts at intensive psychotherapy are, for the most part, inappropriate. Although it is less glamorous than the therapeutic mystique, we believe that the emphasis must be on discharge planning and the related issues of housing, income, counseling support, etc. For many men the experience is habilitation not rehabilitation.

The non-skid row alcoholic obviously is different in the extent of his problem, family supports, health, job, etc. His ability to make use of programs that are briefer or more intense is significantly different.

Therefore, the community comprehensive alcoholism program will need inpatient facilities that focus on programs of 1 or 2 months for short-term care; 2 to 6 months for intermediate; and from 6 to 18 months for long-term care.

Clinical experience and each client's unique situation can help determine first whether inpatient care is appropriate and, if so, within which facility.

One specific treatment tool that needs to be considered is Antabuse. We believe the question is not whether to use Antabuse, but rather under what circumstances. Appendix C presents a more detailed statement.

Temporary Housing

The skid row alcoholic has the problems of other alcoholics and then some. This is particularly true when one looks at the area of housing. Nothing more graphically depicts the sordidness of skid row than the flop hotels, dirty rooming houses, and emasculating missions. While periodically a man may "carry the banner" or walk the streets all night, at most times his need for some type of housing almost matches his need for some type of alcohol. Therefore any program that plans to work with the public inebriate needs to help him face and resolve the problem of housing. If the housing is on the row, the social contagion forces him back to drinking. If he is relocated away from the row and on his own, the loneliness and anxiety without daily support will drive him back to either alcohol and/or the row. Special housing then is needed at all levels of the program.

Temporary Housing is the type of facility that the "Y's" handle for some transients or those in need of a few days' shelter before further plans can be implemented. It should not be used for those coming off the binge but rather as a place where a man can remain for a few days after detoxification or while his medical-social-psychological work-up is being completed. It should be supervised to protect the residents. Low-key recreation and counseling should be included. The alternatives are commercial hotels that are too expensive and unsupervised or the skid row housing that can quickly destroy the man's rehabilitation efforts. Temporary housing also represents an alternative to the alleged role that skid rows have to play. The rows should be destroyed, but some of these services must be replaced and improved.

Transitional Housing

The halfway house is similar in function to the temporary facility except that it should work for a fixed period of time with those coming from institutions back to the community. The population of the house should not be contaminated by those on the way from the community to institutions. The halfway house represents the pause after institutionalization just prior to the return to reality. The program should reflect this, with counseling around specific problems plus the support needed to help people re-enter a situation that was in part responsible for their problem.

Special Boarding Homes or Small Hotel

It is to be expected that a large number of alcoholics will "make it" only if they live in a minimally supervised situation. Special boarding "homes" would house 12 to 15 men, with a resident manager-cook. They should be scattered around the city in neighborhoods similar to the background of the men. They would be boarding homes and not identified as housing skid row men. Some of these men will work, and others will receive social security, VA benefits, or public assistance. The homes could be self-supporting except for the availability of counseling services and medical attention as needed. They should be coordinated through the agency responsible for the community comprehensive alcoholism program. These are not temporary but permanent housing arrangements -- still respecting each man's right to choose his own place to live.

Domiciliary

All of the previously described were in the city and near "the action." Now we plan for those men who require special medical, social, and recreational services, for the man for whom all programs have failed. He can't "make it" with minimal supervision and needs to be away from the action for his own protection.

The domiciliary is a bottom through which no man would have to fall. Although the facility is primarily a one-way street, some men might in time leave it.

The program should have ample space and make minimal demands, at first, on the residents. Some experience suggests that after many months of minimally structured programs men thought of as hopeless do begin to function at a higher level and might be able to move to other facilities.

While some men can be helped to return to their family or live independently with friends or a live-in job, the majority of these men will need housing guidance. This flow of housing resources is another dimension of the treatment program. As that program needs flexibility and coordination, so does the housing component.

THE RESOURCES

Designing a system that delivers services to the public inebriate is relatively easy. Translating it into action is far more difficult. It requires the active support of the political and civic leadership. It also requires the support of those programs that already exist. There can be no room for competition, and there must be agreement that the array of services be coordinated by a responsible public agency.

It also means that personnel who work for the public agencies must recognize their role as one of helping and coordinating, rather than

assuming that their appointment brings with it instant wisdom and the inherent right to dictate policy.

Programs work or fail to work because of the people involved. One of the critical resources is that of the recovering alcoholics.

How important is it to have recovered alcoholics on the staff? We have found it extremely valuable to have some in our program. Almost a third of our staff have "been through the mill." They occupy a variety of positions: drivers, receptionists, community organizers, research assistants, group leaders, halfway house managers, counselors, administrative assistants, and program directors. The person's alcoholic history is quickly made secondary to his job performance and growth. We do not deny a man a job because he is a former alcoholic, nor do we automatically assume that he is an expert on the problem and hire him because of it. We are particularly wary of the punitive individual who subtly can give patients a difficult time by indicating that since he has "made it" there must be something wrong with the client who is still a boozer. Obviously, the mere presence of people in various positions who have been successful in their recovery is an asset.

Another major resource is funding. Even the most dedicated staff cannot function without support. Some of the monies already exist because of mandates to mental health and vocational rehabilitation. Unfortunately the mental health centers have tended to give the alcoholic a low priority. It is equally sad to note the lack of official pressure from the State and county officials to have the mandate followed. A new State law is simply another technique to reinforce the provision of services by the mental health centers. Other monies are available through Medicare and Medicaid. Local United Funds and foundations can assist in a limited way.

It is a basic tenet in health that prevention is better than cure. In the case of the skid row public inebriate this does become a legitimate alternative. If there is no major skid row, there are no longer those men identified as "skid row bums." There will be, of course, those men who do get intoxicated in public but not necessarily treated as they tend to be on the row.

The elimination and control of skid rows are desirable and feasible. The row is a foul place, and few men would chose to remain there if they were helped to leave and sustained in their relocation. Leaving the row would be part of the rehabilitation of the alcoholic and an essential factor in removing the man who drinks to excess because he is on the row and drinking is part of that life style.

Those institutions that interact and use the residents in a parasitic way must also be controlled to prevent the development of new skid rows. These include the flop hotels, bars, restaurants, rooming houses, missions, blood banks, day labor organizations, etc.

However, no program that works can be totally negative. It must offer the men an array of programs and resources that provide in a healthful way those services previously provided in such a demeaning fashion.

A good, comprehensive program for the public inebriate will be expensive. Few short-cuts can be taken and still maintain the probability of success. Of course, there will be saving to the community, although that amount is still to be determined. The basic problem will be one of "packaging" i.e. redirecting the funds now available with those added from the Federal, State, and local levels.

The law, manpower, and funding all become integral parts of the new program, but only with proper coordination and direction.

SOME FINAL THOUGHTS

Throughout this paper I have stressed the equation of the public inebriate to the skid row man. I realize that a number of individuals do get arrested as public inebriates outside of the row. Many arrests take place in those police districts bordering along skid row and others in the areas identified as lower socioeconomic black neighborhoods. Arrest for public intoxication is not commonly a middle- or upper-class phenomenon.

There may be significant differences concerning the black public inebriate but not in his need for the same kinds of service suggested for the skid row inebriate. The first effort is still to keep the man alive; then help him to evaluate his problems; then develop a plan that is realistic in both implementation and goals with a focus on life style, rather than merely abstinence from alcohol. It is this effort to create basic individual change within the alcoholic that utilizes the incident of public intoxication as the "grabber" for entrance to a total treatment program.

The question of civil commitment was not raised here except to note that it should be an integral part of any legislative changes. This medical-legal area needs considerable study before a law is enacted. But, perhaps even more important, the process needs to be reviewed, evaluated, and, if appropriate, changed. We must look at the issue of commitment to what kind of facility. At what point is an alcoholic dangerous to himself or others? When does society assume the responsibility of not allowing a man to slowly commit suicide? Is there an inherent right to treatment for all alcoholics as a public responsibility? Who is qualified to exercise the necessary judgments on the alcoholic medical-legal status? How desperately we need answers to these and other significant unknowns!

Part of the answers must come from research -- legitimate, honest research. Program people have the responsibility to do a good job and evaluate their successes and failures. But they need to have the luxury of failing without fear that their granting agencies will suddenly withdraw support. This is not an excuse for sloppiness or poorly planned programs but rather a plea for a contract that essentially states: "You have a treatment modality you want to try. O.K., try it and give it your best, but evaluate what you are doing. Then you can help your program and others. Don't be afraid to try and fail, but try to know why!" Few program administrators would fail to respond with a high degree of enthusiasm and support.

While I have used the term housing throughout the paper it might be better to coin the word "homing" to illustrate the intent of these facilities. A place to eat, sleep, and perhaps lounge around watching television is not enough - even with the assumption that the quality of bed and board are safe and good. The essence of the "housing - homing" program is the personal relationships that evolve. It is the importance of having someone worry about you, of enjoying the luxury of worrying about someone else. It really means being alive!

The stress on the emotional overtone to the program also carries with it a strong pragmatic factor. The objective of the process is to assist the man's handling of his alcohol problem and to alter his life style so that it supports sobriety. Formal treatment can only go on for a limited amount of time. At some point, if successful, he must make it by utilizing his daily resources. Housing is the most critical of the resources and if he gains support - physically and emotionally - from his living arrangement, he is well on his way. Housing is then the longest-acting component of this rehabilitation plan.

SUMMARY

The problem of the public inebriate is basically a legal-medical-social one that can be resolved. This can be achieved by a public policy that is dedicated to the destruction of skid row and its institutions plus an effective program of rehabilitation and rehousing for the men who live there. Any program that is developed to serve the man with the greatest array of needs should also be equipped to offer selected services to the alcoholic and alcohol abuser who came from other segments of society.

The public inebriate, perhaps more than any other, offers to a variety of agencies the opportunity to work together for a common objective -- the salvaging and reclamation of a human being. In no job can there be greater satisfaction.

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Appendix A

WHAT POLICE SHOULD LOOK FOR IN THE EXAMINATION OF THE PUBLIC INEBRIATE

A. Signs of injury - muscle or bone injury affecting mobility; evidence of beating; bleeding.

B. Absence of consciousness.

C. Rationality of affect.

D. Evidence of medical illness - fever, tremors, confusion, abnormal gait (locomotion).

Ideally, every public inebriate should be brought to a designated place for medical examination and evaluation. Until that time, the policeman may find himself confronted with making a decision as to where to take the person.

The policeman should observe the following:

Locomotion. Is he only staggering slightly, is he almost falling every few steps, is he relying entirely on the side of a building to stay on his feet, is he rooted to one spot and swaying, or is he sitting or lying motionless?

If he is moving in one of the described patterns, then it might be said that the lesser the degree of motor control the greater may be the urgency for hospitalization.

Consciousness. If he is stationary, then is he awake, asleep, unconscious, or dead. If awake, he may be resting or unable to stand due to injury, weakness, or intoxication.

If eyes are closed, a slight shaking of his body may demonstrate merely sleep. If unresponsive to this, then a pulse must be searched for - at the wrist or throat; if absent, delivery to hospital is urgent, for ventricular fibrillation may be present and may respond to electroconversion.

If a pulse is detectable, then firm fingertip pressure against the bony ridge over the eye, near the base of the nose (the supraorbital notch, site of emergence of the supraorbital nerve), will produce a sufficiently painful stimulus to differentiate deep sleep from a more serious unconsciousness suggestive of febrile or liver toxicity or intracranial emergency (hemorrhage, thrombosis) or internal bleeding elsewhere.

Of course, external signs of trauma dictate hospital or medical services. Injuries are more likely multiple, and the visible bruises may be of least importance.

Test for broken extremities before attempting ambulation. More than one public drunk has been forced inadvertently to walk on a fractured foot, leg, or hip.

Rationality of affect is an important consideration for the policeman to deal with, because it may challenge his patience, his understanding, and his individual style of handling people. The public inebriate may be placid and cooperative; hostile and acting out his anger (toward the police or society in general); or confused or psychotic. If confused or psychotic, then he cannot be expected to listen to reason but should be talked to as though he is in fact the rational one, thus getting his cooperation in being led to appropriate treatment.

Prepared by: Dr. Jerome Kohn, Medical Director, DRC.

Appendix B

GUIDELINES FOR PHYSICIANS EXAMINING THE INEBRIATE REGARDING REFERRAL TO HOSPITAL OR SUB-ACUTE DETOXIFICATION UNIT

A. Possible complications during Acute Withdrawal Syndrome (AWS)

B. Inebriate's presenting physical conditions

C. Availability of necessary supports

A. It is important to note that the severity of the acute withdrawal experience is not predictable. The decision whether or not to hospitalize the acute irebriate cannot be made comfortably from any specific, accurate criteria or guidelines. A knowledge of the pathological physiology of the Acute Withdrawal Syndrome (the early period of recovery from the effects of excessive intake of ethanol) indicates to us that the acute inebriate may experience life-threatening complications during his binge and during recovery, and therefore presents a potential emergency situation deserving of, and in fact demanding, close medical surveillance and treatment during this critical period. Thus, hospitalization would be ideal every time. For example, a well-known complication during withdrawal is delirium tremens. It represents a progressive complex of psychophysiological reactions which may terminate in a convulsive seizure, which in turn may lead to brain damage, coma, or death. This frightening complication may occur up to seven days or so after cessation of drinking, most often on the third day. The mortality rate for DT averages 15 percent. It is preventable with proper treatment. So too are the other possible drinking complications - cardiac, hepatic, renal, respiratory.

B. The actual physical condition of the inebriate when he is first seen is another factor influencing the decision whether or not to hospitalize. For example, pneumonia is statistically the most common acute infection found in this patient. He is likely to be in a debilitated state from the combined effects of excessive alcohol intake, inadequate sleep, malnutrition, exposure to the elements. Untreated, he may succumb to the pneumonia. His cardiac condition may be critical and kill him if untreated. Thus the necessity for a medical screening prior to disposition.

C. The availability of necessary supportive services may modify one's decision regarding hospitalization. For example, if the inebriate's medical screening indicates absence of immediate need for intensive care of observation, then he may be sent to his home or a sleep-in situation provided that

there is present such person or persons who will watch his progress carefully and follow instructions of physician about medications and nourishment and nursing care. He should be seen daily by the physician for at least one week, or the responsible person caring for him should report important data to the physician daily in the absence of direct doctor-patient contact. The patient needn't necessarily be house-confined or bed-ridden.

Prepared by: Dr. Jerome Kohn, Medical Director, DRC.

Appendix C

THE SPECIAL ROLE OF ANTABUSE AS A TREATMENT TOOL

One of the questions most frequently raised of our alcoholism treatment program concerns the use of Antabuse.

Antabuse is a drug which blocks the excretion or elimination by the body of acetaldehyde - a toxic end product of alcohol metabolism. The assimilation of this toxic product accounts for the physical illness which results when the individual drinks while taking Antabuse.

Our agency makes selective use of this drug as part of the overall program. To those who view Antabuse as the answer to alcoholism, we respond by paraphrasing the AA view that there is a difference between being dry and being sober. Abstinence from alcohol alone is not an effective treatment goal.

On the other hand, those who decry the use of Antabuse as a chemical crutch and an inappropriate treatment tool need only face the frustration of repeated efforts to get the drinking alcoholic into the early stages of program. One cannot counsel the patient who isn't there or in such a deteriorated state that no working relationship can be established.

The DRC then views Antabuse as a useful deterrent tool in assisting some alcoholics in maintaining sobriety.

Its use may be for either short or long term based on the medical, social, and psychological appropriateness.

1. Short-term use:

   a. Important in the very critical time period between the cessation of the latest binge and the involvement in a treatment setting.

   b. During the early phase of therapy while the patient's identification with treatment setting and his acceptance of it is developing. He is very fragile at this time.

2. Long-term Use:

   a. The working alcoholic who requires the psychological re-enforcement of this absolute deterrent.

   b. The alcoholic whose history has demonstrated an apparent incapability of abstaining from drinking with any combination of other kinds of reenforcement (AA, group therapy, individual therapy).

Medical supervision is necessary and the following is recommended.

1. Screening before Antabuse begins:

   a. Rule out contraindications.

   b. Explain alcohol-Antabuse reaction and its dangers.

   c. Explain value of Antabuse as a deterrent, its time-buying value to allow for a change of mind when he has reached a point of frustration or exasperation, when he customarily would have started drinking. Since he must wait at least five days after stopping Antabuse before he can drink with some safety, he has those five days to find an alternative to drinking.

2. Periodic medical screening with long-term usage - observation for skin reactions, depression manifestations, psychotic break, emergence of psychotic or sociopathic patterns that had been suppressed with ethanol.

Some special points to consider are:

1. Close supervision and observation at the beginning:

   In a form to obviate avoidance -- e.g., crushed in apple sauce and washed down with water; or swallowed whole, washed down with liquid, followed by some spoken phrase. This is possible in a controlled setting, as in a residential or outpatient program.

2. Buddy system:

   Responsibility for administration is given to third party (friend, relative) who sees patient daily.

3. Self-responsibility:

   The working alcoholic who has demonstrated sufficient reliability to create some comfort about allowing him to take his own medication.

DISCUSSION:

Several topics came up repeatedly: housing for the public inebriate; coordination among interested agencies; funding programs for the public inebriate.

Points raised on housing:

1. Unless there is some residential facility for the chronic public inebriate, he will simply go back to skid row and the program will be revolving door.

2. HUD is in a position to help private institutions serving the public inebriate to construct facilities through its mortgage insurance programs for medical care facilities.

3. Some areas carry the chronic inebriate on assistance rolls, and their monthly checks can be used in part to pay operating costs for a residential facility.

Coordination issues:

1. Federal agencies have means of coordination, such as the agreement signed by the secretaries of DOT and DHEW, and the Federal regional councils in the field.

2. Are Federal agencies asking local agencies to do their job? Federal agencies should get together on assumptions and plans before asking State and local people to cooperate. The needs felt by State and local people must "filter up" and thus influence funds and program.

3. There is need for Federal accountability and a strategy to secure Federal coordination. If pressure is exerted by community people, something will be done.

4. State plans must have inputs from the consumer, the practitioner, and the decision-maker at the State level. The plan is not an end in itself; the sincerity and intent of the planners are the real bases of success.

5. There is a need for regional meetings.

Funding issues:

1. The workshop challenged LEAA's one-year funding as unrealistic. Programs cannot be initiated, operated, and evaluated in such a short time, and hiring is terribly impeded. Pressure should be put in the State planning agencies to push for multi-year funding.

2. Federal money is seed money. Its purpose is to stimulate other support, so that the program will not die when Federal support ceases. But local sources are often not able to pick up the whole tab after a single year.

THE PUBLIC INEBRIATE AND THE HIGHWAY TRANSPORTATION SYSTEM

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This paper discusses the risk that the public inebriate creates as a pedestrian within the Highway Transportation System and ways in which this risk can be managed.

THE RISK-MANAGEMENT CONCEPT

In the United States a complex group of social systems has been created to meet the needs of our complex society. Each of these systems is intricately interwoven with others. Each may be thought of as having a basic objective which results in some function that creates a utility for society.

Unfortunately, real world systems do not operate perfectly, so that almost every social system may be said to create some disutility as well as utility. In the same sense, the objectives of all social systems are not in precise agreement, so that behavior which may be consistent with the objectives of one system may constitute a disutility in terms of another system.

While it is impossible to eliminate all disutility within society, it is clearly desirable to minimize it. To manage the risk of disutility, a series of sociolegal systems has been designed. The most formal of these systems is the Criminal Justice System.

"Risk management" may be defined as an entire process by which a sociolegal control system responds to manage the risks of dysfunctions which create disutility within social systems.

"Risk" can be defined as the combination of the probability of occurrence and the degree of seriousness of a dysfunction. Thus, high-risk dysfunctions are those that occur frequently with serious consequences, and low-risk dysfunctions are those that occur infrequently with minimal damage. A broad spectrum of dysfunctions exists between these two extremes.

When one considers the relatively limited resources of sociolegal systems and the complexity of the risk that such systems are expected to manage, the need for conscious management is apparent. The limited resources of the sociolegal system must be deliberately allocated to deal effectively with risk. This is the "risk-management process."

This process consists of three distinct stages. At the first stage the precise nature of the risk must be determined and defined relative to other risks the system must manage. This involves the identification of the cause of the risk and the degree of the risk to society.

Secondly, the identified risk must be examined to determine whether the system should attempt to manage it. It may be more appropriate to refer the risk to another social control system. Or, if the cost of managing the risk exceeds the cost of the risk, it may be more practicable to accept the risk or engage in only token risk-management response. At this stage, managing the risk must be balanced against the cost of managing other risks in light of the limited resources of sociolegal systems.

If the decision is deliberately made that the risk must be managed and resources are allocated for that task, the third stage, which is the selection and implementation of countermeasures, is initiated.

To function effectively any risk-management system must accurately perceive risk, precisely measure risk, determine priorities among risks, and selectively allocate limited resources to manage risk.

The foregoing is suggested as a conceptual framework for the examination of the risk of the public inebriate to the Highway Transportation System (HTS).

The HTS is the complex social system consisting of the major functional components of man, machine, and highway environment as well as all the subsystems necessary for its functioning.

The HTS is one of the larger social systems of our society. Its functioning involves almost one-quarter of our Gross National Product, some $250 billion. Almost 15 percent of the population is directly or indirectly employed in conjunction with the system. The United States has over 3.7 million miles of highway and some 100 million registered vehicles. Drivers operating these vehicles over our highways travel some 1.3 trillion miles each year.

The utility of the HTS can be measured in terms of the mobility of our society, the ease by which we transport people, goods, and services from one point to another. However, the operation of the HTS is not without dysfunction and disutility. Motor vehicle accidents result in excess of 55,000 deaths and cause some 17 billion dollars in losses each year.

Society has created a formal social control system within the Criminal Justice System to manage risk within the HTS. This system is known as the Traffic Law System.[1] It consists of four major functional components:

Law Generation

Enforcement

Adjudication

Sanctioning

The effective operation of this risk-management system is dependent upon public cooperation and the support of other social systems, notably education and rehabilitation services.

The following sections of this paper examine the nature of the risk that the public inebriate presents within the Highway Transportation System to support recommendations for the management of such risk by the agencies of the Traffic Law System and other sociolegal systems.

RISK IDENTIFICATION

The term "public inebriate" could be used quite broadly to include any person impaired by or under the influence of intoxicants who is simultaneously in a public place. This could include the college student drunk on beer at a football game, the working man after a few drinks at the neighborhood tavern or a party on a Friday evening, or the skid row derelict who is a chronic alcoholic. It is this latter category - the chronic alcoholic - that is the principal focus of this paper.

The typical public inebriate is most visible in the worst neighborhoods of the major metropolitan areas, although even the smallest village may have a "town drunk" who reflects the same behavior characteristics.

Many studies of this population group have been made.[2] He is inebriated because he is a chronic alcoholic or on his way to being one. He is

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1 K. Joscelyn and R. Jones, A Systems Analysis of the Traffic Law System: Summary Volume (Bloomington, Ind.: Institute for Research in Public Safety, Indiana University, 1972)

2 See, for example, President's Commission on Law Enforcement and the Administration of Justice, Task Force Report: Drunkenness (Washington: Government Printing Office, 1967); P. Stern, "Public Drunkenness: Crime or Health Problem?" Annals 374:147, 1967.

in a public place because he has no home or job to provide a private place in which to be.

Most of us agree that the public inebriate is an unpleasant phenomenon. In the same sense, we accept the disutility of traffic deaths, injuries, and property damage. However, too few of us accurately perceive the relationship between the two phenomena. Thus the typical response to the chronic alcoholic has been to merely remove him temporarily from public view.[3]

In recent years we have become quite concerned about the role alcohol plays in the generation of traffic crashes. The principal focus has been upon the intoxicated driver. In this context the impact of the public inebriate has often been ignored because such individuals are seldom drivers. Usually, the tenant of skid row has no vehicle nor does he have access to one. Driving is inconsistent with his behavior patterns. However, the public inebriate does present a clear risk to the Highway Transportation System in his role as a pedestrian. This role is not well recognized and is sometimes denied.[4]

National data on vehicle accidents reflect that, of the some 55,000 deaths each year, 18 percent of the fatalities are pedestrian accidents--approximately 10,000 deaths each year. (See Table 1.) The pedestrian fatality problem is more acute in urban areas. Approximately 37 percent of urban fatalities involve pedestrians, while only 9 percent of rural fatalities involve pedestrians. Thus, a major urban problem is pedestrian deaths--some 6,000 per year.

Researchers tend to agree that alcohol impairment is a significant factor in pedestrian accidents.[5] A study in Wayne County, Michigan found

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3 R. Nimmer, "St. Louis Diagnostic and Detoxification Center: An Experiment in Non-Criminal Processing of Public Intoxicants," Washington University Law Quarterly, 475:476-477, 1970

4 "Alcohol is NOT a significant factor in older pedestrian accidents," In Pedestrian Safety, Virginia Health Bulletin #6, Virginia State Department of Health, April 1969.

5 E. Mueller and W. Rankin, Traffic Control and Roadway Elements--Their Relationship to Highway Safety, rev. 1970 (Washington: Highway Users Federation for Safety and Mobility), ch. 8.

Table 1. Motor vehicle and pedestrian fatalities by year, 1966-1970

	1966	1967	1968	1969	1970	Average
Total motor vehicle fatalities	53,041	52,924	55,200	56,400	54,800	54,473
Urban	16,300	16,620	17,500	18,000	17,500	17,184
Rural	36,740	36,300	37,700	38,400	37,300	37,288
Total pedestrian fatalities	9,400	9,400	9,800	9,800	10,400	9,760
Urban	6,000	6,100	6,400	6,400	6,700	6,320
Rural	3,400	3,300	3,400	3,400	3,700	3,440

Source: Data from National Safety Council, Accident Facts, 1960-1969 (1970) and Accident Facts (1971).

alcohol in the blood of 61 percent of pedestrians over 12 years of age who were killed in traffic accidents. Of those killed, 57 percent had blood alcohol concentrations (BAC's) in excess of 0.10 percent and 46 percent had BAC's of over 0.16 percent.[6]

Other studies have also supported the conclusion that alcohol plays a significant role in pedestrian accidents and that the majority of the involved pedestrians are not mere social drinkers.[7] Several authorities estimate that half to three-quarters of all fatally injured pedestrians have perceptible BAC's.[8]

This would indicate that at least 5,000 of the 10,000 pedestrian fatalities each year involve alcohol. Further, of those fatalities involving alcohol, approximately one-half (2,500 fatalities) involved BAC's in excess of 0.10 percent which is the legal limit for intoxication in many States.[9]

Thus a minimum statement of the risk that the public inebriate generates within the Highway Transportation System may be thought of as 2,500 lives per year with the attendant pain, suffering, and monetary losses. This represents significant disutility which should be reduced by deliberate countermeasures.

THE RISK-MANAGEMENT RESPONSE

The objective of this section is to discuss briefly what appropriate responses the control systems of the HTS may make to manage this risk and reduce the disutility created by the public inebriate.

Please note that this consideration is limited to the management of the risk of the public inebriate within the Highway Transportation System.

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6 D. Huelke and R. Davis, A Study of Pedestrian Fatalities in Wayne County, Michigan (Ann Arbor, Mich.: Highway Safety Research Institute, University of Michigan.)

7 J. Waller and H. Turkel, "Alcoholism and Traffic Deaths," New England Journal of Medicine 275:532,535,1966; and Waller, "High 'Accident'Risk among Middle-Aged Drivers and Pedestrians," Geriatrics, 21:125,131, 1966.

8 Huelke and Davis, loc. cit.,p.11; W. Haddon et al., "A Controlled Investigation of the Characteristics of Adult Pedestrians Fatally Injured by Motor Vehicles in Manahttan," Journal of Chronic Disease, 4:655,1961; and J. McCarrol et al., "Fatal Pedestrian Automotive Accidents," JAMA, 180:127,128 (April 14, 1962).

9 Huelke and Davis, op. cit., pp. 11-12.

Quite clearly the public inebriate presents a broader risk to society and an equally broad societal response is required. Our concern in this paper is with a narrower issue.

Three basic approaches are suggested:

1. Physically separate vehicle traffic and pedestrian traffic to make contact minimal.

2. Restrict sources of alcohol to low traffic density areas. Strictly regulate sales to apparent inebriates.

3. Remove the public inebriate (when intoxicated and a risk) from public areas and address specifically his drinking problem.

Separating Public Inebriates and Motor Vehicle Traffic

Quite simply, the primary cause of the 10,000 yearly pedestrian fatalities is the fact that those pedestrians collided with motor vehicles and emerged second-best. If pedestrians remained in pedestrian walkways and motor vehicles remained in roadways, such pedestrian/motor vehicle collisions would be physically impossible. Of course, at various times it is necessary for pedestrians to cross roadways. Seven out of ten pedestrian deaths and injuries occur when such crossings are attempted. Although it is normally safest to cross at roadway intersections, 30 percent of all pedestrian deaths and injuries occur at intersections, with 40 percent occurring between intersections.[10]

That two-thirds of pedestrian fatalities occur in urban areas (See Table 1) is not surprising because urban areas simply have a higher density of pedestrians and motor vehicles. A short tour of almost any major metropolitan area will reveal certain fairly well-defined areas with a relatively high density of public inebriates. Such areas are commonly referred to as skid row. If that same area also has heavy traffic routes, then the possible number of public inebriate/motor vehicle collisions is great. Envision a one-way four-lane major traffic artery lined by cheap bars and flop houses. Crossing such a roadway while in full control of one's faculties is difficult enough. Stumbling across it while intoxicated is suicidal.

One of the beneficial effects of limited-access freeways transversing such area is that motor vehicles and pedestrians are not required to use the

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10 National Safety Council, Accident Facts (1971), p. 55.

same areas. If pedestrian crosswalks go over or under roadways, then much of the hazard is alleviated. This is particularly important if the motor vehicles are traveling at relatively high rates of speed.

If possible, high-density traffic routes should be routed around skid-row areas. If not, then the high-density traffic roadways should be physically separated from pedestrian walkways. If the roadway is an elevated freeway, much of the problem is avoided. If this is not feasible, sidewalks and other strictly pedestrian areas can have some kind of physical barriers separating them from the roadways. Such barriers can channel pedestrian traffic to specially designated roadway crosswalks. If all pedestrians could be forced to cross only at specified crosswalks, these crosswalks can be surrounded by warning signs and lights alerting motorists and pedestrians.

If protection of public inebriates was the only justification for elevated roadways and/or pedestrian walkways or for sidewalk barriers, they might well be dismissed as impractical. However, when included with the other benefits from such facilities, such as improved pedestrian and motor vehicle flow patterns and speeds, such responses to the risks created by public inebriates seem more reasonable.

Alcohol Source Management

Most States have a body of law, both statutory and administrative, that regulates the retail sale of alcohol. (e.g., Indiana code, secs. 7-1-1-1 et. seq., 1971.) Such laws apply to the sale of liquor both by the drink and by the bottle. Enforcement is often accomplished by specialized enforcement agencies with limited jurisdiction, but in the majority of States most of the laws could be enforced by duly constituted law enforcement agencies.

Frequently, the laws provide for regulation of the location of the alcohol source whether it be a tavern, liquor store, or neighborhood grocery.

In most jurisdictions the regulation of such sources is variable and reflects, as many police services do, the changing demands of the community. Some sections of cities have concentrations of cheap bars, cut-rate liquor stores, or other retail outlets. In many instances their clients are the problem drinker and the public inebriate. In the absence of demands for service--e.g., fights, trouble calls, requests for assistance-the police tend to leave such areas alone.

It would seem logical to attempt to restrict through control of licenses the development of concentrations of alcohol sources adjacent to high-density traffic areas. If a jurisdiction is experiencing an alcohol-related traffic safety problem involving either drivers or pedestrians in a particular locale and associated with specific alcohol sources, it would seem logical to ensure that existing laws were complied with by such establishments.

Many jurisdictions have laws prohibiting the supplying of alcoholic beverages to individuals who appear intoxicated. (E.g;, Indiana code, sec. 7-1-1-32, 1971.) While such laws are difficult to enforce, a clear posture by an enforcement agency that such laws will be enforced frequently induces suppliers to reduce sales to the obviously inebriated.

The enforcement of law in this area is fraught with complexity and is often avoided simply because the level of effort required from limited enforcement resources seldom seems justified by the results. In light of the risk to the Highway Transportation System posed by the public inebriate, it appears advisable to deliberately assess the value of countermeasure activity focused on the alcohol supplier.

Removing Public Inebriates from Public Areas

A more direct risk-management approach is to remove public inebriates from public areas and place them in custodial or quasi-custodial facilities. The public inebriate is no stranger to the criminal justice system. The approximately two million arrests annually for public inebriates constitute over one-third of all criminal arrests each year.[11] Typically, the primary justifications given for public inebriate arrests are fear of their involvement in various non-traffic crimes[12] or public pressure to remove the unsightly derelicts from view.[13]

Removal of public inebriates from public areas is one rational risk-management response to this dysfunction. However, identification of the agency which should be entrusted with this authority and responsibility is a more difficult question. Criminal justice agencies have been given this task in the past as a result of tradition, expediency, and the indifference of other agencies.[14] Although this paper focuses upon removing public inebriates from hazardous areas and not upon subsequent procedures, it should be noted that commentators[15] and even the Supreme Court (Powell v. Texas, 392 U.S. 514,528-530, 1968) have recognized the inadequacy of post-arrest criminal justice processes in dealing with public inebriates.

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11 President's Commission, op.cit., pp. 7, 1.

12 F. Grad et al., Alcoholism and the Law (Dobbs Ferry, N.Y.: Oceans Publications, 1971), pp. 2-3.

13 Nimmer, loc.cit., p. 476.

14 Id; pp. 475-476.

15 D. Pittman and W. Gordon, Revolving Door: A Study of the Chronic Police Case Inebriate and Nimmer, loc.cit., (New Brunswick, N.J.: Rutgers University, 1958)

The responsibility for initial detection of the public inebriate and his removal from public areas is commonly placed upon the criminal justice system's law enforcement component. Often, a specialized squad of officers performs this function in skid row areas.[16] The propensity for law enforcement personnel to provide extra-legal assistance to non-skid row public inebriates but to arrest skid row public inebriates is common. One explanation for this differential enforcement is that the only way to protect the skid row public inebriate is to arrest him.[17] However, the primary task is removal of the public inebriate from public areas, and arrest is simply one readily available means of accomplishing this task.

Criminal arrest by law enforcement personnel is not the only means of removing the public inebriate from public areas. If civil detoxification and/or treatment systems are available to receive public inebriates, then many of the problems inherent in processing public inebriates through the criminal justice system can be avoided. However, the initial means of identifying the public inebriate and removing him from public may be quite similar. The public inebriate could be arrested by police officers for violation of a public intoxication or intoxicated pedestrian statute. The public inebriate in the District of Comumbia can be detained only for a relatively short period of time.[18] If the police-initiated pickup and detention is based upon a voluntary request for transportation to a detoxification center then the public inebriate technically never enters the criminal justice system. Understandably, the choice between criminal arrest and volunteering for detoxification has caused some concern and is typically called "voluntary or else."[19] Further discussion of the legal and social problems resulting from the precise form of initial detention is beyond the scope of this paper, but note that either technique satisfies the immediate goal of removing the public inebriate from the public area.

An alternative to police removal of the public inebriate from hazard is the use of civilian personnel specially trained to work with alcohol-related behavior. At present public inebriates detained by civilian teams must consent to such detention. Supporters of the civilian concept point to the voluntary nature of the inebriates' participation and the more

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16 Nimmer, loc.cit., p. 476.

17 W. LaFave, Arrest (Boston: Little Brown, 1965), p. 108.

18 D.C. Alcoholic Rehabilitation Act of 1967, D.C. Code Ann. secs. 90-492 (supp. 1968).

19 Nimmer, loc.cit., p. 482.

20 Id., p. 499.

persuasive argument for the civilian team is that such activity would free specially trained police resources for enforcement functions.

It should be noted that not all individuals who are public inebriates, in the sense that they are intoxicated in a public place and create a risk to society, require formal sociolegal response. A simple ride home may solve both society's and the individual's problem.

The authority to arrest public inebriates typically comes from public-intoxication, drunk-and-disorderly, or common-drunkard statutes.[20] These kinds of statutes have been discussed and criticized by many commentators.[21] The National Conference of Commissioners on Uniform State Laws has suggested that such statutes be replaced with a progressive Uniform Alcoholism and Intoxication Treatment Act which reads in part:

> SECTION 12. Treatment and Services for Intoxicated Persons and Persons Incapacitated by Alcohol
>
> (b) A person who appears to be incapacitated by alcohol shall be taken into protective custody by the police or the emergency service patrol and forthwith brought to an approved public treatment facility for emergency treatment. (If no approved public treatment facility is readily available he shall be taken to an emergency medical service customarily used for incapacitated persons.)
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> ********
>
> A taking into protective custody under this section is not an arrest. No entry or other record shall be made to indicate that the person has been arrested or charged with a crime.

Section 19 of this proposed act prohibits traditional criminal public intoxication laws but not criminal laws dealing with driving while intoxicated. This approach -- taking the public inebriate into "protective custody" and then to a treatment facility rather than arrest and then processing through the criminal justice system -- is preferable and its adoption is recommended for all jurisdictions.

However, if the non-criminal approach is not desired, a criminal statute that directly procribes the precise deviant behavior which generates

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20 Grad et at., op.cit., pp. 7-10.

21 P. Hutt, "The Changing Legal Approach to Public Intoxication," Federal Probation 31:40, 1967; and Stern, loc.cit.

serious risks is preferable. That is, in lieu of the traditional public intoxication statutes, a statute such as that proposed by the Uniform Vehicle Code is recommended:

§ 11-XXX -- Pedestrians under the influence

A person who is under the influence of intoxicating liquor or any drug to a degree which renders himself a hazard shall not walk or be upon roadway.

While the issues are not clear concerning the debate on the criminality and the general societal risks created by public inebriates, the traffic safety risks generated by inebriated pedestrians are relatively clear. So is the need for laws -- either civil or criminal -- directly addressing those traffic safety risks.

Simply removing the public inebriate from public place represents at best a tactical solution to an immediate risk. The long-range handling of the public inebriate requires more than a criminal justice system response to manage the risk. Communities must develop broad-based rehabilitative programs for the problem drinker and the alcoholic. Lacking such programs, any law system response will simply be a revolving door.

CONCLUSIONS AND RECOMMENDATIONS

The public inebriate is a major social problem that requires an integrated societal response.

The risk posed by the public inebriate to only a single social system can be seen by examining the disutility generated by alcohol-related dysfunctions within the Highway Transportation System. Pedestrian fatalities account for one out of six highway deaths and one out of three urban traffic fatalities. Estimates indicate that 25 to 50 percent of pedestrian deaths are alcohol-related. Inebriated pedestrians account for 2,500 to 5,000 deaths each year. Additionally, alcohol is involved in a significant number of non-fatal pedestrian accidents each year.

This risk is sufficient to demand a response from the agencies of the Traffic Law System which are primarily responsible for the management of risk within the Highway Transportation System.

Various approaches have been suggested. One approach would be to reduce conflict by physically separating pedestrian traffic and vehicle traffic. While this approach may be too costly if viewed simply as a countermeasure for the public inebriate, separate utility factors such as traffic flow and mobility make consideration feasible.

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A second approach is to manage alcohol sources with the objective of locating such sources away from high-density traffic areas and reducing the supply to the obviously inebriated.

The third approach, the most direct, contemplates the removal of the identified risk, the inebriated pedestrian, from hazardous areas. This latter approach, which may be performed by a variety of agencies, reflects a short-run tactical solution to the problem of the inebriated pedestrian.

If it is accepted that the predominant number of inebriated pedestrians are problem drinkers and/or chronic alcoholics, simple removal will be only a temporary solution to the risk. Long-range risk management will be dependent upon the identification and implementation of rehabilitative techniques that can effectively reduce the risk of an individual becoming an inebriated pedestrian on a subsequent occasion.

Acceptance of this concept leads one to realize that the issue of the intoxicated pedestrian, while a real and immediate dilemma for highway safety managers, is symptomatic of the larger problem of the public inebriate in our society. Implementation of risk-management countermeasures within the Highway Transportation System cannot be accomplished effectively without appropriate consideration of the scope of the larger problem and the efforts of related risk-management systems operating within other social systems.

A multi-disciplinary, multi-agency, multi-system approach to this problem is essential. Implementation of single-agency countermeasures may result in unanticipated effects on other agencies which can be counterproductive. An overall systems approach within the risk-management conceptual framework appears to be the most rational approach.

2,000,000 UNNECESSARY ARRESTS

Raymond Nimmer

American Bar Association

A recurrent theme in virtually every study of the criminal justice process is a gross inadequacy of resources. Our police are understaffed. Our courts are overextended by an unmanageable disparity between their caseload and their limited resources. Our correctional institutions are overcrowded, underfinanced, and unable to provide meaningful programs to rehabilitate or even to assist most of their inmates.

Despite this lack of resources, up to 50 percent of the total resources available to the criminal justice system are often needlessly squandered upon social problems unrelated to the system's primary responsibility of control and prevention of violent crime. This misuse of scarce resources has been researched and commented upon for many years. Solutions have been repeatedly proposed, but have been seldom implemented and the improper use of resources continues to be the rule rather than the exception.

In terms of volume, the most serious misapplication of funds and manpower involves arrests and prosecutions for public drunkenness. Each year, approximately two million arrests for public drunkenness are made in this country.[1] The arrestees are prosecuted through the lower criminal courts, consuming valuable court time, and many receive jail sentences, their numbers adding to (and in some cases being the primary cause of) the notorious overcrowding of the local jails.

The present practice is clearly undesirable. The currently important issue is in what manner the problems created and symptomized by the arrest process can best be eliminated. There are several alternatives, but this article deals with only the three most promising possibilities. The first involves "police initiated" detoxification programs. This alternative,

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1 See Raymond Nimmer, Two Million Unnecessary Arrests, (Chicago: American Bar Foundation, 1971) p. 1; and President's Commission on Law Enforcement and Administration of Justice, Task Report: Drunkenness (Washington: Government Printing office, 1967). Adjusting the seven Uniform Crime Reports of the FBI prior to 1967 to include nonreporting jurisdictions gives a reasonable estimate of 2 million arrests for public drunkenness.

recommended by the President's Commission on Law Enforcement,[2] involves a short-term hospital facility to which persons picked up by the police for public drunkenness are taken and treated without criminal labels or sanctions. The second is a "civilian-initiated" treatment procedure involving a medical care unit entirely divorced of the criminal justice system to which patients are taken by civilian "rescue teams." The third is to take effective steps to stop arrests, and to consider and act upon the desirability of providing medical or other care for the men involved as a separate issue. The third alternative, although least discussed is the most direct and realistic response to the problems created for the criminal system by the large-volume arrest process.

POLICE-INITIATED PROGRAMS

Police policies control the rate of drunkenness arrests, and also determine the circumstances in which the arrest power is invoked. Many arrestees are not intoxicated when arrested. This refers not only to the few instances in which sober men are inadvertently arrested, but includes, more importantly, arrests based upon criteria which apply regardless of the fact that skid row men are intoxicated. These criteria reflect widely divergent purposes, ranging from a desire to harass the skid row men to the purpose of providing overnight shelter to some of them.

The underlying social problem of which the drunkenness arrests are merely a symptom is indelibly interwined, if not identical with, what might be called the "skid row problem." Recognition of this fact is crucial because of the manner in which the treatment issues associated with this general problem have commonly been characterized. Most of the literature and the proposals for reform assume that the underlying problem is alcoholism as manifested in public intoxication. This reflects an unwarranted and inaccurate inference drawn from the formal label attached during the criminal process. Given the judicial disinterest in the issue of the guilt of the accused, given also the existence of a variety of statutes applicable to skid row behavior--i.e., vagrancy and loitering--the statute employed in justifying arrest and prosecution is interchangeable with several others. The fact that certain jurisdictions use drunkenness statutes is largely a matter of tradition, a vehicle for administrative efficiency, and the label hardly identifies the underlying problem. The relationship of the various skid row statutes has been recognized, but vagrancy, loitering, and similar arrests have been explained as "alcohol-related." Under this same false

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2 The Challenge of Crime in a Free Society, and Task Force Report: Drunkenness. See also Raymond Nimmer, "The Public Drunk: Formalizing the Police Role as a Social Help Agency," Georgetown Law Journal, 58:1090; and D. Gillespie, ed., Alcohol, Alcoholism, and Law Enforcement, (St. Louis: Washington University, 1969), p. 38.

reasoning, the happenstance that a locality uses a vagrancy statute to arrest the same men might identify a "vagrancy" problem, whose basic cause is poverty, and in connection with which the drunkenness arrests are "poverty-related." Either result works to obscure the nature of the underlying problem--skid row.

For convenience, we have labeled the first alternative "police initiated" detoxification systems. This model is widely regarded as the appropriate response to the "drunkenness problem." Its objectives are numerous, but they can be summarized in terms of two categories. The first, which might be labeled the "system concerns," relates to achieving reduction of the drain upon the resources of the police, courts, and jails and a lessening of the flow of money from the public treasury upon this problem. The second, which could be labeled "service concerns," relates specifically to the well being of the men and calls for provision of medical attention for minor disorders (especially intoxication), diagnosis of serious physical problems, and the provision of rehabilitative therapy and referral. This detoxification model stands for the idea that attention to either the system or the service concern requires attention to the other.[3] In cities in which the detoxification model is applicable to all public drunkeness contacts made by the police in the entire city, and its use is required in all cases, the prospective patient is given no alternative. The District of Columbia system admits "walk-in" patients--a group which amounts to almost 50 percent of the total clientele of the center. Under existing statutes, men brought in by the police may be held for a maximum of three days of treatment. However, the men spend only one day at the detoxification center and are then taken to a subacute treatment facility located on the grounds of a large alcoholism hospital. This procedure is required because a single center is responsible for the entire city and must maintain a high-volume rapid turnover in order to handle all of the patients.

While at the center, the men receive medical attention and food and are permitted to lounge in the facility. Little or no effort is made to develop referrals for the individual. However, a pro forma procedure provides each patient with a standardized referral to another health facility upon release. Efforts to motivate toward treatment of the underlying alcoholism problem are deferred until the man reaches the subacute facility.

A theme common to the program is strained relationships with the local police. In the District of Columbia the police are a major intake source through which patients enter the treatment program. Despite their

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3 Nimmer, Two Million Unnecessary Arrests, pp. 80-81. See an unpublished paper by H. Mattick and R. Chused, The Misdemeanant Offender, 1967, p. 37.

importance to the overall program, individual officers are disenchanted with and disinterested in the new system. These attitudes affect the manner in which the officers employ the program and hence the type of men reached by the system.

The critical importance of the police is manifest when we examine the rationale of having any affirmative mechanism for seeking out and bringing patients into the treatment facility. Men are brought in because, in theory at least, their physical condition, location, or lack of motivation would otherwise prevent them from making use of needed treatment services. However, the police reaction to the new program results in many men who fit this purpose being left on the street, thereby at least partially frustrating the purpose to which the police are retained. In the District of Columbia, police contacts under the detoxification scheme total less than one-tenth of the arrest rates prior to the introduction of the new system. A local Alcoholism Council frankly admits that this lower level of contacts is the direct result of many men being left on the street, rather than taken to the detoxification service.

The reasons for this police reaction are numerous, but two are of greatest importance. The first is that the police do not fully accept the efficacy of the treatment rehabilitation model emphasized by the detoxification programs.[4] In the District of Columbia many officers disgustedly note that men who had previously been confined for up to thirty days in jail are now returned to the streets "overnight." Upon their return to the streets they create additional problems for the police, and their physical condition, which under the criminal process would have been restored by the lengthy confinement, shows no substantial improvement.

The second explanation of the lack of police cooperation is an emerging recognition that handling skid row men ("drunks") is or should be a secondary, low-priority concern for the agencies of criminal justice.[5] This attitude is actually reinforced by the rhetoric of the reform movement whose slogan might be paraphrased "the public drunk is a public health, not a criminal law concern." A number of officers in the District of Columbia suggest that the statute creating the detoxification scheme is an affirmative public statement that the public drunk is no longer a "police problem."

This general disaffection with the effect of treatment in terms of rehabilitation of the patients seems to be justified. The data from the District of Columbia program are inconclusive and, given the hurry-up processing forced upon the center by a heavy caseload, a low achievement rate would be predictable. It should be noted, however, that the phenomenon

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4 Nimmer, Two Million Unnecessary Arrests, p. 91.

5 Id., p. 84.

of a heavy caseload forcing efficient, but less effective, processing is characteristic of the criminal process and, although it is only conjecture at this point, the District of Columbia might be in the first stages of a devaluation of services in the face of the caseload. Similar caseload-resource imbalance might be predictable in other cities adopting the detoxification procedure.

Two additional factors paint a picture of success which, at best, must be regarded as qualified. The first concerns the impact of the new programs upon total public expenditure for this problem. Quite obviously, this factor involves two measurements--the costs incurred under the pre-existing criminal system and the cost of the new system. Unfortunately both of these are variable. The Washington system costs $20.00 per day for three days. Costs under the criminal justice process were estimated at over $3,000,000 annually.[6] The picture is clouded by the fact that changes in police policy can alter the rate of contacts dramatically, with obvious effects upon the total money spent. However, it is clear that, assuming a rate of contacts under the new system similar to that under the criminal process, the District of Columbia would save a substantial amount of money under the detoxification process. Perhaps the best that can be said concerning the money variable is that, if prior costs were high and the new system is designed economically, some money can be saved in the transition from a criminal to a medical model.

The second factor is the extent to which the new system conserves the time and resources of the criminal justice agencies. Obviously, the impact of the new process upon the courts and the jails can be dramatic. The courts are removed from the process by eliminating the adjudication stage, while the burden upon the jails is relieved by shifting the incarceration of the men to the detoxification center. The system does not, however, conserve what may be the most available resource squandered on the criminal processing of skid row men--police manpower. Rather, by constituting the police as a primary intake mechanism, the new process ensures that the diversion of police resources will continue.

CIVILIAN-INITIATED PROGRAMS

The effects that the system has upon the police, both in partially frustrating the purpose for which the police pickups are employed and in institutionalizing the diversion of police resources upon this problem, form a persuasive argument against the police-initiated model. The obvious alternative is to devise treatment programs which divorce themselves from police operations. Depending upon the interpretation given to this alternative, the frequency of its use is either extremely wide or severely limited.

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6 Nimmer, "Public Drunk." p. 1092

It is, for example, possible to include within this category of alternatives the many church and Salvation Army missions giving services to skid row men. However, these operations and the many other skid row service agencies do not consider themselves as alternatives to the criminal process, and our attention focuses upon those few non-police-initiated programs which do.

The prototype of the civilian-initiated approach is operated by the Vera Justice Institute on New York's Bowery. Presently, the Vera effort involves three elements. As initially designed and implemented, the entire program consisted of a detoxification center similar to that employed in the District of Columbia. Patients for this unit are, for the most part, brought in by a civilian rescue team which patrols the Bowery at irregular intervals. The rescue team approaches only Bowery men who are found on the streets in severe physical distress. The team offers the prospective patient the opportunity to accept transportation to the detoxification center. The choice is voluntary, and the men who refuse help are left on the street. The detoxification center also accepts walk-ins and referrals from other Bowery agencies. 7

The patient's initial treatment period involves medical diagnosis, and treatment, cleansing, and sleeping off the drunk. Later, each patient is assigned to a social worker who, with the assistance of other members of the staff, devotes substantial attention to the organization of a plan for referral of the patient upon release from the center. Patients are released between 3 and 5 days following admission. They are given transportation to the service to which they have been referred.

The two additional elements of the Vera program as presently constituted were responses to observed deficiencies in the initial format. The most important addition is an emergency medical clinic. This facility is designed to meet and deal with medical needs of Bowery men before they reach the advanced stage observed at the detoxification center, and to provide services for a larger number of men than could be handled by the detoxification program. The second addition to the overall program is an aftercare unit. This addition responded to an observed low rate of acceptance of referrals given to patients at the center. The aftercare unit provides a variety of counseling services for the men and deals with the patients over longer periods of time than does the detoxification unit.

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7 The program reflects the results of a preliminary study which indicated a need for (1) emergency street rescue services; (2) long-term rehabilitation programs; and (3) complete reliance on voluntary operations. Of all the centers studied, the Vera project comes the nearest to being purely voluntary. There is no police figure to imply coercion, no fear of prosecution, and walk-ins are accepted along with referrals.

The civilian process forces the planners of the program to make a critical evaluation of the goals and the treatment priorities of the program. Under the police-initiated model the temptation, easily fallen into, is to assume that men picked up by the police form a rational treatment group and that the primary task is merely to meet their needs.[8] However, the fact that the arrest practice is controlled administratively and operates on criteria unrelated to treatment needs suggests that this assumption is not accurate. On the other hand, where a civilian rescue squad is used, the program, through this agency, controls the type and number of on-the-street situations it reaches. There must be an affirmative definition of whom the program wishes to reach in order to guide the rescue squad.

The Vera Institute approached this definitional task as a question of what services were most needed in the Bowery. They avoided the trap of predetermining the issue on the basis of the criminal labels attached by the criminal process. However, after analysis of the Bowery service network, the conclusion was that intoxicated men in severe distress on the streets were most in need of additional assistance. Later, as the operation of the detoxification system identified other problems, the Vera people developed the medical clinic operations--a procedure which reaches men regardless of whether they happen to be intoxicated.

Despite assuming and implementing a highly rational posture with respect to the treatment problems, the success of the Vera program and its potential as a model for reform are questionable. As with the District of Columbia program, the Vera project suffers from the malady of high costs and indifferent returns with respect to rehabilitation of the patients. The cost of the Vera detoxification center is approximately $38.00 per patient per day. A large portion of this is accounted for by the intensive counseling and referral effort. There is no reliable study concerning the improvement induced among the patients, but most of the patients are recidivists, and the staff suggests that "improvement" rather than complete rehabilitation is the proper standard to measure the effect of the efforts of the system. With respect to referrals to long-term agencies, the acceptance rate originally hovered around 50 percent of the patients, but following the creation of the aftercare unit, acceptance increased to about 65 percent.

More important is the equivocal success of the voluntary pickup aspect of the program. Sixty-seven percent of the men approached accepted assistance. Although proponents suggest that this figure establishes that the voluntary system can be effective, the data are less than conclusive. Since all of the men approached were, by definition, in severe physical distress, a basic policy issue is posed. Can an expensive program for providing

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8 Nimmer, Two Million Unnecessary Arrests, pp. 132-133.

medical care to debilitated skid row men tolerate a refusal rate amounting to one-third of the men observed in severe physical distress? Such a refusal rate may be too high a price to pay for the voluntary model.

Obviously, the acceptance rate will vary according to the type of services provided. For example, the medical clinic, which gives short-term care and releases the patient after a few hours, reports an acceptance rate of over 83 percent. The Bowery men apparently are more willing to accept medical assistance and a short confinement period than to submit to intensive counseling over a longer period. What the rate might be for services which the men regard as unnecessary or ineffective is unknown.

A serious drawback in the civilian approach as contrasted with the police-initiated system is the implementation of an expensive large-scale program which may do nothing to relieve the diversion of police, court, and jail resources.[9] The experience of the Vera project, although its size is somewhat smaller than its originators might regard as necessary to fully serve the Bowery, had no direct effect upon police arrest practices. The Vera experience justifies the prediction that a civilian treatment program and an arrest-prosecution system can, and probably will, coexist unless additional steps are taken to convince the police that they can and should stop arrests. The arrests are an administratively controlled response to skid row in general. Any treatment program, no matter how effective it is in helping the skid row men, cannot end the arrest process by eliminating or dealing with its cause, unless the program is able to eliminate skid row. The police-initiated model, because it alters the consequences of the police procedure, will always conserve some criminal justice resources. The civilian model, by itself, will never directly cause a savings of criminal justice system resources.

SYSTEM CONCERNS AND SERVICE CONCERNS

These observations lead directly to a third alternative, an alternative which, although seldom discussed may be the best approach to the problem. This approach views the problem as involving two distinct aspects. The first, which might be labeled the "system concerns" refers to the diversion of criminal justice resources. The second, which might be described as the "service concerns," relates to increasing the quality and quantity of services provided to the skid row men. Under this approach, efforts towards reform would aim towards action effective to eliminate the arrest-prosecution process and consider the service issues as a separate problem.

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9 Id., pp. 137-138

Most commentators have assumed that relief of the system problems requires response to the service issues. The recommendation of the President's Commission on Law Enforcement is illustrative of this approach:

> Drunkenness should not in itself be a criminal offense....The implementation of this recommendation requires the development of adequate civil detoxification procedures. 10

The effect of this assumption has been disastrous. Attention has focused upon the service issues; the problems for the administration of criminal justice generally are implicitly relegated to secondary concern. The proposals for service programs have been numerous, and invariably they are expensive. They seldom are implemented, and, failing in implementation, they are discarded or forgotten while the arrest and prosecution of skid row men continues as before.

One obvious purpose of describing the two reforms as if they were necessarily a single reform issue is political in nature, and seeks to avoid the monetary constraints that a realistic reformer must contend with concerning skid row reforms. Linking the two problems portrays the service program as an essential step in a criminal law reform for which large amounts of Federal funds have been available. In fact, each of the programs discussed in this paper was begun with a Federal grant. However, when the short-term "demonstration" grants expired, money problems developed which seriously affected the services provided. Also, Federal money is no longer readily committed to demonstrations of service programs in this area. How often can the Federal agency justify funding a demonstration program for public drunkenness? In any event, even during the period in which money was available, most of the proposals never left the drawing boards, and the shattered hopes that the forgotten proposals enshrine died, with disastrous effects upon the criminal justice process.

Two additional arguments support the notion that the relief of the service and system problems should or must be considered as a single problem. The first suggests that simply stopping arrests would leave the skid row men worse off than before.[11] The second suggests that simply stopping arrests would be inconsistent with a community desire for "clean streets"--streets cleared of undesirable derelict men.[12]

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10 The Challenge of Crime in a Free Society, p. 236.

11 Nimmer, Two Million Unnecessary Arrests, p. 143.

12 Id., p. 144.

Simply stopping these arrests would not harm the arrestees in most cases. Nevertheless the assumption guiding reform policy has been that a net detriment would invariably result. The unique services which might be lost are numerous, but mostly illusory. Many police officers and some judges suggest that a long term can beneficially dry out the arrestee and rebuild his physical condition,[13] but most jails have no medical or counseling services for skid row men. Most often, however, the services allegedly provided are short-term. The arrestees are removed to shelter from the elements, and into overcrowded, bug-infested, filthy cells. They receive free meals, and feast upon baloney and water, occasionally coffee. They are protected from assault, although assaults and robberies do occur in the cells. They receive little assistance for their weak physical condition, and occasional deaths illustrate the complete lack of medical attention.

These services hardly seem sufficient to justify continued arrests. One crucial point is lost in the reform fervor which surrounds this entire problem area. The issue should be one of balancing the value of the services against the costs of continuing the arrest process. The value of the services must outweigh, or be sufficiently substantial to justify, the costs incurred. However, the services are most often illusory or meager, the costs substantial, and the result of any balancing of costs and benefits is clear. Additionally, the reform programs proposed as necessary replacements do not replace the criminal process in the sense of providing identical benefits but actually provide substantially improved services. Thus, properly stated, the issue is not whether the existing services must be duplicated but whether the existing process must continue until <u>better</u> services are provided.

The second argument against simply discontinuing arrests is that this would be inconsistent with a community desire to have the skid row men removed from the streets. Under this argument, the new service program might be described as a form of "acceptable harassment."[14] It removes the men from the streets, satisfying the public's craving while providing services which satisfy the reformers' humanitarian zeal. Not surprisingly, this argument is seldom expressly stated as justifying a replacement program.

Undoubtedly, the arrest responds to a perceived community interest in removal of skid row men from the streets for aesthetic purposes. However, this perceived interest is seldom tested for accuracy, and is, I would suggest, grossly overrated. Skid row men tend to remain within skid row colonies or in out-of-the-way locations seldom frequented by the "community." On those occasions where they leave these areas and their presence elsewhere

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13 Nimmer, "The Public Drunk."

14 Nimmer, Two Million Unnecessary Arrests, pp. 144-145.

produces a complaint, the police can, and often do, simply remove the man to a less controversial location--without arresting him. Certainly, even if arrests are made, such situations are not so numerous as to justify the massive arrest process which exists today. So long as the men remain on skid row, the aesthetic desire to remove some of them from the street can hardly be considered great. If the issue were put as to whether the community desires to use up to 5 percent of its policeman-hours in handling drunks rather than violent crime, the alleged community interest in aesthetics would hardly prevail.

The data concerning actual cutbacks or discontinuation of arrests are meager and inconsistent. In New York, the police discontinued arrests of Bowery men but reinstituted the arrests after a short period, in response to public pressure. The nature, source, and extent of this pressure is unclear.[15] In Washington, D.C. pickups for drunkenness fell from 40,000 annually to less than 4,000. After an initial period of complaint, the lower rate is generally accepted. It may be that, just as enforcement practice is shaped by traditional methods and perceptions, community attitudes can be a conditioned response which, it might be predicted, will become accustomed to few or no skid row arrests.[16]

CONCLUSIONS

Of the alternatives discussed here, the most promising is the one which has been least discussed in the literature. Similarly, the most discussed police-initiated model, appears, upon analysis, to be the least appropriate. It entails high costs, produces a few "cures," and institutionalizes the diversion of police resources upon this problem. On the other hand, the civilian model, although it is somewhat more attractive, also involves high costs and offers no certainty that its implementation will have a positive effect upon the diversion of criminal justice resources.

The question which must be critically examined is: Why should we tolerate continued diversion of criminal justice resources upon this

15 Id., p. 138

16 At any rate, if community response fails to become acclimated to few or no skid row arrests, procedures can be instituted which will reduce the amount of negative public response while attempting to utilize an acceptable alternative to all parties involved. For instance, the previously stated method of "acceptable harassment" allows the police officer to fulfill his function within the system, and provides an adequate response to the needs of the derelict without use of the usual method of incarceration. Finally, arrest rates, prosecution policies, and sentencing practices are subject to manipulation to the point where they can provide adequate response to community needs yet reduce the burdens of the system.

problem? To use substantial resources to mete out what at best is a minimal social service process and at worst is a token street-cleaning system is an absurd waste of valuable and scarce resources. To countenance this waste pending implementation of expensive reforms for fear that the targets of the process might lose some substantial benefits or that a public vitally concerned with violent crime will object, is an equally absurd waste of opportunity.

As noted above, simply stopping arrests has seldom been regarded as a viable reform procedure. An important factor preventing its full consideration is the ease with which it can be misinterpreted as involving the idea that the problem can best be solved by simply ignoring it. However, the position suggested is that doing nothing is, in both the short and the long run, a solution to the problems created by the arrests, and marks a substantial step forward from the existing state of affairs. Certainly, this does not preclude, but may stimulate, careful consideration of what is the best response to the underlying social ill--skid row.[17]

17 See page 98 for discussion

DISCUSSION FOLLOWING JOSCELYN AND NIMMER PAPERS:

Attention was given to pinpointing the interest of the several agencies in the public inebriate. DOT is interested in him as a pedestrian and a driver, part of the highway traffic system. The objective is to prevent accidents to or death of the public inebriate and the effects on other persons involved. LEAA is concerned with criminal justice problems which are alcohol-related and in preventing crime generally. NIAAA is responsible for developing treatment and rehabilitation programs for the alcoholic person, including the public inebriate. DOT and LEAA are not primarily interested in skid row drunks, who form a small proportion of the total problem of alcohol abuse.

How can agencies work together at all levels to provide programs? At present, the system looks like this:

Federal level	LEAA	DOT	NIAAA
Regional level	"	"	"
State level	State Criminal Justice Planning Agency	Governor's Representative	State Alcoholism Agency

Can we function within the reality of the present system with its overlaps and conflicts? Should we create another mechanism for coordination? On the State level, all Federally funded programs must be cleared through BOB-A95, to avoid gaps and duplication of effort. The effectiveness of this clearance wanes in the States.

There are, however, differences in the Federal agencies' methods of focusing programs, in the reviewing process, in control and accountability, and in coordination of regional with central offices.

Eighty-five percent of LEAA's funds are disbursed in the form of block grants to the States, practically a form of revenue sharing. The State planning agency develops the program. This is quite different from the two other systems, where control comes from outside the State. It was noted that LEAA has discretionary grant money (the other 15 percent) which it grants to programs of special interest that do not come within State plans. LEAA now plans to commit some of its discretionary funds over a period of two years for direct assistance to "high-impact" cities to help them reduce street crimes. The cities are between 50,000 and 1 million in population.

Returning to one of the major thrusts of this conference, it was suggested that future regional conferences should include the State agency decision makers.

Lack of cooperation between Federal agencies has had its basis in the power of legislators who want political mileage and are not necessarily interested in the needs of the situation. To counteract this, we must come up with sound scientific answers based on research. (This concept was not accepted by the total group.)

Some effort was made to distinguish things that could be done only (or more effectively) at the Federal level. These included risk identification, research, and influencing public perception of the risk by disseminating information about the public inebriate.

There was a feeling on the part of some workshop members that skid row alcoholics are not so important as other segments of the total alcoholic problems, because their numbers are relatively small. But it was maintained that the skid row man is important because he is visible and by publicizing his problems public concern can be aroused to develop community programs at any level.

MEANINGFUL EMPLOYMENT OF THE PUBLIC INEBRIATE

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For over a quarter of a century the State Employment Service has maintained a unit in one of the Boston offices devoted exclusively to serving casual workers. These men commonly work by the day and consist of dishwashers, bus boys, cleaners, etc. The majority are very likely to fall into the classification of public inebriate.

SOME CHARACTERISTICS OF CASUAL WORKERS

As a result of a modest study of casual workers that was made by two counselors, the following conclusions were drawn:

1. The most prevalent behavioral problem among the group was a drinking one, past and/or present. The men frequently mentioned former successful interpersonal relationships, which usually were interrupted by an excessive use of alcohol.

2. The majority listed skilled jobs in their biographical briefs. A large number had the educational background to qualify for positions on a professional level.

3. The average grade completed by the group was 10.6, and ranged from third grade to the Bachelor of Science degree.

4. The interviewers were impressed by the number who seemed to have the intellectual potential to perform complex jobs.

5. The men seemed to accept reluctantly the day-work routine as a way of life, expecting only their pay at the end of the work day.

6. About half were non-white.

7. A majority were veterans.

8. Some used the wages earned at day work to supplement other income, such as social security, veterans benefits, or disability payments.

The writer has been supervising manager of this particular office for over three years. As an outgrowth of this experience, he has developed a philosophy regarding a practical approach in establishing a program of occupational rehabilitation aimed at retraining these men who are in a perpetual cycle of intoxication and unemployment or underemployment. The validity of the overall hypothesis may be tested by a demonstration project which could be created when funds and resources are available.

INVOLVING EMPLOYERS

Those who undertake to find employment for the disadvantaged and the handicapped very often overlook a very important force that is working against them. Getting a job is in truth a transaction between a buyer and a seller. The interests and needs of one are arrayed against concomitant interests and needs of the other.

Thus, any program designed to restore public inebriates as full partners in society must take affirmative action to involve prospective employers. Such cooperation serves to reduce the otherwise high risk factor surrounding any effort in behalf of these people.

Experience testifies to the fact that one would indeed be naive to believe that large numbers of employers will sacrifice their own apparent self-interest in order to hire an unknown quantity--let alone a public inebriate. It takes more than good will to hire such people when there are countless highly qualified replacements on the market who can be hired at about the same price.

Employer involvement in the problem should not be seen as a panacea. It goes far, however, in creating a psychological set that permits making a more objective evaluation of the rehabilitant's worth. Knowledge gained through active participation will dispel the fear and prejudice born of ignorance. Indeed, employer involvement is an essential ingredient in any formula that seeks to find meaningful employment for individuals that manifest alcohol-based occupational problems.

MEANINGFUL EMPLOYMENT--STATUS POSITION

Traditionally, the notion of meaningful employment and that of status position have been synonymous. As a matter of fact, public inebriates, as well as other disadvantaged or handicapped persons, perceive "meaningful" as the manner and degree to which a particular occupation fulfills their needs and satisfies their interests.

The comprehensive occupational rehabilitative program proposed herein would eliminate the feelings of inferiority which seem to exist in each of the victims. With this tunnel vision eliminated, the concept

"meaningful employment" and "status position" would approach the congruency which they have for society in general.

RESISTANCE OF TARGET GROUP

The majority of those afflicted with such a drinking problem historically have resisted even special efforts to attract them to take part in available manpower programs. Consistently they have ignored every overture for counseling, testing, or training.

Underlying reasons for this apathy may lie in the following characteristics which employment security counselors have observed in day workers.

1. These men lack the time to become involved in occupational counseling and training because their primary concern lies in earning enough money to get through the day.

2. Day workers have their own culture and peer group with whom they are able to relate and identify. Removing them from a familiar environment and placing them in a more structured and unknown setting proves traumatic and causes them to retreat.

3. They express a sense of helplessness suggesting that they feel a minimal ability to control their own lives.

WORK AS THERAPY?

Contemporary society shows a tendency to emphasize rehabilitation of public inebriates and to reject the idea and use of punitive measures. Instead of confinement, work will be seen as an alternative. The transition to this form of "treatment" will inevitably increase the demand for day work--or permanent work of low grade.

Unfortunately, the erroneous opinion will persist that work per se has almost complete therapeutic value. On this assumption, many of those playing a role under changed conditions will make a direct substitution of work for confinement. This may result in a clamor for jobs without any attempt at rehabilitation.

Regardless of the motivation for using day work, demand for jobs will exceed supply. The supply itself will continue to decrease as technology substitutes new methods for manpower.

The practical significance of using work as therapy is its inability to cope with the individual's alcoholic-based problem.

Aside from defects inherent in the system, there is yet another one that is contributed by the inebriate. As stated above, day workers demonstrate a sense of helplessness. This helplessness, coupled with a reluctance to venture into a new environment, is intensified by a low

tolerance for tension. As a result, it becomes virtually impossible for them to avail themselves of the network of independent services that exists for rehabilitation and finding meaningful employment.

Traditional occupational rehabilitation of the alcoholic is conducted in an atmosphere where each discipline remains almost completely isolated from all other relevant professions. The parochial treatment dispensed by each belies the mixed and complex working environment of the real world. Each ignores the interrelatedness of one man's problems and acts as if it is possible to treat, cure, and close the case. The person is dismissed or transferred to another agency or practitioner for similar treatment. If the helping agency feels that its part is done and ignores additional aspects of a problem, referral may be made to the Employment Service for a job.

It is understandable that public inebriates scorn treatment and accept day-to-day existence on the best terms possible.

HOUSING AND EMPLOYMENT

It may be appropriate to examine in three dimensions a number of different facets of living--from the inebriate's point of view, from that of society, and from that of a potential employer.

The inebriate has very little real concern about adequate housing. He is content to sleep in doorways, cellars, old cars, and what have you. In benign weather the open fields will suffice. Recently, the Employment Service was called upon to aid in identifying the body of a man who had been referred to a job and who (after having finished his work late at night) had frozen to death sleeping in a doorway.

Traditionally, society takes the need for proper housing as a "given." The drifter is looked upon with misgivings and is seen as a bum, hobo, skid row drunk, etc. He is regarded as a de facto thief, immoral, capable of any crime. Indeed, housing is a central social question of the day.

The view that adequate housing is essential has merit. The drifter who lacks housing is prone to disease and usually is filthy personally and in appearance. As a result, he has little chance to secure employment--at least in a meaningful job.

Employers divide into two categories in their outlook on the necessity for housing.

The employer who is hiring for full-time or for the higher-type job invariably insists upon someone having housing. In the majority of cases, a permanent address of some duration is a basic requirement to assure an interview.

One attractive feature for day work, from the inebriate's point of view, is the fact that the boss has no interest in where a man lives and never asks for references. Neither is he very much concerned with names or the genuineness of a social security number.

In the case of a few large hotels, a kitchen man will be provided shaving material, made to take a shower, and wear a uniform provided by the establishment.

It might be concluded then that those engaged in placing public inebriates in meaningful employment must concern themselves with housing facilities. Housing is correlated with personal cleanliness, proper seasonal clothing, rest, and relaxation to prepare for a day's work. It plays a prominent role in promoting good physical and mental health. It must be considered an integral part of any rehabilitation program.

HEALTH AND JOBS

As stated above, the public inebriate is shunned by the general public. He is looked upon as the source and carrier of all types of disease.

Outwardly he exhibits little interest in matters pertaining to his health as long as he can get about. As far as day work goes, this is no great deterrent to getting a job. The employer is looking for raw labor, and his interest is limited to the man's ability to perform physically.

The employer seeking full-time permanent employees is far more selective. Most larger companies insist on physical examinations (some also require psychological testing) as standard procedure. In addition to those ailments that might be considered as a serious liability or hindrance, blemishes, scars, missing parts, those things that come under the heading of cosmetic defects, are also considered. Public inebriates very frequently have such inhibitors.

There is little question of the need for psychiatric or psychological help. The alcoholic problem in itself bespeaks this.

One aspect that too often goes unnoticed and one that falls into the category of health problem is that of dietary deficiencies. Many other problems may be traced to improper or insufficient food. No one knows how many day workers would willingly work a full week if they had the stamina.

COURT RECORDS

Part of the stereotype society has of the inebriate is that of his "criminal" tendency. Just as the idea he "has everything" (disease-wise) is common, so is the notion that he has committed every type of criminal or moral offense.

A similar degree of concern is expressed by employers as to court records. The day-work employer has little curiosity about a man and what he has done. On the other hand, the permanent employer looks for an almost unblemished past.

EDUCATION

The public takes a dim view of the educational level of these men. They are regarded as ignorant, dropouts, unskilled.

Employers share this concept. In a world that insists on credentials and diplomas for ordinary work, this approach penalizes the public inebriate by lowering his chances of obtaining an interview.

A rehabilitative program will have to take steps to dispel such an erroneous notion. In addition, those who fall short of the minimum educational entrance requirements for employment will need remedial assistance.

AGENCY LIMITATIONS

The foregoing will serve to emphasize the complexity of the problems the public inebriate has and the barriers that must be overcome in order to provide him with a meaningful job.

Many people who utilize the Employment Service do not understand how interlaced are the various factors which affect a man's occupational choice. Nor are the limitations of the agency understood.

While employment counselors are equipped to contribute occupational information and expertise in vocational planning, they are not social workers, medical experts, or therapists. Once there is a manifestation of physical, mental, or environmental difficulties which appear to present an impediment to functioning in a work situation, the employment counselor must solicit help from someone with competency in the appropriate field.

Current practice dictates that such a case be referred to the agency which specializes in a single facet of the problem. Thus a determination must be made in the multi-problemed case to select a single agency to which the client can be referred.

Progress will be made only with the universal recognition that these medico-social problems are not discrete entities. Public inebriates are multi-problem clients who need a wide range of services if the goal of meaningful employment is to be attained.

Any meaningful effort to deal with the situation will require an interdisciplinary approach. The expertise of several individuals trained in different disciplines must be focused on the problem to provide a solution. This calls for the cooperation of a number of organizations in a manner that permits each to subordinate any selfish idea of autonomy, utilizing a comprehensive team effort directed towards the goal of steady meaningful employment for each client. Pooling resources will eliminate a number of the difficulties alluded to above and will avoid duplication of effort, and at the same time provide each man with the best rehabilitative services available.

STIPENDS AS INCENTIVES

One of the most important components of any such program will consist of providing a stipend to overcome the reluctance to participate that has characterized previous attempts. This relieves him of his concern for earning enough money to get through the day and will permit him to become involved in the program.

AN INTERDISCIPLINARY PROGRAM

The following is an outline of a proposed program. It should be borne in mind that the order of presentation carries no real significance. Each component overlaps with others and, except for intake, may follow in that sequence deemed best suited to the needs of the participant.

Employment Security would provide skills and resources dealing directly with employment and be responsible for interest and aptitude testing, vocational training, vocational counseling, and job placement. In all probability, it would act as the paying agent for the stipends.

Psychiatry would be called upon to provide psychiatric evaluation, focused and goal-oriented psychotherapy, drug and other temporary supportive treatment as necessary.

Psychology would be utilized to make psychological evaluations via interview, behavior observations, and whatever standard testing is appropriate. It will also provide therapy and counseling to both individuals and groups.

Social Work would assume a major role and responsibility for what might be termed the environmental life of the rehabilitant--housing, family relationships, follow-up, etc.

Occupational Therapy would play an effective part in planning personal and work adjustment evaluations and evaluate work performance, as well as collaborating in the occupational plan of the individual.

The health professions will find an important outlet for their skills. Examination and treatment of eyes, teeth, and hearing, diet supervision--these are some of the areas that would benefit from their expertise.

Education, particularly Adult Education would provide intelligence and achievement testing, participate in group counseling, be responsible for remedial education, and participate in vocational planning as appropriate.

An Alcoholic Center would provide detoxification, have a major responsibility for specific evaluation of the client's alcoholic condition, and provide basic resources in the area of food, clothing, housing, etc.--at least for a temporary period.

THE SHIFT TO PERMANENT EMPLOYMENT

The program cannot be considered a success if, after active participation, the rehabilitant is placed in menial or casual employment.

There will be those who will never be able to work a full week. These men must have the feeling of attachment--of being part of the work force. A new approach will have to be undertaken.

Employers have a need for continuity of service. In a normal operation they cannot hire a person for one or two days. If, however, rehabilitated men could be organized to accept time-certain assignments and the employer could have reasonable assurance that his needs will be met, these day workers could be converted to permanent employees.

It has been observed that significant numbers of public inebriates possessed trades and skills in the past. It may be that they would meet resistance were they to try for a comeback. Or perhaps alcohol has taken such a toll that they are no longer competitive.

As has been suggested elsewhere, these men could be helped to organize a corporation composed exclusively of rehabilitated public inebriates. They would bring an understanding of the common problem and would follow the AA principle of mutual support. Since the possibility exists that they will not be able to compete, non-profit and governmental agencies could make contracts available for these business ventures.

A consortium of industries could be utilized to help in providing on-the-job training for those needing it. These same concerns could in combination buy services from the groups which rehabilitants form. For instance, a small apartment house owner would not be able to hire a painter full time. Five or six such owners, in consortium, could provide continuous work for several public inebriates.

The interdisciplinary team approach will permit the coordination of multi-facet treatment programs. This setting of professional cooperation and concentration of a specific client population will foster an unparalleled opportunity to gather new understanding and develop new approaches in this area of crucial concern to society.

DISCUSSION:

Mr. Walsh made a plea for aid from other agencies in treating the "whole man," so that the skid row drunk could become employable in some meaningful work--meaningful to him, not necessarily a status job. The historical system simply does not work--vocational training by one agency, health care from another, public assistance from another. For example, a man who needs teeth in order to be employable can probably get them in time from OVR or a health agency, but there must be someone to take the responsibility for steering him to the right agency and keeping him going there until his need is met.

On-the-job training was advocated. The trainee is then an employee, not a student in a vocational class where he is too old or too educationally handicapped to benefit.

There is need for interesting college students in working with the skid row man. Not many feel so inclined now. It was suggested that recruitment might be done through the LEAP college training programs now being funded by LEAA.

CONCLUDING DISCUSSION

It was agreed that some mechanism is necessary for disseminating information about research in alcohol problems and about programs, such dissemination to be done by both central and regional offices. Federal materials should stress information about the state of the art.

LEAA has a computerized system about ready to go into operation by which information can be retrieved on projects operating in a specific interest area. This kind of information could be very helpful to State and local program people.

One underlying problem of the public inebriate is unique--homelessness. Housing becomes a sine qua non for him, and the three agencies sponsoring this conference have no funding mechanism to support this essential part of service to alcoholics. Housing will gain recognition and support when it is given priority by the Federal agencies. Backup services, including employment, are an essential part of comprehensive care.

Decent housing provided for public inebriates should be dispersed, so that it is not converted into another skid row. There is need to attack the institutions that perpetuate skid row--cheap hotels, bars, etc. The public inebriate who has a check for a day's work or a welfare check usually can get it cashed only in a bar, which then may recoup most of it in selling him liquor. Some private employment agencies along skid row prey on the inhabitants. The State agencies will have to exert leadership and find ways around this problem as well as the bars and flophouses.

The current emphasis on securing enactment of the uniform State law on alcoholism makes it essential to consider carefully the recruitment and training of manpower needed to carry out the mandate of the law.

WORKSHOP III -- THE DRINKING DRIVER

Moderator: Robert B. Voas

Recorder: Melvin Personett

Papers: Youth, Alcohol, and Collision-Involvement
Richard Zylman

The Drinking Driver: Prevention and Deterrence Through the Mass Media
James W. Swinehart

Analysis of the Use of the Motion Picture In Alcohol Education
Alex Sareyan and Pamela Wilson

Can Communities Re-Educate the Drinking Driver?
Harold Sackman

YOUTH, ALCOHOL, AND COLLISION-INVOLVEMENT

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There is general agreement that young drivers are involved in disproportionate numbers of collisions in comparison with older drivers. On the other hand, there is little agreement as to the extent of such over-involvement or the reasons why younger drivers are involved in more collisions. The title of this paper suggests that the use of alcohol by young drivers may be a major cause, even the major cause of such events.

The subject of collision-involvement among youthful drivers who have been drinking should not be discussed as a single problem phenomenon. It must be recognized that the excessive use of alcohol by youth may be one problem and that collision-involvement by youth may be a totally different and unrelated problem. This paper is concerned with the combination of those two problems, which results in the third: alcohol-related crashes involving youth. By definition the third problem includes just those collisions which would not have occurred had the driver not been drinking. This will include drinking that may not have been a problem if the drinker had not been driving.

A brief review of the literature on drinking among youth will be presented along with an effort to identify the sources of "the problem" and with a discussion of the differences between youthful drinking and driving and the same activity by adults. Because both driving-after-drinking and collision-involvement of drivers under 25 years seem to be different from those who are 25 years and older, the term "youth" as used here, will include those who are 24 years and younger.

YOUTHFUL DRINKING

The studies surveyed (1-38) are in agreement that many teenagers use beverage alcohol at least occasionally but that, for the most part, they are a temperate group. Most studies show that among young people, as among adults, only a small proportion engage in inappropriate drinking practices; i.e., too much or too frequently or at the wrong times and places. About 2 to 6 percent of the youths in these studies could be considered intemperate drinkers.

There are wide variations both in the proportion of young people who use beverage alcohol and also in the frequency and extent of use. The studies show more users and more frequent usage in New York, Massachusetts, Wisconsin, Kansas, and Canada, where a majority of students studied drink at least occasionally. In North Carolina, Michigan, Mississippi, and Utah only a substantial minority reported some pattern of drinking. The proportion of youth who have established some pattern of drinking varies from 25 percent in the South to 90 percent in one of the northern studies.

It should be noted that these differences might reflect differences in definitions and methodology of research as well as actual differences in drinking practices. For example, the same question may elicit one kind of information on a mailed questionnaire, several kinds of information if administered in groups by many teachers throughout the country, and still another kind of answer if administered through personal interview.

Usage is more prevalent among urban youth than among rural and small-town youth.

There are strong religious and ethnic influences at work. A majority of Jews are users of beverage alcohol but indications of problem drinking are almost nonexistent. Catholic youth and those who claim no religious affiliation are among the more frequent users, with a higher proportion of heavy drinkers.

The widely held belief that peer-group pressure is the principal influence determining whether or not teenagers begin to drink is not well founded. Rather, it is the home influences that determine their attitudes toward drinking and their choice of friends. On the other hand, their friends may influence their mode of drinking; i.e., when, where, what, and how much they drink.

It is well established that practices and attitudes of youth regarding the use of beverage alcohol reflect parental custom as well as ethnic and religious backgrounds. Children of moderate-drinking parents are more likely to be moderate drinkers, and children of abstaining parents are more likely to be abstainers. On the other hand, intemperate drinkers are more likely to come from homes of abstaining parents, from homes of heavy drinkers, and from homes where there is strong disagreement between parents regarding drinking, than from homes where parents drink in moderation and permit their children to drink in the home.

A study of peer-group cliques revealed that drinkers whose parents disapproved of their drinking were more likely than drinkers whose parents were neutral to choose drinkers as friends. Youths who felt they were not very close to their parents or whose parents were very strict were more likely to be heavy drinkers, whereas there was no relationship between heavy drinking and closeness to permissive parents.

There is no evidence that the use of alcohol causes delinquency. There is considerable evidence, however, that youths who drink intemperately frequently exhibit other antisocial behavior as well and that such antisocial behavior is more likely to occur when they have not been drinking. It appears that antisocial behavior and the intemperate use of alcohol may be two separate manifestations of the same underlying personality problem, but the one does not necessarily cause the other. Although a small number of teenagers may be categorized as problem drinkers, it is more likely that they are drinkers with problems.

Young problem drinkers are distinguished from normal adolescent drinkers by using alcohol more often and in larger amounts and by drinking more often for the purpose of becoming intoxicated. They are also more likely to display aggressive or destructive behavior when drunk and to become drunk when alone. Although these behaviors are also characteristic of adult alcoholics, caution is advised in labeling them "pre-alcoholic," for there is a dearth of longitudinal research in this area. It is known that some early "heavy drinkers" later become moderate drinkers--this happens even within the narrow span of the teen years--and that some youths who are abstainers through their teen years later become problem drinkers. There is evidence that abstaining teenagers who later become users are more likely to become problem drinkers than moderate drinking teenagers.

The implications of these studies are that many teenagers and a majority of young adults drink and that the majority of those who drink do so in moderation. Whether or not there is a "teenage drinking problem" depends on one's definition. If it is believed that all teenage drinking is bad, then, of course, we have an epidemic of major proportions to deal with. On the other hand, if teenage drinking is accepted as part of the socialization process, a normal part of passing from adolescence into adulthood, we have taken a long step toward a rational approach to identifying the minority who are (or are judged) more likely to become problem drinkers. From this category we may then identify those who drive and who have driving problems, and, subsequently, what proportion of their driving problems is related to thei use of alcohol.

YOUTHFUL DRINKING AND DRIVING

If youthful drinking is not per se a problem of major concern, can the same be said of youthful driving-after-drinking?

This is a very different question. It is known that alcohol may have a greater effect on people who are learning to drink and that learners might be affected differently from more experienced drinkers. It is also known that young drivers are involved in disproportionate numbers of collisions compared with more experienced drivers. It is reasonable to assume, then, that young drivers who are still learning to drive and learning to drink suffer considerably greater risk when engaging in these activities at the same time rather than separately.

To learn whether youthful driving after drinking is a cause for major concern it is first necessary to learn: (1) how frequently young drivers operate a vehicle after drinking; (2) whether young drivers are involved in substantially more collisions than older drivers; and (3) if so, whether the over-involvement can be attributed to the use of alcohol.

How Often Do Young Drivers Drive After Drinking?

In reply to the first question, it can be stated that comparatively few young drivers combine the two activities--drinking and driving. In the Grand Rapids Study (41) each driver randomly selected from the population-at-risk as a control was asked how frequently he would drink, and each driver interviewed was also asked to give a breath specimen for analysis. Table 1 shows that of all drivers in the Grand Rapids Study, those who were 16 or 17 years old were the most infrequent drinkers, had the lowest percentage of drivers with any alcohol in their system, and provided no drivers with a Blood Alcohol Content (BAC) of 0.05 percent or higher. Those aged 18 or 19 had more occasional drinkers than the 16- and 17-year-olds (but still a low percentage), had only 5 percent with any alcohol in their systems, and had just 1 percent with 0.05 percent BAC or higher. In the 20 to 24 age group, a decided change occurs; the proportion with any alcohol in their system rises to 11 percent, and 3 percent had BAC's of 0.05 percent or higher. The figures for drivers 25 to 54 years old are all higher. Although drivers between 20 and 25 were similar to those older than 25, they did not drink more often than older age groups, nor were their BAC's higher, as is widely believed. (50)

Further evidence of the moderation in drinking and driving practices by young drivers can be found in the Washtenaw County Survey (42), where just 2 drivers among 150 who were 16 to 20 years old were found with BAC's of 0.05 percent or higher compared with 12 percent for drivers 21 to 30 in age, 15 percent of the 31 to 40 age group, and 11 percent of those over 40. A similar study in Mecklenberg County, North Carolina (as reported in the Washtenaw County Survey) showed that 5 percent of those from 16 to 20 years old had BAC's of 0.05 percent or higher compared with 13 percent for the 20 to 29 age group, 16 percent of the 30 to 39 age group, and 11 percent of those who were 40 and older.[1] In the Vermont study (59), among 1,125

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1 The Washtenaw and Mecklenberg County surveys were conducted in the evening and early morning hours when most recreational driving and most driving after drinking takes place. The results of these surveys cannot be applied to the general driving population of those or any other counties. It is also important to note that the locations were picked in respect to traffic flow and convenience. Whether there are important differences between this kind of selection and the selection of cases based on times and places of collision experience is open to question.

TABLE 1.

NUMBER OF DRIVERS WHO SAID THEY DRINK AND
NUMBER OF DRIVERS FOUND WITH POSITIVE BAC'S IN CONTROL

Age Group	N [1]	Percentage who drink once a month or more	Percentage with BAC's 0.00 percent	Percentage with BAC's 0.01 - 0.04 percent	Percentage with BAC's 0.05 percent and higher
16-17	183 184	23.0	98.4	1.6	0.00
18-19	480 472	36.5	94.9	4.0	1.1
20-24	966 930	64.3	88.9	8.0	3.1
25-34	1597 1562	68.19	87.64	8.32	4.04
35-44	1666 1618	65.97	87.95	8.03	4.02
45-54	1295 1257	61.24	87.19	9.31	3.50
55-64	762 737	49.74	90.23	6.92	2.85
65-69	214 205	46.72	87.80	9.76	2.44
70+	124 120	34.68	93.33	4.17	2.50

Source: Previously unpublished data from the Grand Rapids Study.

1 Differences between first and second figures for each age group are attributed to lost samples or refusals; i.e., in some cases the driver cooperated in the interview and gave a breath specimen but the specimen was lost through mechanical failure, or the driver may have cooperated in the interview and then refused to give a breath specimen. Within each age group the top N represents interviews completed and the bottom N represents breath specimens analyzed.

drivers interviewed and tested at times and places similar to where serious crashes occurred, just 5.5 percent of the drivers under 20 years had BAC's below 0.05 percent and 4 percent were at levels of 0.05 percent or above. Of those 20 to 24 years old, 8.3 percent had positive BAC's below 0.05 percent, and 7.3 percent were at 0.05 percent or higher. Although this figure was higher than among the 25 to 29 age group, it was lower than the figures for those aged 30 to 49. It should be noted in respect to the Vermont study that serious crashes are predominantly a nighttime phenomena. Categories of drivers selected with these limitations are highly relevant to crashes but must not be confused with all drivers.

In general, the studies show that comparatively few young drivers operate vehicles after having been drinking, especially drinking more than minimal amounts.

Are Youthful Drivers Involved In Disproportionate Numbers of Collisions?

The answer to this question has been "yes" since the days of the horseless carriage. Although there has been general agreement with this answer, there is controversy about the methods used for achieving the conclusion and, consequently, about the magnitude of the disproportion. A usual answer to the question is provided in Accident Facts of 1970 (39) which shows that drivers under 25 years old held 21 percent of the driver licenses in the United States but were involved in 35 percent of all crashes. This traditional method for determining whether certain age groups are involved in disproportionate numbers of collisions consists of examining the distribution of age and sex groups among collision-involved drivers and comparing them with the same groups in the driver license files or "claims paid" files of insurance companies. Using this measurement it is plain to see that if drivers under 20 years old hold 7 percent of the drivers' licenses and are involved in 12 percent of the collisions for the year, they are obviously being involved in more than their share of collisions. By the same reasoning, if drivers over 65 hold 6 percent of the drivers' licenses and are involved in just 3 percent of the collisions, they are much safer than young drivers and any aspersions cast upon the ability of the older drivers are unjustified. The weakness in this reasoning is that any such conclusions are based on the assumption that because drivers under 20 hold just 7 percent of the drivers licenses they also represent 7 percent of the driving population and that because senior citizens hold 6 percent of the licenses they also do 6 percent of the driving.

When one considers the great differences in modes of life between youth, middle age, and old age, it must be suspected that young drivers operate vehicles more often and for different reasons that either middle age [1]

1 The term "middle age" as used herein includes persons from 25 to 69 years old.

or older drivers and therefore experience more exposure to risk and could be expected to be involved in more collisions. There is an obvious need to measure exposure.

One method for generating a control which allows for exposure is to randomly select and interview drivers who are using the highways and streets at the times and places where collisions occur but who are not involved in collisions (the population-at-risk) and compare characteristics of that group with the characteristics of those drivers involved in collisions. Theoretically, given the method of selection, each driver interviewed would have a chance of being stopped equal to that of being involved in a collision--if collision-involvement were a matter of chance; i.e., if collision-involvement were a matter of chance there should be about the same distribution of positive BAC's and age groups among the collision-involved drivers as among the control drivers. On the other hand, if collision-involvement is associated with alcohol and age, one would expect to find a different distribution of BACs and age groups in the collision group than in the control group.

Three such studies have been made in this country and Canada (41, 54, 55, 66). The largest and most comprehensive was the Grand Rapids Study (41), which includes information about more than 9,300 drivers involved in collisions (including minor fender-benders as well as serious and fatal crashes) and more than 7,300 drivers randomly selected at times and places where collisions had occurred. (See Table 1.) It was a year-long round-the-clock operation. Data from that study (most of them previously unpublished) are also the basis for the following discussion.

Table 2 shows the distribution of age groups among collision-involved drivers in Grand Rapids, with corresponding distributions in the driver license files for the State of Michigan being used as a control.[1] Also shown are the collision-involvement indices which are derived from the results of a chi-square analysis. It can be seen that young drivers are involved in a great many more collisions than would be expected on the basis of their representation in the driver license files, and that older drivers are, indeed, better drivers. But this can be assumed only if one disregards factors related to exposure.

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1 In an earlier study Zylman (65) proposed to study the difference in collision-involvement indices by age group if the population-at-risk was used as a control rather than the driver license files. Current information about the population-at-risk and collision populations were already available from the Grand Rapids Study, but there was no current information about the Michigan driver license files. However, an earlier study by King (49) provided a random selection of more than 11,000 drivers from the Michigan driver license files giving age and sex distributions. Although that study was done five years before the Grand Rapids Study, it was the best information available for Zylman's evaluation.

When the Michigan driver license files were being changed to computer operation a few years later, one of the first products was a series of tables showing age and sex distributions among more than one million drivers whose names began with A, B, or C (43). Those tables showed considerable changes in the distributions of age and sex categories over the study by King ten years earlier. The 1968 study showed a larger proportion of drivers among the younger ages and among the very oldest and also showed that almost 42 percent of the driver licenses were held by females as compared with the 31 percent of ten years earlier. This indicated a possible bias in Zylman's analysis because the control and collision data for that study were gathered in 1962-63, by which time the estimates of 1958 had probably changed. Zylman's data are re-analyzed in the present paper with corrections for age and sex distributions in the driver license files. For example, if drivers under twenty years old held 9 percent of the licenses in 1958 and 11 percent in 1968, it was assumed that the change was gradual and that at the halfway point, 1963, half the change had taken place. So the data from the 1958 study were recalculated, giving the drivers under 20 years old 10 percent of the total. Similar adjustments were made for each age group.

For the purpose of this study it is assumed that the age and sex distributions of drivers in Grand Rapids were similar to those distributions in the State as a whole.

TABLE 2.

DISTRIBUTION OF AGE GROUPS AMONG LICENSED DRIVERS IN MICHIGAN AND AMONG COLLISION-INVOLVED DRIVERS IN GRAND RAPIDS, WITH COLLISION-INVOLVEMENT INDICES

Age Groups		15-19	20-24	25-34	35-44	45-54	55-64	65-74	75-Older	Totals
Licensed drivers in Michigan[1]	N	824	1359	2673	2514	2032	1380	717	293	11792
	%	6.99	11.52	22.67	21.32	17.23	11.70	6.08	2.48	99.99
Collision group	N	1482	1612	1910	1708	11192	855	425	125	9309
	%	15.92	17.32	20.52	18.35	12.80	9.18	4.57	1.34	100.00
Totals	N	2306	2971	4583	4222	3224	2235	1142	418	21101
	%	10.93	14.08	21.72	20.01	15.28	10.59	5.41	1.98	100.00
Collision involvement index[2]		+45.68	+22.99	-5.53	-8.30	-16.20	-13.29	-15.60	-32.20	

$X^2 = 692.40$; d.f. 7; $P < .001$

Sources: Ibid. and King (1968).

1 Random selection of licenses from the Michigan driver license files (King, 1958).

2 The collision-involvement index presents observed n's within each age group of those involved in collisions. A positive sign indicates that the observed are overrepresented in that respective cell; a negative sign indicates that the observed are underrepresented in that respective cell. The differences are expressed in percentages. This method was first used in the original report on the Grand Rapids Study (Borkenstein et. al., 1964).

Table 3 shows the same comparisons using the population-at-risk as a control. It can be seen that age was still very much related to collision-involvement, even when allowing for exposure. But the relationships are not only different; they are sometimes in the opposite direction from those indicated by simple driver license comparisons. Using the population-at-risk as a control, drivers under 20 years old appeared in collision 22 percent more often than would be expected on the basis of the control, and drivers between 20 and 24 years old appeared in the collision group nearly 13 percent more often than would be expected, but drivers 74 and older had a collision experience worse than the 15-to-19-year group.

It is clear that the practice of evaluating age contribution to collision-involvement on the basis of drivers' records alone is grossly inadequate. Such methods overestimate the involvement of young drivers and underestimate the contribution of older drivers. In reply to the question as to whether young drivers are involved in disproportionate numbers of collisions, the answer is: "Yes, but not to the extent that has generally been asserted." By allowing for exposure, their over-involvement is cut by half.

Does Driving After Drinking Among Youthful Drivers Account For Their High Frequency of Collision-Involvement?

The Grand Rapids Study established the fact that elevated BAC's were the most important variable in collision-involvement and that age was second most important. That the young and the very old drivers have the poorest collision experience and middle-age drivers appear in collisions less often than would be expected has already been discussed. The question now arises as to whether that overinvolvement of youth is related to the use of alcohol.

In another earlier paper also based on data from the Grand Rapids Study, Zylman (64) stratified the data into eight 3-hour periods to re-examine the relationship of collision-involvement to alcohol and various demographic characteristics as they were related to the time of day. It was found that the frequency of elevated BAC's varied widely over time of day and so did the mixture of demographic variables. For example, between 3 a.m. and 6 a.m., 22 percent of the control had BAC's of 0.05 percent and higher, but between 9 a.m. and noon just 0.3% (three in every thousand) had BAC's in that range, and between 3 a.m. and 6 a.m. only 6 percent of the control drivers were female as compared with 26 percent between noon and 3 p.m. These are just two examples of many such differences found.

These wide variations in the makeup of the driving population over time of day were reflected in the collision-involvement of every variable examined. In the post-midnight hours, even drivers with BAC's as high as 0.07 percent appeared in collisions less often than those who had nothing to drink, but in rush-hour traffic the very low BAC's appeared in collisions slightly more often than those who had nothing to drink. The collision-involvement of the different age groups also varied over time of day. It is

TABLE 3.

DISTRIBUTION OF AGE GROUPS AMONG THE CONTROL DRIVERS AND
COLLISION-INVOLVED DRIVERS IN GRAND RAPIDS, WITH COLLISION-INVOLVEMENT INDICES

Age Groups		15-19	20-24	25-34	35-44	45-54	55-64	65-74	75-Older	Totals
Control group	N	689	950	1608	1682	1317	767	292	49	7354
	%	9.37	12.92	21.87	22.87	17.91	10.43	3.97	0.67	100.00
Collision group	N	1482	1612	1910	1708	1192	855	425	125	9309
	%	15.92	17.32	20.53	18.35	12.80	9.18	4.57	1.34	100.00
Totals	N	2171	2562	3518	3390	2509	1622	717	174	16663
	%	13.03	15.38	21.11	20.34	15.06	9.73	4.30	1.04	99.99
Collision involvement index[1]		+22.19	+12.63	-2.82	-9.81	-14.96	-5.64	+6.10	+28.59	

Sources: Previously unpublished data from Grand Rapids Study. $X^2=330.89$:d.f.7;$p<.001$

1 See Table 2, Footnote 2.

quite likely that those variations are dependent on such variables as the mix of demographic characteristics, density of traffic and experience in coping with traffic problems, purpose for driving, and the use or nonuse of alcohol.

Table 4 shows the distribution of age groups among the control and collision drivers between 6 a.m. and 9 a.m. and the collision-involvement indices as derived from a chi-square analysis. Again it can be seen that the young and old drivers are overrepresented in the collision column. The 16- and 17-year old drivers appear in collision 75 percent more often than would be expected from their representation in the population-at-risk during that period, and the other age groups under 25 years also appeared in collisions substantially more often than expected. Is this overrepresentation related to the use of alcohol? The answer must be "no." Of 135 drivers under 25 years old in the control for that time period, just 4--all of them older than 20 years--had been drinking, and among 132 drivers between 16 and 24 years old who were involved in collisions during that period, just 2 had been drinking. In fact, of 795 drivers of all ages in the control during that period, just 8 had BAC's of 0.05 percent and higher, and of 503 drivers involved in collisions, just 10 were in that range. When all drivers with positive BAC's were deleted from the data and the chi-square analysis repeated, the resulting collision-involvement indices were almost identical to those shown in Table 4; if anything, the young and old drivers showed up slightly worse. This similarity in results, with both tests showing very high-collision-involvement rates for the very young driver is probably achieved because there were very few drinkers on the streets at that time and, without the modifying effects of alcohol, the problems related to youth and driving experience overshadowed the effects of alcohol and other variables.

A similar series of tests was run for each 3-hour period of the day but for the sake of brevity, only the period between 9 p.m. and midnight will be discussed. These are leisure hours when more drinking can be expected and when much driving is done for recreational purposes; it is reasonable to assume that the two activities might be combined by some drivers. Tables 5 and 6 show the distribution of BAC's among the various age groups in the control and collision groups for the period 9 p.m. to midnight, and it can be seen that there is a good deal of driving-after-drinking going on--even among young drivers.

If younger drivers were involved in more collisions than older drivers because of the excessive use of alcohol, it would be expected that:
(a) young drivers would show a higher frequency of driving-after-drinking

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In discussing this phenomenon Zylman said, "Alcohol, then, is not only a problem in its own right but is also a problem of a surprisingly different sort; it tends to hide or at least to mitigate other factors which may, under some circumstances, be as important as alcohol.... These examples suggest that alcohol is not a single-factor explanation of accidents--there are times, places and conditions when other factors are more important." (64)

TABLE 4.

DISTRIBUTION OF AGE GROUPS AMONG ALL TESTED CONTROL DRIVE AND ALL TESTED COLLISION-INVOLVED DRIVERS IN GRAND RAPIDS BETWEEN 6 A.M. AND 9 A.M., WITH COLLISION-INVOLVEMENT INDICES[1]

Age Groups		16-17	18-19	20-24	25-34	35-44	45-54	55-64	65-69	70-Older	Totals
Control group	N	8	38	89	178	176	182	97	19	8	795
	%	1.01	4.78	11.19	22.39	22.14	22.89	12.20	2.39	1.01	100.00
Collision group	N	17	40	75	116	111	70	53	14	7	503
	%	3.38	7.94	14.91	23.06	22.07	13.92	10.54	2.78	1.39	100.00
Totals	N	25	78	164	294	287	252	150	33	15	1298
	%	1.93	6.01	12.63	22.65	22.11	19.41	11.56	2.54	1.16	100.00
Collision involvement index[2]		+75.47	+32.33	+18.01	+1.82	-0.20	-28.32	-8.82	+9.48	+20.42	

Source: Data from Grand Rapids Study. $X^2 = 31.71$; d.f. 8; $p < .001$

1 Cases in which the driver may have refused to cooperate, or in which a collision-involved driver was not tested, or in which the breath specimen was lost through mechanical failure are not included in these data; hence, the term "tested."

2 See Table 2, Footnote 2.

TABLE 5.

DISTRIBUTION OF BAC'S BY AGE GROUP AMONG CONTROL DRIVERS BETWEEN 9 P.M. AND MIDNIGHT

Blood Alcohol Concentration

Age Groups		0.00	0.01 0.04	0.05 0.07	0.08 0.10	0.11 0.14	0.15 Over	Totals	%
16-17	N	37						37	4.95
	%	100.0						100.00	
18-19	N	81	4	1				86	11.50
	%	94.19	4.65	1.16				100.00	
20-24	N	132	19	3		2		156	20.86
	%	84.62	12.18	1.92		1.28		100.00	
25-34	N	129	30	6	2			167	22.33
	%	77.25	17.96	3.59	1.20			100.00	
35-44	N	105	18	5	3	4	2	137	18.32
	%	76.64	13.14	3.65	2.19	2.92	1.46	100.00	
45-54	N	79	15	2	1	1	2	100	13.37
	%	79.00	15.00	2.00	1.00	1.00	2.00	100.00	
55-64	N	41	6	1	1	1		50	6.68
	%	82.00	12.00	2.00	2.00	2.00		100.00	
65-69	N	8	1					9	1.20
	%	88.89	11.11					100.00	
70-over	N	6						6	0.80
	%	100.00						100.00	
Totals	N	618	93	18	7	8	4	748	100.00
	%	82.62	12.43	2.41	0.94	1.07	0.53	100.00	

Source: Data from Grand Rapids Study.

TABLE 6.

DISTRIBUTION OF BAC'S BY AGE GROUP
AMONG COLLISION-INVOLVED DRIVERS BETWEEN 9 A.M. AND MIDNIGHT

Blood Alcohol Concentration

Age Groups		0.00	0.01 0.04	0.05 0.07	0.08 0 10	0.11 0.14	0.15 over	Totals	%
16-17	N	69	2					71	10.96
	%	97.18	2.82					100.00	
18-19	N	92	8	1	1	2	2	106	16.36
	%	86.79	7.55	0.94	0.94	1.89	1.89	100.00	
20-24	N	99	15	2	5	5	8	134	20.68
	%	73.88	11.19	1.49	3.73	3.73	5.97	99.99	
25-34	N	68	23	7	10	11	10	129	19.91
	%	52.71	17.83	5.43	7.75	8.53	7.75	100.00	
35-44	N	35	9	9	3	8	9	73	11.27
	%	47.95	12.33	12.33	4.11	10.96	12.33	100.01	
45-54	N	34	8	3	5	3	7	60	9.26
	%	56.67	13.33	5.00	8.33	5.00	11.67	100.00	
55-64	N	38	3	5	1	3	2	52	8.02
	%	73.08	5.77	9.62	1.92	5.77	3.85	100.01	
65-69	N	8					1	9	1.39
	%	88.89					11.11	100.00	
70-over	N	12			1		1	14	2.16
	%	85.71			7.14		7.14	99.99	
Totals	N	455	68	27	26	32	40	648	100.01
	%	70.22	10.49	4.17	4.01	4.94	6.17	100.00	

Source: Data from Grand Rapids Study.

than older drivers; and (b) that young drivers would have a worse collision-involvement index among all drivers, whether they had been drinking or not, than among alcohol-free drivers. A comparison of Tables 7 and 8 shows that this is not true. In the absence of alcohol, age is an even more important predictor of collision-involvement. This happens because the higher BAC's are concentrated among the middle-age or "best" driving groups, and it can be assumed that those high BAC's are accompanied by some impairment. When the positive BAC's are removed from the data the impaired drivers are also removed, so the "best" age groups become better and the "worst" age groups show up relatively worse. It must be concluded that characteristics related to age are more important to the collision-involvement of youth and old age than alcohol.[1]

Are Youthful Drivers More Likely To Be Involved In Collisions At Lower BAC's Than Older Or More Experienced Drivers?

Because age seems to be a stronger factor than alcohol in the collision-involvement of youth, it does not follow that alcohol can be ruled out as a causal factor in some youthful collisions. Tables 5 and 6 show that some of the youthful Grand Rapids drivers had been drinking and that the positive BAC's are more frequent among the collision-involved drivers than in the control group. Hyman (48) examined the collision-vulnerability and BAC's in the Grand Rapids Study by demographic characteristics and found that young drivers are more likely to be involved in collisions at low BAC's than older drivers. Table 9 presents his calculations by age, sex, and BAC. It can be seen that young drivers (and old drivers) especially males, have a higher vulnerability ratio than intermediate age groups at each BAC and that the difference between age groups increases at each level of BAC. For male drivers under 18, who already had the highest vulnerability ratio at 0.00 BAC, the ratio increased three-fold even at the one-or-two-drink level. There was not sufficient data to carry the test further for that age group. For the males 18 to 19 years old the collision-vulnerability ratio increased from 1.55 at 0.00 percent BAC to 2.29 at 0.01-0.04 percent, and 4.17 at the 0.05-0.09 percent BAC level. The vulnerability ratio for 20 to 24 year old males was the same (1.12) at both the 0.00 percent level and at the 0.01-0.04 percent level, but increased to 1.78 at 0.05-0.09 percent and 9.38 at 0.10 percent BAC and higher, and the ratio for drivers between 35 and 64 years old was lower at BAC 0.05-0.09 percent than for drivers under 20 who had nothing to drink. This seems to reconfirm the earlier statement by Zylman (67) and laboratory work by Carpenter et al. (68), that experienced drinkers, who are also quite likely experienced drivers, can indulge in small amounts of alcohol and still perform better than the less proficient drivers who had nothing to

[1] It is worth noting that, given this method of analysis, older drivers have a collision experience as bad or worse than that of young drivers and that their involvement index is much worse during hours of darkness than in daylight (Tables 4-8). This suggests the need for more study of the gerontological changes that may affect the operation of motor vehicles.

TABLE 7.

DISTRIBUTION OF AGE GROUPS AMONG ALL TESTED CONTROL DRIVERS AND ALL TESTED COLLISION-INVOLVED DRIVERS IN GRAND RAPIDS BETWEEN 9 P.M. AND MIDNIGHT, WITH COLLISION-INVOLVEMENT INDICES[1]

Age Groups		16-17	18-19	20-24	25-34	35-44	45-54	55-64	65-69	70-over	Totals
Control group	N	37	86	156	167	137	100	50	9	6	748
	%	4.95	11.50	20.86	22.33	18.32	13.37	6.68	1.20	0.80	100.01
Collision group	N	71	106	134	129	73	60	52	9	14	648
	%	10.96	16.36	20.68	19.91	11.27	9.26	8.02	1.39	2.16	100.01
Totals	N	108	192	290	296	210	160	102	18	20	1396
	%	7.74	13.75	20.77	21.20	15.04	11.46	7.31	1.29	1.43	99.99
Collision involvement index[2]		+41.62	+18.94	-0.46	-6.11	-25.11	-19.21	+9.83	+7.72	+50.80	

1 See Table 4, Footnote 1.

$X^2 = 45.15$; d.f. 8; $p. < .001$

2 See Table 2, Footnote 2.

Source: Data from Grand Rapids Study.

TABLE 8.

DISTRIBUTION OF AGE GROUPS AMONG ALCOHOL-FREE CONTROL DRIVERS AND ALCOHOL-FREE COLLISION-INVOLVED DRIVERS IN GRAND RAPIDS BETWEEN 9 P.M. AND MIDNIGHT, WITH COLLISION-INVOLVEMENT INDICES

Age Groups		16-17	18-19	20-24	25-34	35-44	45-54	55-64	65-69	70-over	Totals
Control group	N	37	81	132	129	105	79	41	8	6	618
	%	5.99	13.11	21.36	20.87	16.99	12.78	6.63	1.29	0.97	99.99
Collision group	N	69	92	99	68	35	34	38	8	12	455
	%	15.16	20.22	21.76	14.95	7.69	7.48	8.35	1.76	2.64	100.01
Totals	N	106	173	231	197	140	113	79	16	18	1073
	%	9.88	16.12	21.53	18.36	13.05	10.53	7.36	1.49	1.68	100.00
Collision-involvement index[1]		+53.51	+25.41	+1.07	-18.60	-41.04	-29.04	+13.43	+17.91	+57.21	

Source: Data from Grand Rapids Study.

$X^2 = 65.75$; d.f. 8; $p. < .001$

1 See Table 2, Footnote 2.

TABLE 9.

PERCENTAGES OF ACCIDENT-INVOLVED DRIVERS (A) AND OF CONTROL DRIVERS (C), AND ACCIDENT-VULNERABILITY RATIOS (A-VR), IN EACH AGE-SEX-BAC CATEGORY

	Blood Alcohol Concentration									
	0.00%			0.01%–0.04%			0.05%–0.09%			0.10%+		
	A	C	A-VR	A	C	A-VR	A	C	A-VR	A	C	A-VR
Sex[a]												
Men	63.3	69.3	0.91	5.8	6.8	0.85	3.2	2.2	1.45	5.5	0.8	6.88
Women	20.1	19.7	1.02	1.0	1.0	1.00	0.3	0.2	1.50	0.8	0.0	c
Age[b]												
Men												
<18	4.86	2.04	2.38	0.22	0.03	7.33	0.05	0.00	c	0.02	0.00	c
18–19	7.35	4.75	1.55	0.48	0.21	2.29	0.25	0.06	4.17	0.13	0.00	c
20–24	11.11	9.29	1.12	1.05	0.94	1.12	0.48	0.27	1.78	0.75	0.08	9.38
25–34	12.23	15.10	0.81	1.49	1.59	0.94	0.90	0.56	1.61	1.62	0.24	6.75
35–44	10.25	15.00	0.68	1.10	1.54	0.71	0.67	0.59	1.14	1.50	0.27	5.56
45–54	7.44	11.75	0.63	0.84	1.47	0.57	0.40	0.44	0.91	0.72	0.16	4.50
55–64	5.75	7.56	0.76	0.35	0.63	0.56	0.28	0.24	1.17	0.62	0.04	15.00
65–69	1.74	2.10	0.83	0.15	0.27	0.56	0.08	0.06	1.25	0.13	0.01	13.00
70–74	1.47	0.78	1.88	0.10	0.04	2.50	0.07	0.03	2.33	0.05	0.00	c
75+	1.05	0.56	1.88	0.05	0.01	5.00	0.00	0.00		0.00	0.00	
Women												
<18	1.22	0.71	1.72	0.03	0.01	3.00	0.00	0.00		0.00	0.00	c
18–19	1.81	1.56	1.16	0.05	0.06	0.83	0.02	0.01	2.00	0.05	0.00	c
20–24	3.56	2.38	1.50	0.22	0.10	2.20	0.03	0.04	0.75	0.03	0.00	c
25–34	3.49	4.16	0.84	0.20	0.24	0.83	0.08	0.07	1.14	0.20	0.00	c
35–44	4.34	5.03	0.86	0.23	0.30	0.77	0.12	0.06	2.00	0.25	0.00	c
45–54	2.76	3.71	0.74	0.13	0.18	0.72	0.07	0.03	2.33	0.07	0.00	c
55–64	1.92	1.82	1.05	0.07	0.08	0.88	0.00	0.01	0.00	.13	0.00	c
65–69	0.42	0.44	0.95	0.02	0.01	2.00	0.00	0.00	c	.02	0.00	c
70–74	0.32	0.17	1.88	0.02	0.00	c	0.00	0.00		.00	0.00	
75+	0.28	0.08	3.50	0.00	0.01	c	0.00	0.00		.00	0.00	

Source: Reproduced with permission from Quart. J. Stud. Alc., Suppl. No. 4, 1968.,p. 39.

a Total sex and BAC reported: 5988 accident-involved and 7529 control drivers.
b Total sex, age and BAC reported: 5983 accident-involved and 7092 control drivers.
c The ratio cannot be calculated since there are no controls.

drink. This could be true even though they may have deteriorated from their pre-drinking proficiency.[1]

Drivers over 69 years old have a vulnerability ratio very similar to that of teenagers, although probably for very different reasons.

Is There A Stronger Relationship Between Youthful Drinking and Fatal Crashes Than Between Youthful Drinking and "All" Collisions?

The most recent studies of fatal crashes show that a disproportionate number of them involved drivers under 25. It is often stated that many of those younger drivers, especially those between 20 and 25 years old, had engaged in heavy drinking prior to their fatal trip. Although even one such case might be judged too many, younger drivers killed in crashes actually show lower frequencies of alcohol-involvement than do those 5, 10, and even 20 years their seniors. In Wayne County, Michigan (46) 11 percent of the drivers killed were under 20 years old, of whom 29 percent had BAC's of 0.10 percent or more; while for drivers from 20 to 25 years old (who represented 25 percent of all the driver fatalities), 63 percent had BAC's of 0.10 percent or higher. This compares with drivers from 26 to 35 years old who were killed, among whom 81 percent were at 0.10 percent BAC or higher and those from 36 to 45 years, among whom 73 percent were at that level.[2] Other studies also show low frequencies of high BAC's among young drivers as compared with middle-age drivers.

Initially, it must be recognized that a considerable portion of the overinvolvement of young drivers in fatal crashes may be explained by the greater exposure as described in previous pages. For example, in the Wayne County study the point is made that drivers between 16 and 25 years old comprised 36 percent of the fatalities but only 21 percent of the licensed population as represented in the Michigan Driver Profile (53). The figures relating to driver licenses here are derived from a random sample of the Michigan driver license files and do not allow for exposure. Supposing it were possible to determine the age distribution of all drivers using the highways at the times and places where those Wayne County fatal crashes occurred and it was learned that 30 percent of the drivers are under 25 rather than the 21 percent as shown in the driver license files; then the

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1 This indicates that the widely used curve from the Grand Rapids Study showing the probability of causing a collision at various BAC's cannot be applied indiscriminately to every age group. (67)

2 Regarding these data, Filkins et. al. said "it is now known that the alcohol involvement of the younger crash-involved fatalities is less than that of their older fatality counterparts. Young people are more often involved in crashes, whether it be due to driving inexperience, drinking inexperience, or a combination of the two conditions perhaps exacerbated by more reckless attitudes about driving." (46)

overinvolvement of this age group would be reduced by more than 70 percent. If it were found that 36 percent of the drivers on the highways at the times and places of fatal crashes were in that age group,[1] then there would be no overinvolvement of drivers under 25; they will have appeared in collisions in direct proportion to their representation in the driving population.[2] This point must be made because failure to allow for exposure inflates the problem of traffic deaths as it relates to youth. This may be a major source of the alarm over youth involvement in fatal crashes.

It is difficult to reconcile the figures found in studies of fatal crashes with the information presented earlier regarding youthful drinking, youthful driving-after-drinking, and youthful involvement in "all" collisions after drinking. It cannot be said that the large number of alcohol-related fatal crashes involving youth reflect orgy-like drinking on the part of a major segment of the young driver population; nor can it be said that large numbers of young drivers are driving after drinking huge quantities of beverage alcohol. It is more likely that those who are involved in fatal crashes while intoxicated are a typical group, a small group with characteristics that set them apart from the majority of young drivers. A number of studies have already identified such unique characteristics among drivers involved in fatal crashes after heavy drinking as well as among those convicted of driving while intoxicated or impaired, or who are just "bad drivers" (40, 44, 45, 47, 48, 52, 56-63). There is an urgent need to synthesize the studies from the fields of sociology, psychiatry, psychology, education, and other disciplines regarding the problem driver, with the work done in what is generally called the alcohol problems field. Much is known in that field about the etiology of "problem people" which would logically be applicable to the traffic field; however, it is not being used. Knowledge about cultural and religious influences, socioeconomic status, parental practices and family relationships, peer-group pressures and sex identification as they are reflected in drinking practices and attitudes toward drinking must be applied to the alcohol-involved traffic problems field so that this small but tragically important group of problem drinker-drivers can be identified at an earlier age--when major difficulty may still be prevented.

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1 In Washtenaw County, adjacent to Wayne County, the survey of drivers in the nighttime traffic showed that more than 48 percent of them were 16 to 25 years old. However, this is probably an unusual situation because two large Universities are located in the sample area. (42)

2 In the only bonafide controlled study of fatal crashes that appears in the literature, McCarroll and Haddon (55) reported "The case subjects were suggestively older / emphasis theirs / in both responsible and questionably responsible groups. However, the differences were not statistically significant. As a result, no age adjustment has been made in the case-control comparisons which follow."

SUMMARY AND CONCLUSIONS

A survey of the literature reveals that, while there is great national concern about something called "alcohol and youth," there is little in objective studies to show that excessive drinking (or its usual disapproved accompanying behaviors) is even as frequent in this age category as in any of the succeeding 5-year age brackets. In fact, the extent of such problems is markedly less among those usually labeled as youth or teenagers. Many teenagers drink, and by the age of 18 or 19 a majority use beverage alcohol at least occasionally. It is well established that youthful drinking reflects the attitudes and practices of their parents and the influence of cultural and religious backgrounds. Drinking among youth, like drinking among adults, is a societal function and, as among adults, a small minority drink intemperately. This minority frequently engages in other antisocial behavior as well. There is no evidence that the antisocial behavior is caused by alcohol alone. Rather, it is believed that both forms of aberrant behavior reflect the same or similar underlying character or personality problems and the same or similar stressful situations.

The practice of driving after drinking by young people is not as widespread as generally believed. Under the age of 18, driving after drinking is quite rare. However, the frequency and intensity of driving after drinking increases rapidly for drivers 18 and 19 years old and the practice for those who are 20 to 25 years old resembles those who are older than 25. The heaviest frequency and greatest intensity, however, occur in various age groups between 25 and 54, depending on which studies are considered.

Young drivers are involved in disproportionate numbers of collisions. However, when allowances are made for exposure by comparing collision-involved drivers with drivers using the highways at the times and places of collision occurrences, rather than with the driver license files, their reported overinvolvement is cut by half. At the same time, using this measurement, the collision-involvement index for drivers over 69 years old is increased several fold. Drivers between 25 and 69 appear in collisions less often than would be expected on the basis of the population-at-risk. Collision-involvement indices also vary widely over the time of day.

Young drivers are not involved in more collisions than older drivers because of the use of alcohol. If that were the case, one would expect to find that young drivers drive more often after drinking than older drivers, and that the collision-involvement index for young drivers would be worse when drinking and nondrinking drivers were considered together than when nondrinkers were considered separately. Neither hypothesis is true. A greater number and proportion of drivers between 25 and 69 is found at every BAC above 0.00 percent. When the age distributions are examined by chi-square, the collision-involvement indices for both the very young and very old drivers are worse when just the nondrinkers are considered than when all drivers are included.

In spite of the less significant role of alcohol in highway crashes involving youth, there is an important relationship of alcohol to youth-involvement in collisions which sharply differentiates them from the other age categories up to age 69. This concerns the impact of small amounts of alcohol; i.e., those resulting in BAC's which are positive but less than 0.05 percent. Among teenagers such low concentrations are an important component in crashes, whereas in all other groups up to age 69 such concentrations are of no significance at all. There is evidence that drivers under 18, who already have the worst collision-vulnerability ratio with nothing to drink, increase that vulnerability threefold after just one or two drinks. At that level (0.01-0.04 percent BAC) all age groups between 25 and 69 appeared in collisions less often than in the control.

Drivers under 25 years old appear to be involved in disproportionate numbers of fatal crashes. However, whether or not that disproportion is attributable to the heavy use of alcohol is open to question on at least three points: (a) if allowances were made for exposure, the overinvolvement of young drivers would quite likely be reduced substantially; (b) some of the deaths among young drivers probably occur after light to moderate drinking--the kind of drinking that would not have lead to a fatal crash if the driver had been more experienced in either drinking or driving or both; (c) it seems plausible that at least a portion of the youthful fatalities might be attributable to problems associated with youth and inexperience rather than alcohol.

Finally, we cannot blithely explain away a major part of the fatal crash problem among youth and dismiss the remainder as "expected." The fact remains that thousands of young drivers die each year and a substantial number of these unnecessary deaths are related to some use of alcohol. The implication of this paper is that we must put the various sub-problems in their proper perspective before we can make a rational attack on the whole problem. There is a need to apply the knowledge and skills of the alcohol problems field to the alcohol-traffic problem. This would allow both identification of problem people at an earlier age and, hopefully, also prevention of problem drivers. It would also allow identification of problem types of drinking (clearly different for young as compared with older persons) and allow attack on this aspect of unnecessary death and injury on the highways.

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DISCUSSION

Discussion stemmed from the findings of the paper that:

1. Young drivers are involved in a disproportionate number of crashes.

2. Many of the crashes occur with youth whose BAC is relatively low.

3. Hence perhaps the high involvement of youth in crashes results in part from inexperience in both driving and drinking.

A number of approaches to the problem were discussed.

1. Measures like that in New York, where a BAC of .05 is presumptive evidence of intoxication for young drivers, as against higher BAC's for older drivers. Is this discriminatory? Some participants felt that it was. Is it advisable? Possible as one approach, but the problem is much greater than BAC.

2. Driver education in high school, which would emphasize dangers of driving after drinking. Driver education, according to one youth present, is largely skill training, not very effective in all skills, either. Moreover, it gives little attention to attitudes. Youths have the same problem as adults in not being able to relate their own drinking practices to what is safe. The Grand Rapids study showed negligible difference between crash-involved youth who had had driver education in high school and those who had not.

3. Prediction of performance on the basis of known characteristics. While studies show that high BAC's at the time of crashes are correlated with certain characteristics--e.g., young males from lower socioeconomic groups--very little has been discovered that would serve as basis for prediction. Moreover, there is a dearth of longitudinal studies. What has developed from the few done shows that some youth who are problem drinkers later are able to handle drinking adequately, and vice versa.

4. Special problem groups. It was pointed out that cultural groups differ widely in their attitudes toward drinking. Some groups which introduce children to alcohol early and in the family circle seem to have fewer problems with uncontrolled drinking when the children grow up. In other cultures, heavy drinking and alcoholism are reaching crisis proportions.

   This appears to be true of many Indians, both those who live on reservations and those who have migrated to the city. Arrest rates for drunkenness are high among them. Indian drinking may be a search for oblivion, an attempt to forget the frustrations rising from the clash of two cultures. On the other hand, arrest rates may reflect police attitudes. One study indicates that arrest rates are high among Chicanos and blacks too.

After extended discussion of the problems of drinking among minority groups, particularly among Indians, the workshop concluded that the right approach is to look at the problem community by community, to see how it can best be met.

Returning to the problem of youthful drinking and driving, the group agreed with Zylman that the knowledge and skills of the alcohol problems field should be applied to the alcohol-traffic problem.

THE DRINKING DRIVER: PREVENTION AND DETERRENCE THROUGH THE MASS MEDIA

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The National Highway Traffic Safety Administration, the Law Enforcement Assistance Administration, and the National Institute on Alcohol Abuse and Alcoholism share a concern with the excessive use of alcohol by persons who drive. All three agencies are engaged in a variety of efforts to reduce this problem, including programs of public information and education. There now seems to be general agreement on the need for developing means by which the agencies can coordinate their public information programs with one another and with those produced by various commercial and voluntary groups.

BARRIERS TO NEEDED COOPERATION

When a number of organizations simultaneously use the mass media to convey messages on a single topic, coordination of these messages becomes crucial. If they are consistent with one another, they can be mutually reinforcing and thus have a cumulative impact. If they are <u>not</u> consistent, they tend to produce public confusion and disbelief. In the past, the themes used in advertising on alcohol and highway safety have sometimes been openly contradictory; for example, "Know Your Limits" vs. "If You Drink, Don't Drive." There has been little coordination among the sources of such materials. There have been disagreements about the accuracy, appropriateness, and effectiveness of various messages. Appraisals of campaign effects have seldom been done in a way which would permit confidence in the results, and such appraisals as have been done have only rarely been shared with other organizations which could benefit from the findings. As a result, there is not yet available a sound basis for deciding which themes and media should be used in promoting public understanding of the alcohol/safety problem and acceptance of various control measures.

The government agencies involved at the national level have asked their advertising contractors to do something which has never been done successfully: produce campaigns on alcohol and highway safety which will be demonstrably effective in eliciting public support for control measures, which will be enforced by organizations whose views of the problem differ widely, and which will be significantly different from previous campaigns. It would be unrealistic to expect that these aims will be fully achieved, but a continuous exchange of information by the agencies involved during

the next few years would greatly facilitate progress toward the desired outcome.

"Exchange of information" sounds rather innocuous, and "interagency cooperation" seems so obviously desirable that no one is likely to oppose it in principle. In practice, however, there is a wide gap separating a DOT-DHEW memorandum of understanding and the realities of a competitive existence for agency personnel. Each agency believes (perhaps correctly) that its continued existence within the bureaucracy depends upon its ability to remain visible and autonomous. At a certain level, each agency is competing with others for funds; thus each wishes to demonstrate that its own programs are more effective than those of other agencies. To the extent that needs of this kind take precedence over a desire to see the alcohol/safety problem reduced, cooperation will obviously be undermined.

Interagency competition is a formidable barrier to genuine cooperation, but ideological differences among the agencies could be even more troublesome. The caricatures are familiar to everyone in the field: law enforcement personnel are hard-nosed, rehabilitation people are soft-hearted, and so on. There are some elements of truth here, but the differences within each agency may be greater than those between one agency and another--which suggests that the problem of ideological differences is not insurmountable. The fact that casefinding, court procedures, and treatment are interrelated components of programs being conducted successfully in several cities (and necessarily involving cooperation among people in the legal and health fields) offers a reasonable basis for hope. While extensive public information efforts can give an agency visibility, the most favorable influence on Congress and the public would be exerted by a record of success in reducing alcohol-related crashes and fatalities. Since total program effectiveness depends in large part upon interagency coordination, each agency's self-interest almost demands that it cooperate with others. Once this is accepted, the specific matters requiring cooperative effort need to be identified and the mechanisms for making joint decisions can be developed.

REALISTIC EXPECTATIONS

The public information and education segment of current programs on drunk driving can be said to have three main goals: to convince the public (1) that a major problem exists, (2) that effective means exist for reducing this problem, and (3) that these methods deserve public support. It may also directly or indirectly, alter individual drinking-driving habits; it should make irresponsible drinking less socially acceptable; it will almost certainly help to legitimize the overall effort, involving improvements in legislation, law enforcement, and treatment or rehabilitation.

Realistic expectations regarding the role of the mass media are difficult to set at this point, but some limits on expectations for success are fairly easy to describe.

- The mass media are reasonably effective in conveying information but less so in changing attitudes or inducing action.

- Competition for public service time or space is intense; even with high-quality materials, no organization can expect to receive more than a small portion of the limited time or space available.

- Most of the time and space contributed by the media to public service causes are leftovers--that is, time and space not purchased by commercial advertisers. Consequently, allocations cannot be predicted and placement tends to be poor (on TV, for example, at low-audience times early in the morning or late at night).

- Even when placement of a documentary, news feature, or spot announcement is obtained, it may have little effect. Many people will simply not be exposed to it--they are not watching TV or they are among the 20 percent of the population not receiving a daily newspaper. Many who are exposed will pay no attention. Some of those who pay attention will not understand the message, or not accept it, or not feel that it applies to them. Some of those who understand and accept it will not be motivated to act or will soon forget the message. Many of those who remember it and want to act will somehow fail to do so. This description of diminishing effect may sound pessimistic, but it is accurate. Some commercial advertisers can be quite successful if they effectively reach only a small percentage of the population, but a campaign intended to reach more than a hundred million drivers obviously has a much tougher goal to achieve--especially when many of them prefer to believe they are not directly affected by the problem.

RANGE OF CHOICES

Some of the positive expectations for drunk-driving campaigns have been stated earlier, but before these can be justified it is necessary to develop sound campaign designs. This entails making choices of themes, message sources, and media appropriate to the objectives of the campaigns and to the designated target audiences. Some examples of the kinds of questions which must be answered: How much emphasis is to be placed on each kind of audience--problem drinkers, social drinkers, young drivers, legislators, law enforcement personnel, physicians, community leaders?

For each kind of audience, what information sources will be most trusted and accepted--public officials, "experts," recovered alcoholics, entertainment figures, crash victims? Which channels or media will be most likely to reach each audience efficiently--radio or TV spot announcements or entertainment programs or documentaries, newspaper or magazine ads or articles, pamphlets, transit advertising? What themes or appeals are most likely to have the desired effect with each group--personal risks, parental or professional role responsibilities, acceptance by friends, identification with respected persons, social costs? Whatever the appeal chosen, should the message be serious or humorous? Should it present only one viewpoint or attempt to appear more balanced? Should the recommendations be implicit or explicit? Apart from content considerations, which visual or auditory devices will be most effective? Should a direct attempt be made to counteract competing messages from other sources?

SOME STEPS TOWARD EFFECTIVE COOPERATION

These questions are only samples from a much longer list, but they reflect the range of choices faced and the need for information to guide these choices. Fortunately, there is now available a considerable amount of information on the beliefs, attitudes, and behavior of the general public (and some specific groups) with regard to drinking and driving--for example, national surveys by Opinion Research Corporation for NHTSA and by Louis Harris for NIAAA, and local surveys conducted by the first nine Alcohol Safety Action Projects. Presumably this information can be made available to all of the concerned governmental, commercial, and voluntary organizations for use in planning their own campaigns. Since each would then have access to the same basic data, the chances should be increased that the agencies involved would produce campaigns complementary to one another.

A step of even greater value would be for representatives of the agencies to meet periodically to obtain each other's reactions to decisions made or contemplated. Such meetings seem highly desirable and should be feasible at national, regional, and local levels. With or without such meetings, however, each agency should have an opportunity to review proposed informational materials of other agencies and to offer reactions on at least the following dimensions:

accuracy of information

stated or implied definitions of terms used

appropriateness of content, theme, source, and media for intended audiences

appropriateness of message to stated campaign objectives

technical quality

probable effectiveness in gaining attention, conveying message and eliciting action

probable acceptance by media

Each agency should be willing to present to others the following kinds of information about its campaigns: objectives; media used (and perhaps specific outlets within each medium); themes and the rationale for choosing them; intended audiences; scale or size of coverage; dates of planned releases; and plans for monitoring placement and assessing effects.

Assuming that the periodic meetings could be arranged, perhaps quarterly, they should not be limited to representatives of Federal agencies. They should also include appropriate commercial advertisers (such as insurance companies), voluntary organizations (such as alcoholism and safety councils), lay persons (representing target audiences), communications specialists, media personnel, and governors' representatives. By limiting the number in each category, it should be possible to keep the meetings small--no more than 25 and fewer if possible. By circulating reports of these meetings (without identifying the sources of either materials or reactions), other organizations disseminating informational materials on alcohol and safety could be kept informed of new campaigns and probable reactions of those professionally concerned with this area. It seems reasonable to expect that any new materials produced by these organizations would be influenced to some extent by such information.

It would also seem useful for some organization to monitor, compile, and circulate to each agency (1) informational materials and advertisements prepared by a variety of sources, and (2) reports of research on the impact of these materials. A newsletter might also be produced monthly or bimonthly to include reports of media coverage, descriptions of new programs, abstracts and critical commentaries on selected articles or books, and information obtained through continuing contact with personnel in governmental, commercial, and voluntary organizations. A third possibility is the appointment of a single independent panel of experts to serve in an advisory capacity to all three Federal agencies involved, and perhaps to certain regions or States as well. (Such a panel would probably complement rather than supplant the other items mentioned.) A fourth possible element is the use of a limited number of specialists, perhaps a dozen, to serve as individual consultants to national, regional, State, and local units. Each would have to be acceptable to the major agencies involved, would deal with units of all these agencies, and would serve as a carrier of information upward, downward, and laterally.

ASSUMPTIONS AND IMPLICATIONS FOR PROGRAM DESIGN

Cooperative planning of public information campaigns would be enhanced if the major organizations involved were to agree upon a number of assumptions and the implications of these assumptions for program design. Following are some examples of both categories.

COMMON ASSERTIONS, ASSUMPTIONS, OR FACTS	IMPLICATIONS
1. Legislators are unlikely to pass stringent control measures, and law enforcement personnel are unlikely to use such measures, unless they are convinced that public opinion favors these actions.	Survey data showing that the public feels drunk driving is an important cause of highway crashes and would accept control measures should they be given to legislators, police, judges, and lawyers.
2. The "don't drink and drive" theme may express an ideal, but it is not effective advice because it is contradicted by everyday experience. Having one or two drinks does not significantly increase the risk for persons not otherwise impaired, and most people have driven after drinking many times without experiencing either police contact or a crash.	To whatever extent attempts are made through the mass media to alter individual drinking-driving behavior, emphasis should be placed on the intake-risk relationship and knowing one's own limits rather than on abstinence.
3. Media "gatekeepers" (newspaper and magazine editors, management of radio and TV stations or networks, etc.) are aware that drunk driving is a major social problem, but for them it is only one of many such problems competing for time and space, and they probably do not know the nature and extent of new programs being undertaken to combat it.	Joint efforts should be made by the agencies involved to insure that messages reach the media in some coordinated fashion--consistent, non-contradictory, and scheduled so as to avoid competing with one another. Personal contact should be used whenever possible to convince media personnel that the problem of alcohol and highway safety deserves increased attention--in the form of editorials, features or documentaries, coverage of violations and crashes, public service announcements, and news of legislation.
4. A large proportion of the public believes that drunk driving is a major cause of highway crashes, but there is also a widespread belief that effective methods of reducing drunk driving either do not exist or have not been implemented.	Communication programs should emphasize that effective control measures do exist and should be used, rather than attempting to convince people that the problem is important and "something" should be done about it. Specific control measures should be described and reports of their successful use given prominence.
5. A large number of people manage to combine drinking and driving without hazard to themselves or to others. Their drinking is sufficiently controlled, and their driving sufficiently skillful, that they experience few violations or crashes. They find it hard to understand why drunk driving is such a problem for others.	Some communications should stress the fact that all drivers and pedestrians are threatened by those who abuse alcohol before driving. The number of those who do so, and their disproportionate responsibility for deaths and injuries, should be cited. The causes of alcoholism, and the loss of personal control which is a part of it, should also be covered.
6. Suspension or revocation of a driver's license fails to prevent most problem drinkers from continuing to drive after drinking excessively.	Public information campaigns which feature the threat of license removal are likely to have little effect upon problem drinkers, but this theme may still be effective with social drinkers.

7. Problem drinkers are often unable to control their drinking, and many of them deny this fact.	There is little point in trying to alter the driving-after-drinking behavior of problem drinkers directly through mass communications. The mass media should be used to convey information <u>about</u> the problem drinker rather than <u>to</u> him; that is, to increase public awareness of the problem and support for control measures (including treatment).
8. The relationship between BAC and crash probability is influenced by many factors, and most people are unwilling to believe that they can be affected personally. They feel that both their driving skill and their ability to handle alcohol are better than average, and they probably have not been involved in a crash. They also feel especially confident of their driving ability when they have been drinking.	It is difficult to convey to the public the relationship between amount of alcohol consumed and risk on the highway. Efforts should be made to develop more effective ways of convincing people that risk rises sharply with amount consumed--even for experienced and expert drivers.
9. If control programs are directed primarily at the "problem-drinking driver," many people who define themselves as social drinkers may feel they can drive after drinking without risk.	Some communications should emphasize that the legal BAC levels for "impaired" and "under the influence" are only presumptive, and that drivers can be arrested and convicted at lower levels of BAC. The distinction between "unsafe" and "illegal" should be clarified.

10. Technical solutions (such as ignition locks, improved measures of impairment, increased road patrols, and court-related treatment programs) can significantly reduce the drunk-driving problem, but these solutions will not be implemented unless the public accepts the problem as important enough to justify expenditure of tax money and new incursions on individual freedom.	Communications should include some emphasis on these facts: the costs of controlling the problem are far less than the costs of failing to control it; the per capita costs of effective control measures are quite small; all citizens including problem-drinking drivers, would benefit from a sound program combining enforcement and treatment; the greatest incursion on freedom is unnecessary and premature death.
11. Half of the population has an IQ under 100, and about 2,500,000 people are illiterate. Highway safety is a topic of very low salience for most people, since they are concerned with a multitude of more immediate problems. Everyone is exposed daily to a barrage of messages asking for money, time, interest, loyalty, etc.	Some communications can be subtle and complex, but others should be simple, graphic and direct. The personal relevance of the problem should be stressed: "<u>You</u> or your family can be affected, the consequences could be very severe, and there are some specific things you can do to cut down your risk whether you are a drinking driver or just a user of the highways."
12. Drivers with a BAC of 0.15 or higher (a level indicating excessive alcohol intake, often chronic and uncontrolled) are involved in about two-thirds of the fatal crashes where alcohol is a factor. Thus problem drinkers--an estimated 7 percent of the driving population, or slightly over 7,000,000 people--account for a highly disproportionate share of highway deaths.	Control programs should devote a significant part of their effort to problem-drinking drivers. A major objective of information campaigns should be to elicit public support for various measures (improved casefinding, stricter law enforcement, more treatment facilities, etc.) aimed primarily at this group.

13.	Young drivers who combine inexperience in using alcohol with inexperience in driving constitute a particularly high-risk group.	Special programs should be designed to reach young drivers through youth-oriented media, schools, the military, and companies which employ large numbers of young people.
14.	Many public service campaigns fail because they arouse concern about a problem without offering specific means to deal with it. This is especially true of campaigns which are designed to elicit fear or anxiety.	Campaigns should stress the fact that effective means exist for reducing the drunk-driving problem. Whether or not fear appeals are used (and it seems unwise to emphasize them), specific actions which can be taken by the audience should be described.
15.	Over 95 percent of persons with below-average income and education own TV sets; they regard television as the most believable medium; they are "heavy viewers" of TV; and they regard it as their primary source of news. However, access to TV is limited by high cost and by the great competition for public service time.	Any campaign designed to reach low-income groups should use TV as much as possible (in combination with other media). Agencies producing parallel campaigns should coordinate the release of material with each other so that stations and networks are not forced to choose among them. Attempts should be made to have appropriate content incorporated into entertainment and feature programs.

CONCLUSION

To the extent that control programs which are planned and conducted cooperatively are more effective than programs in which each agency works alone, inadequate cooperation on the part of any single agency might be seen as a failure of public responsibility: The same is true of situations where the best available methods of campaign design and evaluation are not employed.

Some amount of "give" may be required on the part of each agency--in relation to its own mission, campaign theme preferences, definitions of terms, methods of appraising effectiveness, target audiences, and so on. The single most crucial area here is the sharing of information across agencies. Unless each agency is willing to share with others its plans for future public information activities and the results of its past efforts--

and to make a public commitment to do so--cooperative programs will be just a pious hope, present disjointed efforts will continue, and the chances of measurable program success will be markedly reduced. Whatever the final form of the mechanism(s) developed to facilitate cooperation among the agencies involved, there is little doubt that a need exists for some means of assisting agency staff to adopt compatible philosophies of mass media usage. Anyone who questions this should get two or more people together to discuss the assumptions stated in this paper.

DISCUSSION

In the past, campaigns on drinking and driving have been completely uncoordinated, both between private and public agencies and within the agencies themselves. Sometimes contradictory messages go out to the public. If we intend to reach the public with any meaningful message, the campaign must be planned cooperatively by interested agencies. This is being attempted now by the national campaigns sponsored by NIAAA and NHTSA.

Public education on drinking and driving has to aim at many groups, using their own media as well as mass media.

1. Officials--police, courts, treatment agencies. Each has its own channels of communications, such as bar journals, social service journals, etc.

2. Individuals acting as citizens and voters, who can be persuaded by a good campaign to bring pressure on officials.

3. Individuals who can engage in one-to-one action--e.g., friends of the drinking driver who can persuade him to stay off the road.

4. Individuals who must change their own behavior. This is the hardest group to reach through mass media. Anti-drug campaigns have not been markedly successful. Anti-smoking campaigns have apparently had the net effect of increased smoking.

Questions were raised on use of TV:

Q- When you have a good spot, how can you prevent the station from showing a liquor ad within a few minutes? A- You probably can't. Public service time is scarce--the station gets several hundred requests over a few months. Stations tend to use timed material--Heart Week, etc.

Q- When you have material you believe should go into one of the prime time shows--e.g., Marcus Welby--how do you get it there? A- Entertainment is the criterion. Producers are not looking for a message. If you have one to get across, it will have to meet the entertainment criterion.

Several suggestions were generated on reaching special target groups. Materials should be in language and in concept that can be understood. The Albuquerque ASAP is in Mexican Spanish. The Los Angeles ASAP is going to try this. Puerto Rican materials are in colloquial Spanish.

Selectivity among stations will help. For youth, use rock stations and others beamed directly at youth. Ethnic groups also have their own stations in some areas.

Timing is also essential. If we do not have treatment facilities available when people respond to our message, the whole thing is lost, it was asserted. Others maintained that facilities will not be provided until the real need is brought to light when people have to be turned away. It was agreed that campaign planning must take into account other efforts being made, so that removal of public drunkenness from criminal law does not produce too great a time lag between the use of the jail cell and the availability of modern treatment facilities.

It is essential also to get research used. Research in alcoholism has too often been a matter of psychiatrist talking to psychiatrist, engineer to engineer, with nobody talking to the people who need to use the research. Compare this with research in agriculture, which gets into active use on the farm in five years time.

AN ANALYSIS OF THE USE OF THE MOTION PICTURE IN ALCOHOL EDUCATION

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What can the three Federal agencies (NHSTA, LEAA, and NIAAA) do individually and together to bring a consistent advertisement theme to the general public? We might agree that the message and feeling we want to leave with the American public includes personal responsibility for their drinking activities. But personal responsibility can come only with understanding and factual information.

If this can be agreed upon as one of our major underlying goals, then it is necessary for the three agencies to develop a similar philosophical orientation in order to collectively implement a mass media campaign. We cannot continue to hit our public with contradictory, fear-inducing propaganda. We must be able to present a cohesive message, one which serves the purpose of all three agencies and, most importantly, one that can be accepted by the general public.

Recently our organization has taken part in a study under contract to NIAAA which sheds some light on the use of mass med in presenting alcohol education concepts to the general public. Our study has been related to one of the most influential of the mass media--the motion picture. With the aid of a board of consultants, we have reviewed most educational films which have been produced since 1960 on the topic of alcohol use and misuse. We are now in the process of writing up the final report, and in lieu of the final product, we would like to share some of the panel's findings and recommendations as they grew from this evaluation project.

FINDINGS OF THE STUDY

A brief glimpse at what Americans have been exposed to in the way of audiovisual education on alcohol (be it on TV, in the classroom, at community group meetings, or in alcohol education training situations) might give you an idea of where we have been in our feelings and attempts at alcohol education over the past 12 years, and where we might most efficiently direct ourselves in the future.

Stereotypes

To begin with, the American alcoholic is a stereotyped figure, requiring little personal identification on the part of the general public. Many filmmakers have attempted to show him as the skid row bum. Most

of these films have been made for TV use--thus the "human interest" appeal of the skid row derelict has been perpetuated unconsciously by many of those who feel they are educating the public by means of TV. So when the term "alcoholic" is used, the American public has been conditioned to think of the skid row stereotype, thus picturing only about 3 percent of the alcoholic population.

A small number of filmmakers have attempted to correct this situation by moving into the "middle-class professional alcoholic" realm. This might have been a step in the right direction if such presentations had presented real human beings with feelings and problems. But, somehow, they have fallen into the same trap again; the middle-class alcoholic has also become a stereotype; he is the professional who nips from the bottle in his bottom drawer, stops in at the bar with buddies after work, and staggers into his home just in time to cause a scene before his son goes to bed. The picture becomes a soap opera, far removed from the audience's realm of identification.

Another "American alcoholic" who is receiving her share of unrealistic film footage is the woman who drinks herself into alcoholism alone in her suburban home, long before friends and family realize she is lonely.

All of these characteristics may be partially true. But stereotypes remove personal identification, thereby turning a decent message into a semi-entertaining soap opera.

Young People

Films directed at young people seem to credit them with little ability to think for themselves. Admittedly, the message to be presented to this audience is confusing. Responsible drinking when it requires the illegal use of alcohol is a touchy problem for many people. But it is a known fact that young people drink or at least associate with peers who drink. By denying this fact and pretending that abstinence is the norm, we are denying young people the vital information (and understanding) they need to drink responsibly, if they choose to drink. Somewhere in our communication to young people, we have to face a few facts and attempt a little honesty.

Minority Groups

Alcohol education films that speak to black, Spanish-speaking, Indian, and other minority groups are almost nonexistent. Those that are available shed little, if any, light on their cultural attitudes toward alcohol and alcohol use.

Treatment Procedures

Very few of the films currently available give a clear picture of the various treatment programs available to alcoholics. Too often, the only approach illustrated is that of A.A. or, as is the case with so many of the alcoholic soap operas, the moral or religious approach. Some films purport to be studies of alcohol treatment programs but end up being public

relations films for various agencies. Treatment procedures are controversial at the present time, it is true, but providing the public with no information on treatment procedures can only instill fear of the unknown in them.

"Responsible Drinking"

"Responsible drinking" has made its way into very few films. Many purport to be carrying this message, when in actuality they are saying that abstaining is the only responsible act. This only serves to destroy the credibility of the concept.

These are just a few of the images and concepts the general public has had to endure and translate for the past decade. One can only speculate on what went before! After observing these phenomena in 150 films, our consultants spent their last session making recommendations and citing possible productive avenues to be explored. Their suggestions might be of help to us as we attempt to order our thoughts here.

RECOMMENDATIONS

"Responsible Drinking"

First of all, "responsible drinking" is a vague and ambiguous term. It must be defined (and demonstrated) in behavioral terms. What can one expect to be able to do as a result of responsible drinking? At what point is one no longer in control? What are some concrete activities that one can use to judge his level of incapacity? If one is to make a responsible decision concerning drinking practices, what may he use as a yardstick?

We must find a way to translate responsible drinking into specifics for various audiences and admit that responsible drinking changes with the situation as well as the individual. For example, responsible drinking can and must be defined differently for the host at a cocktail party and for his guest who must drive twenty miles home after the party is over. The general public must be made aware that responsibility changes with role and environment.

This type of approach is used in one film concerning drinking and driving which is entitled "A Snort History." This animated film suggests that driving an automobile at any time is a series of risk-taking decisions; it then attempts to show that driving after having taken one, two, and more drinks increases the possibility of error in making these risky decisions. It removes the personal stigma attached to the "drinking-driving" concept and puts emphasis on responsible decision-making behind the wheel. It succeeds in its purpose much more emphatically than ten filmed automobile accidents could ever hope to.

Our consultants felt very strongly that the "responsible drinking" theme and the "drinking-driving" theme need not be separate. In fact, they felt that the basic knowledge presented under the responsible drinking umbrella (how much alcohol affects what actions, etc.) can only succeed in laying the ground for a safe driving campaign. It should be well understood that an individual has the right to make a responsible choice, but

that an irresponsible choice coupled with driving or endangering other people's lives is the right of absolutely no one.

Information and Identification

Our consultants believe it necessary to look at the purpose of a film closely to determine if it is attempting to provide information and/or change attitudes. If a film's purpose is to provide information, then the information should be factual, unbiased, and obvious. If people are allowed to think for themselves and are given adequate information upon which to base decisions, then they can accurately come to the "right decision." We have no alternative but to believe this.

This decision can then be reinforced by a change of attitudes. Personal decisions can be made responsibly, but it takes collective action to change attitudes. In other words, a person can know that one action is responsibly correct, but most often he must have the support of those around him to carry that decision into action.

And how can we best change group attitudes? A possible answer, according to our consultants, is honesty that does not arouse fear unnecessarily. Identification is the important element in connection with drinking, be it drinking which leads to alcoholism or drinking which leads to automobile accidents. Most people have drunk and driven with no accident. Therefore, in order to have this audience identify with a mass media message, we must start with this fact first and build upon it the knowledge necessary for a responsible decision. Fear-inducing messages might be effective in a court-instituted class for intoxicated drivers, but they are not very effective as a mass media message. We cannot sell an idea to an audience by making them feel guilty or upset; they will refuse to identify with such emotions.

Other recommendations were made by our consultants which do not directly relate to the drinking-driving problem, but these ideas might add understanding to the problems we face in reaching our audiences.

Specific Audience and Purpose

Any educational material, before it is produced, must have a clearly defined purpose and a clearly defined audience. To be effective, it must be specific; further, it is suggested no one knows the audience better than a member of the audience himself. In other words, to reach young people, we must consult young people; we must even let them make the film or write the article much of the time. It's interesting to note here, that among the top 13 films selected by our review panel, two were actually made by young people; and those voted above average for use with young peopl were almost always made by, or in consultation with, young people. There were no films rated suitable for use with blacks, Spanish-speaking, or Indian audiences. All of the ones that attempted to reach these audiences were made by establishment-oriented producers.

Vague and Contradictory Messages

Another concern: we are hitting the public with too many vague, contradictory messages. Our consultants warned against Federal control, but they did plead for Federal guidelines. Commercial producers are going to continue to produce and market films; possibly it is the Federal Government's position to provide these companies proof that there is an audience (and purchasers) for factual, honest presentations. We realize we cannot remove from the market films that are already available; but it would be in everyone's best interest if the few good ones were made more easily available. (One suggestion was that the government purchase two or three prints for each State and place them in State libraries.) Some of the films now available are not only bad; they are dangerous.

Federal Monies

There are ways of stretching Federal monies, especially in the area of film production, which might be explored. Some of the best films viewed were made by young filmmaker groups; university cinematography departments might be brought into Federal projects with a minimum of cost and a maximum of creativity. A few good films with an acceptable message might serve as a stop-gap in a market that is glutted with worthless and dangerous productions.

It was also suggested that some Federal monies be spent for training in the use of audiovisual materials. Many of the trainers and educators on our review panel emphasized that much of the problem rested in unskilled discussion leaders, those on the actual face-to-face level who are unable to use information and materials correctly or creatively. It was suggested that many teachers, administrators, and supervisory personnel have to be made aware of their feelings and prejudices in the area of alcohol use and abuse before they can honestly work with people at any age level. For this reason, our consultants felt that a training procedure such as the Social Seminar now being used by NIMH in their drug abuse education program should receive high priority.

SUMMARY

The mass media can be a prime means for focusing the attention of the public on alcohol and alcohol related problems. But, for it to be effective, it has to be a unified campaign with a central theme. We must develop procedures which force identification and internalization of the information provided.

We must allow the viewer to think for himself, but we must also provide him with information which is believable. In many ways, this seems to be easy for us, since factual information available on alcohol use and abuse can speak honestly for itself.

Above all, we must realize that the general public cannot be preached to, frightened into specific actions, or forced into permanent action by law. Attitudes must be changed, and that can only be done through reasoning and personal identification on the part of the general public.

CRITERIA DEVELOPED AND USED BY EVALUATION PANEL IN REVIEWING 150 FILMS ON ALCOHOL USE AND ABUSE*

General Criteria

1. Substance--The material (or film) must say something and show evidence of having been derived from an organized body of knowledge. It should not be superficial (lacking in depth).

2. Validity--The film must be as sound as our present state of knowledge permits. It should not misrepresent or oversimplify.

3. Balance--The film should not include excesses, extremes, exaggerations, incomplete thoughts, half-truths. It should provide enough material to allow for a responsible decision.

4. Authority--Good authority behind a film does not insure that it will be a significant, honest piece of material, but it is an added help which is often good. One must determine if the film was made only because it would sell, or if it does have real authority behind it.

5. Integrity--As used here, integrity means that the motivation behind a film is what it purports to be; that there is no ulterior motive irrelevant to alcohol education; and above all that there is no motive antithetical to sound principles of alcohol education.

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special acknowledgment to Nina Ridenour, Ph.D., author of "Mental ... Education: Principles in the Effective Use of Materials."

Specific Evaluative Steps Applied to Each Film

1. Define the intended audience.

2. Define the purpose or function of the film in relation to the specified audience.

3. Establish how well the film accomplished each purpose, taking into consideration the following points:

   A. Technical quality of the film (Is the photography acceptable? Is it dated in style or technique?)

   B. Factual accuracy (Does the film state opinion as fact? Does present knowledge allow for such interpretations?)

   C. Length (Does its length lend itself to the purpose? Are there parts of the film which could be used?)

   D. General presentation. (Is it interesting? Will it hold the attention of the intended audience?)

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GOOD FILMS

Of the 150 films and filmstrips reviewed, the following films met the criteria of excellence for films in the designated categories.

Responsible Drinking

1. "The Drinking American"--This hour-long documentary provides a look at the many different types of American drinking experiences. Scenes are shot at a party in the "Bible Belt," in a black bar in Harlem, in a single bar, in an all-male bar in San Francisco, in an avante-gard "intellectuals" bar. Throughout the film, pleas are made for responsible drinking by Dr. Morris Chafetz and Dr. Georgio Lolli.--Available from NET Field Services, Indiana University, Audio-Visual Center, Bloomington, Ind. 47401

2. "Alcohol and You"--This film examines the reasons why 80 million Americans drink and what makes one out of every fifteen American drinkers alcoholics. Much of the information is presented humorously. It does not bicker over the question of "when?".--Available from BFA Educational Media, 2211 Michigan Avenue, Santa Monica, Calif. 90404

3. "Hospitality"--This short TV spot shows a man sitting in front of his television with his beer, speaking to his unseen wife. The man is reminded that to "push" drinks on guests is not good hospitality.--Available from Addiction Research Foundation, 33 Russell Street, Toronto, Canada

Treatment

4. "Exploring the Treatment of Alcoholism"--This film shows the imaginative treatment procedures used at Mendocino (California) State Hospital's center for alcoholism and drug abuse. The patient chooses his own therapy from a wide range of possibilities: automatic relaxation, guided daydreaming, "gut-level" confrontation, nonverbal communication, behavior modification through reinforcement techniques, and group therapy. The scenes of the various therapies are inter-cut with an interesting interview with Dr. Ernest Klatte, then superintendent of the hospital.--Available from Roche Laboratories, Department of Education, Nutley, N. J. 07110

Facts About Alcohol

5. "A New Look at the Old Sauce"--This animated filmstrip depicts the history of alcohol usage and explains how drinking affects behavior. One part is concerned with the effects of drinking on driving; another deals with individual differences in drinking habits; there is also a discussion of alcohol as a disease and the myths surrounding it. Ethyl--Agent C_2H_5OH--is the allegorical female who represents the potential dangers of alcohol.--Available from The Texas Commission on Alcoholism, 809 Sam Houston State Office Building, Austin, Tex. 78701

6. "To Your Health"--An informational film on the nature of alcohol and the alcoholic, this film underscores the medically accepted view that the compulsive drinkers suffers from a disease, one which he cannot control alone. Animated images help to explain the action of alcohol in the human body.--Available from Center for Mass Communications, Columbia University Press, 562 West 113th Street, New York, New York 10025

Alcoholism

7. "Alcoholism in the Family: The Summer We Moved to Elm Street"--This is a realistic view of modern suburban life and the various events which effect a child's life. Through the eyes of a nine-year-old girl, the audience witnesses some everyday events in the life of a family that is heading for trouble. Doreen's father drinks too much, her mother is overwhelmed by household problems and worries, and the family moves so often that the children are constantly in the process of establishing friendships. Life at home has many bad moments for Doreen: waking at night to hear her parents quarreling, going for a drive with her father only to be left alone for hours while he stops off for a few drinks, having to give back her father's gift of a dollar because he is short of cash. The film ends with a moving van pulling up to the house, starting the process all over again.--Available from McGraw-Hill Films, 330 West 42nd Street, New York, New York 10036

8. "The Other Guy"--This is a two-part, well-acted story of the progressive development of alcoholism in a businessman. The audience sees how the main character moves from social drinking to alcoholism, and the effects this drinking has on his family and business.--Available from National Association of Blue Shield Plans, 211 East Chicago Avenue, Chicago, Illinois 60611

9. "Spirits Underground"--This cleverly-presented animated film is one young filmmaker's fantasies concerning the use of alcohol. It shows a drinker taking a subway ride, and vividly illustrates the emotions and feelings and hallucinations the drinker is having as he continues to down his bottle of wine.--Available from Youth Film Distribution Center, 4 W. 16th Street, New York, New York 10011

Alcoholism and Industry

10. "Need for Decision"--The problem of alcoholism in industry is tackled in a forthright fashion in this film for supervisory personnel. In a brief period of time, it spells out what a supervisor should and should not do when he suspects an employee of alcoholism.--Available from Peckham Productions, Inc., 9 E. 48th Street, New York, New York 10017

Community Approach to Alcoholism

11. "Problem Drinking: A Call to Action"--The film reveals a typical day in one community's fight against alcoholism. The program in Reading, Pa., combats alcoholism through education and rehabilitation and is directed at all segments of the community: youth, adults, professionals, police, courts, and industry.--Available from Association Instructional Materials, 866 Third Avenue, New York, New York 10022

Philosophical Approach

12. "US"--This film paints a background of the frenetic, ugly environment in which most of us have chosen to pass our lives, while the voices of the air waves drone their daily fare of violence, war and inhumanity. In the midst of this the audience is faced with women who deplore drug use by their children, yet discuss the "pick me up" they get from their amphetamines,

husbands worried about their wives' overuse of pills as they themselves are partaking of an abundance of alcohol. The irony of the way we all choose to pollute our lives is very vivid and real.--Available from Churchill Films, 662 N. Robertson Boulevard, Los Angeles, Calif. 90069

DISCUSSION

Most of the 150 films on drinking which Mr. Sareyan's group evaluated share common failings. First of all, they tend to deal in stereotypes, usually that of the skid row alcoholic. Even the few which use the middle-class alcoholic portray him (or her) in stereotype too. Stereotypes turn a good message into soap opera.

Stereotypes are a real problem for the agency that wants to make a film on drinking. The drinking driver in a party hat is quite clear. But if you show a man who looks fairly sober but is in fact drunk, you have to spend time in proving the state he is in.

Films directed at young people apparently discount their ability to think for themselves. Treatment procedures, when shown at all, tend to show the moral-religious approach.

The concept of "responsible drinking" has been emphasized in a few films, but what these films really meant is total abstinence.

The "responsible drinking" statement set off an extended discussion in the group. Definitions of responsible drinking ranged from total abstinence to "drinking in quantity so as not to interfere to any material extent with the activity expected." Among the points raised were:

1. What responsible drinking is depends greatly on the situation. A definition of an irresponsible drinking driver may be based on BAC. If we had some quantitative guidance, this would go a long way toward solving the problem of driving after drinking.

2. Some kind of a yardstick is essential. Otherwise the drinker will continue to judge his own capacity--I can handle it.

3. Who should give us the yardstick? Health agencies were suggested. A Swedish study indicated thresholds of .03-.07 BAC.

4. We should seek to guide American drinking mores so as to prevent the continued development of new alcoholic persons and new problem drinkers.

5. Perhaps we should not use a common definition. We must aim at the target groups which have widely varying problems.

It was agreed that information should be circulated on films of real excellence. Many bad films now being used really turn people off the basic idea, not off excessive drinking.

It is important to involve the intended audience in making a film. A low-budget film made by a youth group of the Lower East Side in New York was much better than most of the professional productions.

A panel might be set up to give advice to groups which want to make films on alcohol education.

Perhaps it would be useful for Federal agencies to buy and distribute good films. LEAA, the bulk of whose funds finance State plans for reducing crime and improving the criminal justice system, cannot buy directly, it was stated. But if a State sees a new film on alcoholism as contributing to delinquency, for example, it could use its block grant to buy and distribute the film.

Are there any good documentary films on alcoholism? Yes, the first on the list of films recommended by Mr. Sareyan's group. Documentaries, however, are very expensive to produce and they are normally a one-shot deal.

CAN COMMUNITIES RE-EDUCATE DRINKING DRIVERS?

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University of Southern California
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Under the auspices of the Department of Transportation, the Public Systems Research Institute of the University of Southern California conducted a prototype community program to assist and retrain convicted drinking drivers. The object of this program was to assist diverse communities in implementing local Alcohol Safety Action Programs by testing the feasibility, acceptance, cost, implementation, and operational effectiveness of a prototype community demonstration. This demonstration was accordingly designed as an exploratory study and is not represented as a scientific validation effort.

The prototype program included 60 court-assigned subjects who were convicted on drinking driving charges at the Santa Monica Municipal Court in California. These participants were subjected to a 12-week driver assistance and retraining program including the following basic countermeasures: individual counseling, class sessions, group therapy, and crisis intervention in the form of a 24-hour hot line and an emergency cab pickup service for intoxicated subjects. Over the three-month program, only 10 percent of the project participants dropped out. A control group of 30 subjects not taking the 12-week program was used for crisis intervention services only.

OVERALL DEMONSTRATION DESIGN AND PROGRAM EVALUATION

The three main areas of the demonstration design include sampling design, treatment design, and test and evaluation design. These three categories are described after a brief discussion of demonstration objectives. The overall planning process, generalized to ASAP community system development, is summarized in Figure 1.

The demonstration plan reflected pragmatic needs to help other communities to assess the desirability and cost-effectiveness of alternative procedures in handling the drinking driver problem. Consequently, the demonstration plan was eclectic and exploratory, covered a broad terrain, and was aimed at inquiry into a variety of alternatives within project resources. The project was also designed to be rapidly responsive to ongoing performance feedback and to redirection of program strategy and tactics for optimal exploratory yield.

Court Role

Court support essentially amounted to providing 60 convicted drinking drivers for the demonstration program, plus an additional 30 drinking drivers for the hot line control group. The subjects were assigned to the USC driver assistance program on a summary probation status, with reports from this project to the court as to whether each subject met program requirements. Individual failure to comply with program requirements resulted in prompt notification to the court. If the court so wished, satisfactory attendance in the three-month course resulted in reduction or elimination of the fine, with elimination of the drunken driving charge from the individual's record. A certification of completion from USC was issued to each individual successfully finishing this program. (See Figure 2 for the overall court/rehabilitation system cycle in processing drinking drivers.)

Group assignments and subject counts were maintained by USC, and judges involved were informed when demonstration quotas were reached. USC provided an employee at the Santa Monica Municipal Court to process offenders and associated court data after subjects received sentence. The program was described, appointments were made, and responsibilities were spelled out to each individual by the USC representative. Appropriate space and facilities were available at the court to perform this service.

Sampling Design

The sample design was tailored to available time and resources for handling subjects assigned to the project. The subjects were required to report to the USC facility in Santa Monica two hours each week for 12 weeks to complete the training program. Since we did not wish to jeopardize their employment responsibilities, group sessions were held Monday through Thursday, 7:30 PM to 9:30 PM in July, August, and September, 1971.

Educational group sessions consisted of 30 subjects per class for a total of two classes. Therapy sessions consisted of 15 subjects per group, for a total of four groups. Although smaller groups would have provided greater individual attention and larger groups greater economy, it was felt that the group sizes chosen represented a reasonable compromise for a feasible level of program cost-effectiveness with the expectation of a low dropout rate.

The plan for subject assignments is shown in Table 1 which is interpreted as follows. The first 30 subjects randomly assigned to the demonstration program by the court were placed in the first class. The remaining 30 subjects were placed in the second class. This sampling design permitted us to assign subjects as soon as they were made available by the courts and involved virtually no delay in setting up groups and processing them. Delays in subject assignment should be avoided, since they are likely to lead to higher dropout rates.

Table 1. Sampling Plan for Subject Assignment

Category	Total
First Class	30
Second Class	30
Full Program Total	60
Hot Line Only--Court Assigned Control Group	30
Grand Total	90

The lower portion of Table 1 reveals the sampling design for the hot line control group of 30 subjects. The 60 subjects receiving the full program had the hot line and driver assistance service available throughout the demonstration program. The hot line control group refers to additional subjects who also had the same hot line and emergency cab pickup service available throughout the same period; however, they did not participate in any other aspects of the program. Thus, this design would permit us to test for differences in hot line and emergency pickup usage between individuals taking the retraining program and those not taking the program. The original expectation was that those taking the program were likely to use the hot line and emergency services more frequently.

Treatment Design

The treatment design is summarized in Table 2 for the 60 subjects receiving the full 12-week program.

Table 2. Overall treatment design

First Week	-initial counseling, pre-demonstration questionnaires.
Next Four Weeks	-group classes on the effects of drinking and its consequences for driving.
Next Six Weeks	-group therapy aimed at individual problems; two groups led by a Ph.D. psychologist, the other two groups by an experienced paraprofessional.
Last Week	-exit interviews, post-demonstration questionnaire.
All 12 Weeks	-hot line and emergency pickup service, and individual counseling upon request.

All subjects received essentially similar treatment for all phases of the treatment program shown in Table 2 except for group therapy. That is, interviewing, counseling, and educational phases were more or less standardized and essentially equivalent for all subjects, with the proviso, however, that counselors and instructors freely adapt their material, procedures, and approach to the verbal and comprehension level of individuals and groups. The therapy groups were split equally between a Ph.D. clinical psychologist and an experienced paraprofessional who is a Ph.D. candidate. This difference in group leadership is one of the hypotheses tested in the results.

Test and Evaluation Design

The test and evaluation design was based on a systems approach in identifying, tracking, and maintaining continuing feedback on each subject and his progress through the demonstration program. Test and evaluation procedures were designed not only for final evaluation and ultimate dissemination of results but also for continuing feedback for project management. The system cycle is summarized for each phase with associated system test and evaluation.

Court Contact. Personal encounter with the subject, initial identification and biographical records, establishment of first interview appointment.

Initial Counseling. Utilization of diagnostic questionnaire and interview techniques such as the instrument developed by the University of Michigan: counselor and subject feedback on short standardized forms.

Educational Program. Various techniques, such as: pre- and post-class questionnaires; instructor and student feedback on each session on short standardized forms; group debriefing at the end of each session evaluating class effectiveness; exit interview appraisal of retraining program.

Group Therapy Program. Leader and participant feedback for each session on short standardized forms; group debriefing on therapeutic effectiveness at the end of each session; group leader evaluation of individual response to group therapy at the conclusion of the program.

Hot Line and Emergency Pickup Program. Identification hot line form for each call; driver and user feedback on short standard form for each pick-up; evaluation and recommendations from participants in exit interview.

Voluntary Counseling Program. Counselor and subject feedback on short standard forms for each requested interview.

Exit Interview. Post-demonstration statement of self-improvement, interviewer and subject feedback on standard forms for all portions of the program.

Note that the above evaluation plan not only incorporates standard pre-test and post-test techniques but also includes some form of feedback for each discrete interview or group session for each participant and each professional. This event-driven feedback is the basis for real time surveillance and evaluation in the demonstration program. Such feedback was simple and short, never more than one page, tapping spontaneous individual appraisal of the given session on the spot. In addition, the group sessions, educational and therapeutic, called for team debriefing procedures to evaluate overall system effectiveness--a powerful training technique successfully used for many years in military and aerospace team training with generalized potential for facilitating and reinforcing group effectiveness. These efforts at continuing cooperative appraisal of group performance enhanced group and management flexibility and adaptiveness to unforseen problems.

The basic instruments for program test and evaluation are summarized in Table 3. Most forms were short, simple, and easy to fill out. The requirements and parameters of these instruments are discussed in detail in the final documentation listed at the end of this paper.

Table 3. Basic test and evaluation instruments

1.	Court and biographical data form
2.	University of Michigan questionnaire
3.	Counseling evaluation form
4.	Instruction evaluation form
5.	Critical incident form: drinking driver arrest
6.	Self-improvement form: pre-test and post-test
7.	Educational achievement test
8.	Group therapy evaluation form
9.	Hot line call form
10.	Emergency pickup form

RESULTS

Each of the four basic countermeaures--counseling, retraining, group therapy, and crisis intervention--is briefly reviewed for basic results, conclusions and recommednations. The limited scope of this paper precludes elaboration of findings in any detail. Project documentation, listed at the end of this summary report, should be consulted for detailed results and supporting bibliography.

Counseling

Three types of counseling sessions were offered to a sample of convicted drinking drivers referred from court to the demonstration program: an initial counseling session, counseling on request, and an exit interview. Both the initial and exit sessions were conducted by project staff, while ongoing counseling was provided by an outside organization subcontracted to the project.

Each counseling session was aimed at meeting specific project objectives. The initial session was designed to serve as a springboard for the program to provide positive motivation towards ensuing activities. Ongoing counseling was designed to supplement group experiences with personalized individual contacts and was offered to participants as an optional service. The exit interview was intended to serve as a debriefing session providing project staff with participant feedback.

Results of the project indicated that both the initial and exit interviews met most intended objectives. Based on participant feedback, as well as positive introduction to the entire program--providing information, relieving anxieties, and creating sufficient rapport between the counselor and recipient to initiate at least some helpful introspection. Likewise, the exit interview served its intended purpose of providing project staff with enough information to determine the program's overall effect on participants. On the other hand, ongoing counseling met its objectives only to a limited degree, judging from its very low utilization. Although helpful to those who used it, this service apparently was not viewed as necessary by a great majority of sample members.

Class Retraining

The retraining sessions, comprised of films and lectures, provided information on alcohol and alcoholism as related to driving and its risks. Two classes were conducted once a week over a four-week period, with 30 subjects per class. Extensive discussions, both during and following the lecture, provided interaction and identification with others and aided in the learning process.

Results from data analysis indicated the effectiveness of the program in terms of perceived helpfulness, information learned and retained, and motivation to seek further help or do something about the individual's alcohol-related problems. Ability to predict individuals benefiting from the program was not demonstrated with various demographic variables and interviewer ratings. Although not statistically significant, the problem drinker, the recidivist, and the alcoholic tended to benefit more from the retraining program than did other participants. The great majority of participants responded favorably to the retraining program in the exit interview--only 6 percent were "not impressed" or felt that the classes were "a waste of time."

Suggestions for developing more effective programs were derived from the retraining experience. These suggestions relate to retraining as: 1) an educational tool; 2) a step towards greater involvement in the interaction process; 3) an aid to alcohol problem recognition by the individual; 4) a means of attitude change; and 5) a means of reducing the anxiety and hostility of court-forced rehabilitation procedures.

Group Therapy

Fifty-five convicted drinking drivers were randomly assigned to one of four short-term therapy groups. A Ph.D. psychologist and a highly experienced paraprofessional were group leaders, each conducting two groups. Sessions were held once a week for six weeks with mandatory makeup required for missed sessions. Two therapist variables were studied as a function of participants helped or not helped by therapy: therapist's status (professional vs. paraprofessional) and therapist experience with the target population.

Subjects were selected into the helped or not-helped comparison groups on the basis of 1) questionnaires administered after each session, and 2) self and therapist's evaluations. Subjects' responses obtained from an intake interview session and from pre-treatment questionnaires were also analyzed.

Statistically significant results--unusual for the small demonstration samples--indicated that more participants benefitted from later groups than earlier groups. That is, increasing group leader experience with this target population was positively associated with group therapy "helpfulness." In fact, experience with this population for both therapists was found to be more significant for therapy "helpfulness" than professional standing of the group leader, at least for this pilot study. These results appear to be related to special requirements in public programs for accelerated and cost-effective group therapy in contrast to the slower pace and greater permissiveness characteristic of private practice.

On the basis of this exploratory pilot study, convicted drinking drivers as a group exhibit demonstrable need for psychological help, and most of them appreciate group therapy as a valuable and helpful experience. From the ASAP viewpoint of conducting a balanced and comprehensive program, short-term group therapy could serve the extremely valuable function of personalizing the general information on drinking and driving picked up in the retraining class.

The key decision of ASAP management in group therapy cost-effectiveness lies in selection of subjects most likely to benefit from therapy and a balanced combination of professionals and trainees as group leaders. A good compromise can be achieved with specially trained, experienced paraprofessionals who are supervised by professionals familiar with the target population.

Crisis Intervention

A crisis intervention service was offered to project participants in the form of a hot line that may be called in time of severe emotional stress and a taxi service to provide transportation home for drunk project participants. Both of these services were subcontracted to outside facilities established in the city of Santa Monica.

Two samples were selected to assess the effectiveness of these services. The first was a sample of 60 convicted drinking drivers who participated in both the crisis intervention program and all other project activities. The second was a comparison group of 30 that participated only in the crisis intervention portion of the project. Comparisons of the groups were intended to assess the usefulness of a crisis intervention activity both with or without the support of other program activities.

Results of this portion of the program were relatively negative. Both the hot line and transportation service were used in a very limited way by project participants regardless of sample membership. For example, only 6 percent of all subjects used the hot line, and only 9 percent used the cab pickup service. More significantly, the services did not meet fundamental project objectives. The hot line apparently was not perceived as a useful crisis intervention aid, since no one called to discuss even trivial personal problems. During the project's duration, calls were made by subjects out of curiosity or as pranks while in an intoxicated state; none were made for its intended purpose.

The transportation service also did not meet its goal of providing interim assistance to help subjects re-evaluate their drinking and driving behavior through participation in the project. The few subjects who did use the service were apparently motivated more by economic gain for a "free-ride" than by project objectives. Furthermore, this particular type of service lends itself to many virtually unavoidable abuses which became apparent through the behavior of two project members who used the service to obvious excess.

CONCLUSION

The response to the question posed by the title of this paper is a conditional "yes." Communities can successfully begin to re-educate convicted drinking drivers with modest funding and initial assistance from appropriate, experienced professionals. The present demonstration program indicated that short-term measures of drinking dirver re-education can be acceptably cost-effective.

However, long-term success of such community efforts remains to be demonstrated. We have only begun to test the phaseover process from federally supported programs to locally independent efforts. Such testing should receive high priority in follow-up programs. Although many formidable technical management, and budgeting problems lie ahead for community institutionalization of drinking driver re-education, initial experience is sufficiently encouraging for continuing optimism and eventual success in reducing the appalling incidence of death and injury from drunk drivers.

PROJECT DOCUMENTATION

Volume I Guidelines for Developing and Implementing Community Programs to Assist and Re-educate Drinking Drivers

H. Sackman

Volume II Community Demonstration Plan to Assist and Re-educate Drinking Drivers

H. Sackman, O. Didenko, M. Thomas

Volume III Results of the Santa Monica Prototype Program to Assist and Re-educate Drinking Drivers

H. Sackman (Ed.), O. Didenko, M. Thomas, T. Tang

Public Systems Research Institute

University of Southern California

January, 1972

APPENDIX

COMMUNITY PLANNING AND SYSTEM DEVELOPMENT

The basic elements of community planning and the system development cycle are shown in Figure 1. The cycle starts with community needs for meeting the problems and social costs engendered by drinking drivers; this roughly corresponds to policy planning. The next block shows the critical planning stage for translating social needs into feasible and effective programs; this corresponds to strategic planning. The next step in the flow diagram branches out into three parallel activities or subsystems--information, people, and facilities (including equipment). This stage corresponds to system design and production, roughly equivalent to tactical planning. The next stage into which these three activities merge, orientation and installation, is the assembled total system which is tested and shaken down. Once certified, the system becomes operational (operational planning), eventually becomes obsolete, and leads to a second generation system.

Note that the system development process is modulated at all stages by management control (top of Figure 1), and by objective performance feedback through evolutionary test and evaluation (bottom of Figure 1). Thus, the interrelations between planning, management, and evaluation are shown in the context of evolutionary development of community systems.

Looking again at Figure 1, the impact of systems analysis is perhaps most strikingly illustrated in the central block of three parallel developmental activities--people, facilities, and information flow. Each has its own internal plan and each interacts with the other two elements.

For ASAP activities, personnel and facilities are probably more directly understood than the information or "software" subsystem. Most understand that appropriate personnel should be adequately selected and effectively trained in credible situations. The concept of system training--training all personnel as an integral team against partially simulated but realistic problem situations--is a more advanced notion that awaits greater maturity as ASAP develops. The notion of facility and equipment development is also fairly obvious; the detection, apprehension, court processing, and retraining of problem drinking drivers requires appropriately equipped police and adequate court and rehabilitation facilities, all responsive to technological advances, as in accurate and valid measurement of intoxication levels, and in video recording of subject performance at the time of arrest.

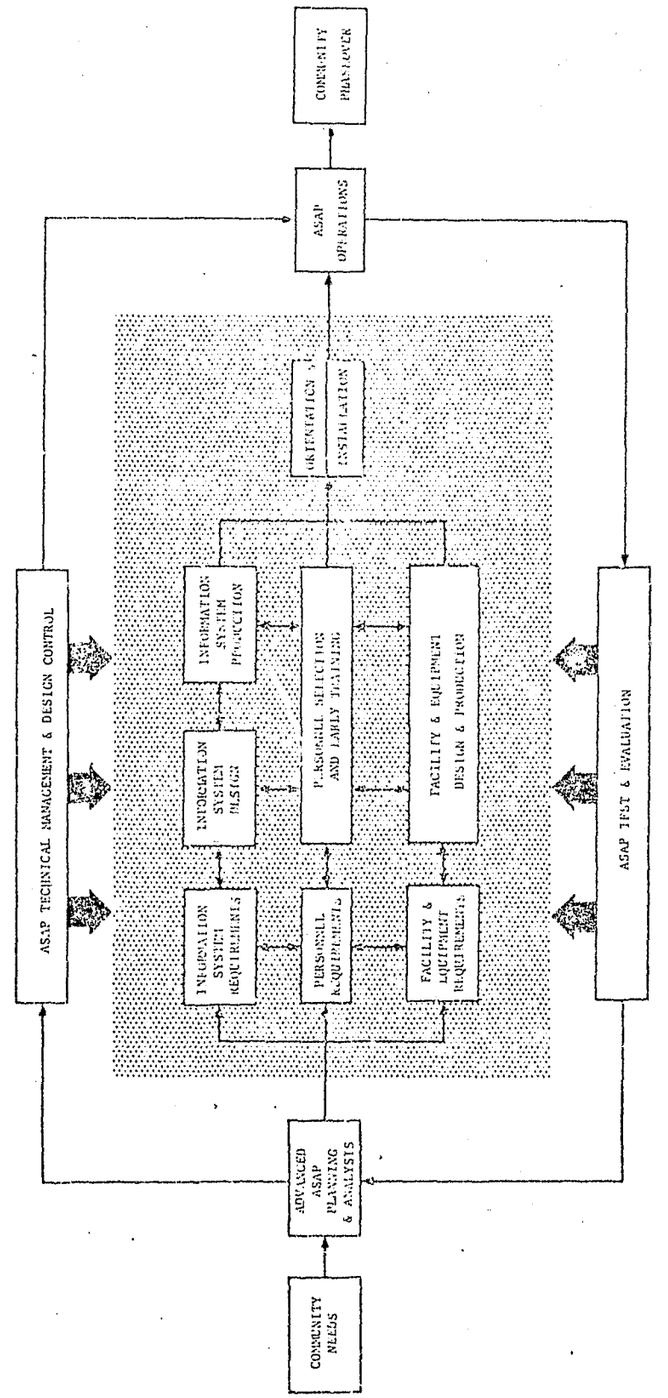

Figure 1. Developmental Planning of Community ASAP Systems

The information subsystem refers to the complete flow of information in processing DWI offenders. The downfall of the many attempts undertaken in the past to obtain reliable and valid information has been incomplete, erroneous, unstandardized with non-comparable records and bookkeeping among the various courts and agencies concerned with drinking drivers. A systems analysis of information needs and requirements for complete processing of DWI offenders for all system users leads to specification of the information subsystem. This specification should be sufficiently complete, then tested and modified in practice, so that it could form the basis for eventual computerization of drinking driver files, ultimately leading to online, interactive retrieval of DWI data.

In the current, manual state of DWI data collection and storage, primary emphasis should be placed on standardized forms. As mentioned earlier, we have done this in the Santa Monica demonstration program for subject identification, monitoring his response to the program, and evaluating his performance.

For ASAP community efforts, the information cycle is more complex and extends over a much longer period, particularly in follow-up validation, than our prototype demonstration. For such programs, a more formal information analysis is required. We are fortunate in having available the initial court systems analysis performed by the Institute for Research in Public Safety at Indiana University.* A flow diagram is reproduced from the original draft report in Figure 2 which shows basic information flow from arrest to completed sentence. Each community ASAP will have its own unique configuration with greater or smaller variations from the prototype system information flow shown in the Indiana University report.

Returning to the system development cycle in Figure 1, note that the information, personnel, and facility subsystems merge into the initial version of the complete system in the installation phase. At this point total system testing is possible, demonstration tests indicate the system is sufficiently stabilized to perform its mission, and, after adequate shakedown testing of components and the system as a whole, the system is ready for real-world operations. The operational phase, although shown as a single box, continues development and improvement of personnel, facility, and information subsystems in the context of the overall system throughout its useful life cycle. For ASAP activities, the final step is phaseover of the program toward self-sustaining community support. The second generation system, the community version, then goes through a similar cycle. With the advent of low-cost

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*A Survey of Court Procedures for Handling Problem Drinkers Convicted of Driving While Intoxicated, Interim Draft Report, Institute for Research in Public Safety, Indiana University, March 1971.

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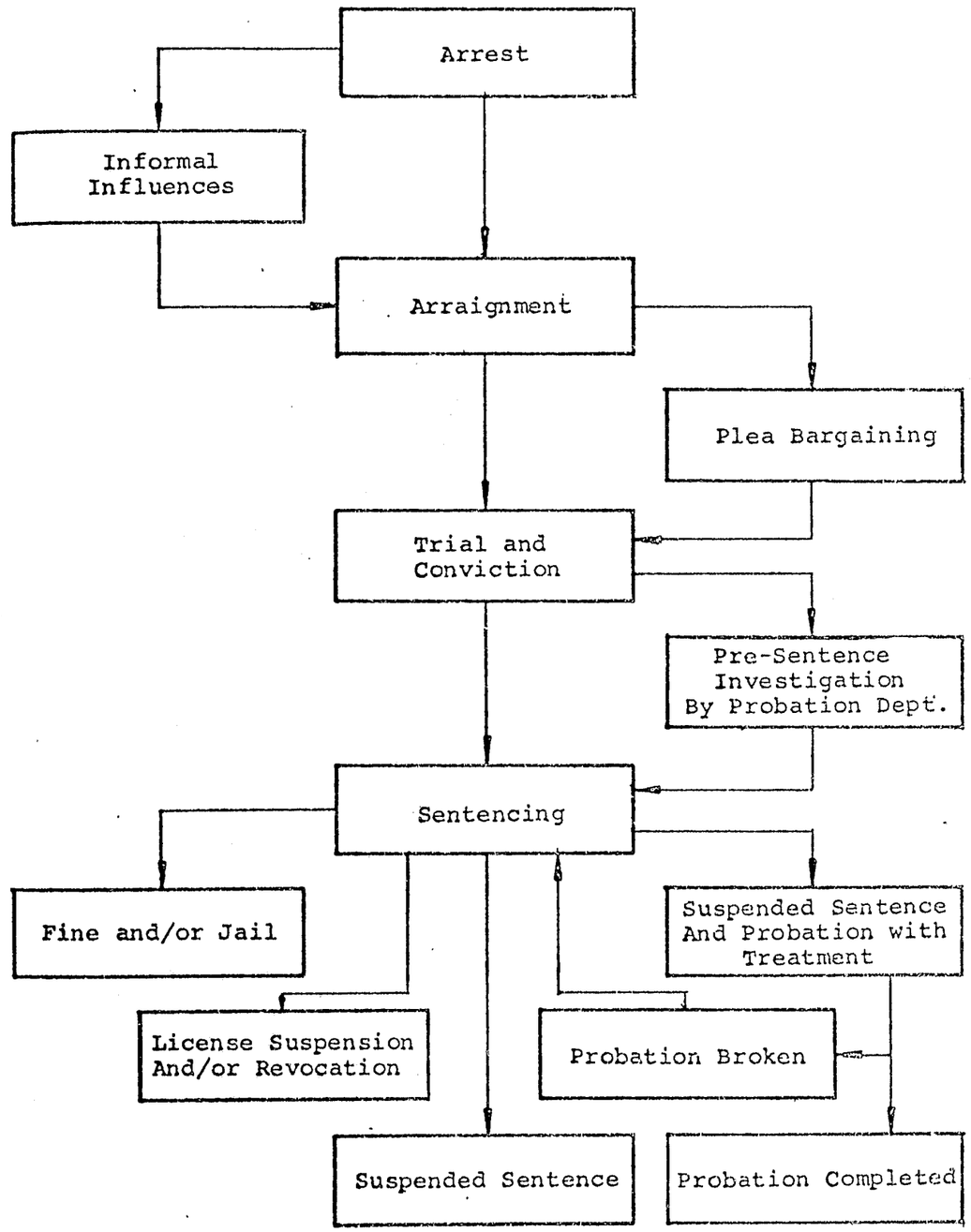

*Figure 2. Generalized Flow Diagram: DWI Processing from Arrest to Completion of Sentence (From Inst. for Research in Public Safet Indiana Universit 1971.

computers and the imminent emergence of mass information utilities, the third generation system could be highly computerized along well-established data-processing lines. Hopefully, by that time (1980's), as a result of national ASAP activities and favorable social developments, the DWI offender could be less of a problem than he is today.

DISCUSSION:

The 12-week Santa Monica study was designed to assist different kinds of communities in implementing ASAP programs for re-educating drinking drivers by testing a prototype program for feasibility, acceptability, cost, implementation, and operational effectiveness.

The subjects were persons convicted of DWI or DWI reduced to RD. If they chose to enter the program, they were placed on 1-year summary probation. The incentive was that if they completed the course, their sentences would be reduced. If they did not complete it, their sentences stood unchanged. Ninety percent of those assigned completed the course.

The sample was probably not representative in that 15 percent were females, 40 percent were blacks or chicanos. There were no non-English-speaking persons. It was representative of the general drinking population, however, in that about one-third were problem drinkers, one-third marginal drinkers, and one-third social drinkers.

The several elements of the program were adjudged as follows in effectiveness:

- Class retraining--very effective and most cost-effective.
- Standardized initial and exit interviews--very effective and cost-effective.
- Group therapy--effective.
- Individual counseling--very effective for those requesting it but also costly.
- Crisis intervention--not effective, costly, subject to misuse.

The program was known to subjects as a prototype, so that they were ready to comment. Such comment gave not only feedback to the leaders but also got rid of hostility.

Group therapy was eclectic. The leaders moved freely from one type to another in line with perceived needs. One group was led by a professional, another by a trained paraprofessional, with no noticeable difference in results. Therapy was hard-hitting and mission-oriented. Subjects initially

engaged in a good deal of dumping behavior, rationalization, and attempted cover-up of drinking behavior, subsequently coming to direct confrontation with personal problems.

Overall, the investigators believed, they showed it was possible to mount a community program at a fairly low cost (except for crisis intervention) with good acceptance (again except for crisis intervention) that seemed to augur well for behavior change.

Judge Mangum described the program he initiated in Phoenix in 1966, which has now become known as ASAP. This is a series of 10 hours of classes. All convicted drivers (except those convicted of manslaughter) must take the course without prospect of reducation of fine. In the first years, income from the required registration fee of $10 was used to buy films and reading materials and some consultation on teaching and testing techniques. Addition of ASAP funds will bring more professional assistance.

Judge Mangum believes that the program has been an outstanding success. It has reduced recidivism among drunk drivers. Many subjects have sought counseling. Others are now members of AA. The program is described in the February issue of Readers Digest. AAA offices have a 27-minute film describing it.

Workshop members were particularly interested in the mechanics of the Santa Monica and Phoenix programs. Also of interest was the need of subjects for vocational rehabilitation, which became obvious in both programs. Phoenix referred many to the State VR division. Santa Monica encouraged participation of spouses and friends in therapy sessions, with negligable results. Such participation is not permitted by Phoenix. In both programs, enormous medical and legal problems were observed. The Santa Monica leaders felt that this situation could be helped by having one class session led by a physician and another by a lawyer. Physical and social work-ups would be very helpful.

CONCLUDING DISCUSSION

There was general agreement that public and private agencies with concerns in the field of alcohol problems should try to reduce alcohol consumption in the U.S. and seek to control abuse of alcohol by individuals. Such action would reduce alcohol-related crime and accidents on highways, in the air, in industry, and in the home, as well as affecting the health and welfare of individuals and their families.

Efforts of the concerned agencies need to be interrelated at the Federal, regional, State, and local levels.

Cooperative efforts should begin with an analysis of the state of the art in safety, prevention, and treatment programs. Each agency should set forth briefly its goals and the values on which the goals are based. Thus, a master plan could be developed that would be scientifically sound and politically acceptable.

The workshop felt that an interagency group should collect, analyze, and disseminate to the field research data on alcohol problems. Moreover, each of the three Federal agencies with concerns for alcohol abuse should furnish to the regions a fact sheet on its programs and operations, a sort of brochure for the information of all interested agencies.

In each region, there should be a committee to coordinate, evaluate, and disseminate information coming from the national level. There should be a standby group of consultants in order to guarantee continuation of successful ongoing programs.

Finally, it was agreed that there should be regional meetings in the alcohol problems area. Plans should be made now for funding such meetings.

LUNCHEON ADDRESS

The Uniform Alcoholism and Intoxication Treatment Act

Allan D. Vestal

THE UNIFORM ALCOHOLISM AND INTOXICATION TREATMENT ACT

Allan D. Vestal
College of Law
University of Iowa

It gives me a great deal of pleasure to come here to tell you about the Uniform Alcoholism and Intoxication Treatment Act which has recently been promulgated by the National Conference of Commissioners on Uniform State Laws.

The National Conference is made up of State officials named by either the legislature or the governor for a term of three years. It is composed of attorneys, professors, and judges and, I think, represents a cross section of the legal profession. The Conference drafts uniform legislation in fields where we believe it is desirable.

You may be familiar with some of these uniform laws. The Uniform Commercial Code, for example, which has been adopted in 49 of the 50 States, controls most of the commercial transactions in the United States. At present we are drafting a Uniform Accident Reparation Act at the request of the U.S. Department of Transportation, an act which would set up no-fault car insurance. The Uniform Probate Code is another product of the Conference.

NEED FOR A UNIFORM ACT ON ALCOHOLISM

About 18 months ago the Conference got involved in the field of alcoholism, for several reasons. First was pressure from the medical profession, which really wanted something done. The American Medical Association had been working with a committee of the American Bar Association in the alcoholism field. Second were the recent court decisions saying that intoxication could no longer be treated as a crime, that drunken people could not be handled as criminals, that they are not in fact criminals. The third reason was the ineffectiveness of the criminal law in dealing with the general problem.

It is necessary to look at alcoholics as individuals. It is a mistake to forget that they are in fact individuals. On the other hand, it is necessary to look at the nature of the total problem. For example, if we do have two million arrests for public drunkenness per year, they are an enormous problem. This is about 40 per cent of the non-traffic arrests in the United States.

An unpublished study of the problem in Indianapolis reports about 8,000 arrests annually for public intoxication, more than a quarter of all the arrests in that city. In one week they had 141 arrests for drunkenness only. Among those 141 men, the recidivism rate was amazing. Forty-three had more than 10 prior arrests for drunkenness. These 43 had a total of 1,579 prior arrests for drunkenness, averaging 38 arrests per man. This suggests that it is an enormous problem for the police to handle these individuals.

President Nixon in his Williamsburg address talking about the log jam in the courts said, "We have to find ways to clear the courts of the endless stream of victimless crimes that get in the way of serious consideration of serious crimes. There are more important matters for highly-skilled judges and prosecutors than minor traffic offenses, loitering, and drunkenness." It would be very desirable to get these drunkenness cases out of the hands of the police and the courts and handle them in some other way. So I think we can say the criminal law approach to alcoholism is illogical, perhaps even illegal or unconstitutional; it is ineffective; and it is impeding the operations of the police and the court system in handling serious crimes. There is a need for an approach different from that which exists in most States.

DRAFTING THE LEGISLATION

Representatives of our Conference started working on this problem about 18 months ago with representatives of the National Institute of Mental Health, the American Medical Association, the American Bar Association, and the National Conference on Alcoholism. I should also mention that Peter Hutt, who drafted the legislation for the District of Columbia and is now general counsel of the Food and Drug Administration, was extremely helpful in drafting this legislation. We also had assistance from Senator Hughes' office. We looked at the existing legislation and the model acts which had been prepared. After a number of committee meetings, we presented a uniform act to the National Conference of Commissioners on Uniform State Laws in August, 1971. After serious consideration, it was adopted by a vote of 47 States to 1. (You vote by States in the National Conference.) Only one State was opposed to this particular piece of uniform legislation. This, then, is a uniform act which has been promulgated by the National Conference and is presented to the various States for adoption. We hope that it will be enacted in many of the States which have a need for this sort of legislation.

PROVISIONS OF THE ACT

I would like to go through this with you and suggest some important parts of the ACT. I think we can indicate the significance of this Act and what it has tried to do.

Declaration of Policy

First, in Section 1 the thrust of the legislation is spelled out specifically in a declaration of policy. Section 1 states: "It is the policy of this State that alcoholics and intoxicated persons may not be subjected to criminal prosecution because of their consumption of alcoholic beverages but rather should be afforded a continuum of treatment in order that they may lead normal lives as productive members of society." We want to take this problem out of the scope of criminal law and provide treatment instead.

In Section 19 you will find that there is a general repealer saying that municipalities, cities, and towns cannot have laws which make intoxication or drunkenness a crime. The State in Section 37 is to repeal any provision which makes a crime of these same matters. So both local government and State government will no longer treat intoxication or drunkenness per se as a crime. On the other hand, States can retain anything that makes, for example, drunken driving a crime. Specifically, 19(c) says nothing in this Act affects any law or ordinance, resolution or rule against "drunken driving, driving under the influence of alcohol, or other similar offense involving the operation of a vehicle, aircraft, boat, machinery, or other equipment." Also, there is a provision in Section 19 that says you can still retain provisions making criminal violations of laws concerning the "sale, purchase, dispensing, possessing, or use of alcoholic beverages at stated times and places or by a particular class of persons."

Division of Alcoholism

Now the key organization as far as the State is concerned will be a division of alcoholism which will handle activities at the State level. This division will be established within either the department of health or the department of mental health in the State. The division has powers that are spelled out specifically in Section 4 of the Uniform Act. It has the power to plan, establish, and maintain treatment programs as necessary or desirable. It can solicit funds. Of course, it can take tax funds; it can ask for grants or money from the Federal Government. It is to coordinate all of the activities in this field in the State, and it has the power to keep records and to engage in research and gathering of relevant statistics. It has a whole range of very broad powers granted under the Uniform Act.

The division's duties are set out in Section 5. It has the duty to develop, encourage, and foster statewide, regional, and local plans and programs for the prevention of alcoholism and the treatment of alcoholics and intoxicated persons. It has the duty to work with the State agency handling prisons to provide for treatment of alcoholics and intoxicated persons in, or on parole from, penal institutions. It is to have a program

for the prevention of alcoholism. It is to work with schools in establishing programs for the curricula for the various schools. It is to engage in research. It has a duty to do this as it keeps statistical information. It has the duty to advise the governor in the preparation of a comprehensive program dealing with alcoholics. It is to work with businesses and governments for the betterment of alcoholic employees. It is to work with the commissioner of public safety or the highway commission in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while intoxicated. It is to encourage general hospitals to admit alcoholics like any other ill persons and not to treat them differently. It is to encourage all health and disability programs to include alcoholism as a covered illness. And it is to prepare an annual report of the activities of the division.

You can skip Section 21 thru 34 for the time being. These are provisions that deal with the administrative procedures within the agency itself. They are put in to assure that the rulemaking and adjudication within the agency will be proper. But they have nothing to do with the substance of the proposal being made. So I would not encourage you to read Sections 21 through 34 until you get to the point where you are really interested in having this adopted in your State.

Now in addition to the division there will be an interdepartmental coordinating committee, under Section 6, that will bring together from various State agencies all of those interested in this particular problem to provide for coordination of activities dealing with it. Then, there is to be a citizens' advisory council on alcoholism, under Section 7, to bring citizens into this program.

Treatment Facilities

Section 8 provides for treatment facilities to be established by the agency. When we talk about treatment facilities, this has a definite meaning. Treatment is defined in the Act and it means not just the traditional sort of medical treatment. Treatment under the Act means the "broad range of emergency, outpatient, intermediate, and inpatient services and care, including diagnostic evaluations, medical, psychiatric, psychological, and social service care, vocational rehabilitation and career counseling, which may be extended to alcoholics and intoxicated persons" (Sec. 2). This is a whole range of things that may be helpful in getting this man back to a normal life within the community. This is what we are trying to provide.

The division is to provide "a comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons." This is to be a statewide program. The division is to provide emergency treatment facilities, inpatient treatment, intermediate treatment, and outpatient and follow-up treatment facilities. Section 8 (c) states that none of these facilities can be provided in a correctional institution except for inmates of that institution. In other words, you can't take a wing of a jail or prison and label

it a treatment facility for alcoholics. You must have separate facilities for the treatment of these individuals. The division has the right to enter into contracts with private organizations to use their facilities as approved treatment facilities. This means that the division could enter into a contract with a private hospital or a municipal hospital to bring it into the State program. Section 9 of the Act provides certain standards which public and private treatment facilities must meet if they are to be approved for use by the division.

There is a provision in Section 18 which should be noted when we talk about the division establishing these treatment facilities. It provides that if a person comes into a treatment facility and later receives some reimbursement for the cost--for example, from a hospitalization program--the division may be entitled to these funds.

This raises a very serious problem about who is going to pay for all this. If you are interested, you might look at Section 18 of the Act to see what provisions are made there. I want to emphasize one thing about this. Whenever the National Conference brackets a provision (puts brackets around it) it means that this is optional and need not be adopted. And if you will look at Section 18, you will find (B) and (C) are bracketed. (B) states that if you treat a person then the family may be required to bear the burden of supporting this individual. That is a bracketed provision, which means that the National Conference does not necessarily feel that this must be adopted. It can be, if the State wants to do so.

DEFINITION OF TERMS

Great care is required in reading the Act because in it three different terms are used. The Act refers to (1) alcoholics, (2) individuals incapacitated by alcohol, and (3) intoxicated persons. Each has a special meaning that is defined in Section 2. "Alcoholic" is defined as a person who "habitually lacks self-control as to the use of alcoholic beverages, or uses alcoholic beverages to the extent that his health is substantially impaired or endangered or his social or economic function is substantially disrupted." A person is "incapacitated by alcohol" if he "as a result of the use of alcohol, is unconscious or has his judgment otherwise so impaired that he is incapable of realizing and making a rational decision with respect to his need for treatment." An "intoxicated person" is defined as a person "whose mental or physical functioning is substantially impaired as the result of the use of alcohol." This may be a person who is staggering. His physical function is substantially impaired as the result of the use of alcohol.

Voluntary Admission

Certain general provisions in Section 10 apply to the operation of treatment facilities. The first is that people should be accepted on a voluntary rather than on an involuntary basis if at all possible. In other words, we are interested in having people come to a treatment facility of

their own accord. Another provision is that outpatient facilities should be used first, rather than putting persons in inpatient facilities. There is a provision that an "individualized treatment plan shall be prepared and maintained on a current basis for each patient." The medical profession feels that this is extremely important. In other words we are not going to have large wards of individuals who are just in there as a group. This section requires that each individual has to have a treatment plan prepared and maintained on a current basis. This is not custodial care. We are interested in treating these individuals. As far as treatment is concerned, again we have the idea that provision shall be made for a "continuum of coordinated treatment service." We are interested in a whole range of treatment for these individuals.

It is expected that many will seek treatment voluntarily. Any alcoholic may apply for voluntary treatment directly to an approved public treatment facility. He can walk in and say: "I am an alcoholic; I need treatment." He then will be cared for, will be treated at the facility. So this is the first way that these people will come in. In addition, an intoxicated person, not necessarily an alcoholic, may come to an approved treatment facility for emergency treatment. This is a man who is intoxicated and feels he needs some assistance. He can come to a facility.

Intoxicated Persons on the Street

Now we get to the matter of handling the alcoholic or the intoxicated person on the street. Let me read these provisions because I think they are extremely important. First, "a person who appears to be intoxicated in a public place and to be in need of help, if he consents to the proffered help, may be assisted to his home or an approved public treatment facility, an approved private treatment facility, or other health facility by the police or the emergency service patrol" (Sec. 12a). In other words, when you run across this intoxicated person who needs help, somebody will offer to help him to a treatment facility or to his home. He will not be arrested. "A person who appears to be incapacitated by alcohol shall be taken into protective custody by the police or the emergency service patrol and forthwith brought to an approved public treatment facility for emergency treatment" (Sec. 12b). He is taken into protective custody. It is not an arrest and the Act so provides: "No entry or other record shall be made to indicate that the person has been arrested or charged with a crime" (Sec. 12b). In other words, this is not an arrest and will not be treated as such. This is a sick person who needs assistance, and that is what we are trying to render to him. When a person who is incapacitated by alcohol comes in, he can be retained for 48 hours unless he must be released. Even if he is still incapacitated by alcohol, he can be held for only 48 hours. If they are going to hold him any longer than this, they must use another provision of the Uniform Act. In other words, when they pick him up, they can hold him for no longer than 48 hours. Then something else must be done with him. This is where you get into Section 13 which deals with emergency commitment.

Commitment

Section 13 is not a judicial proceeding; it's a proceeding before the administrator of an approved public treatment facility. At this point you have an intoxicated person; that is, one whose functioning is substantially impaired because of the use of alcohol. If we are going to keep this man under an emergency commitment, he must have threatened or attempted or inflicted harm on another; and he must be likely to inflict physical harm on another unless committed. That is the first category of individuals subject to an emergency commitment.

The second category subject to emergency commitment are those incapacitated by alcohol, unconscious, or unable to make a judgment as to their need for help. This intoxicated person, who has threatened and will be a threat to somebody in the future or is incapacitated by alcohol, is subject to emergency commitment for a five-day period. Commitment is obtained by going before the administrator of an approved public treatment facility and proving these essentials. The administrator can hold this person for five days. So you may have the 48-hour period and then you go before the administrator and say you need to keep this man. If you prove these things to the administrator, you can keep him for five days. So you have a full week under these two provisions. When the person is committed under the emergency provision, he must be told about his right to counsel within a 24-hour period so that he knows what his rights are.

Beyond the 7-day period, if you want to hold an individual you must go through a judicial proceeding. This is a full-blown hearing where you come into a court, a court of general jurisdiction. You have to show that this person is an alcoholic who habitually lacks self-control as to the use of alcoholic beverages and (1) that he has threatened, attempted, or inflicted physical harm on another and is likely to inflict physical harm on another unless committed or (2) is incapacitated by the use of alcohol. It is required that you have a physician, if possible, who will testify to these facts. You have to prove these things to a judge, and you must show this by "clear and convincing proof." To an attorney this is significant. It requires more than a preponderance of the evidence. The court then has a right to order that the person be held for 30 days. This is a judicial commitment by a court. To show the thrust of this procedure, that we are interested in treatment, there is a provision saying that the court "may not order commitment of a person unless it determines that the division is able to provide adequate and appropriate treatment for him and that the treatment is likely to be beneficial." The Act is not designed to put a person into some sort of custodial home; the Act involves treatment. The court must find that the division can treat the individual. If the division can't provide suitable treatment, then the man should not be committed under this section. You have this 30-day period for which he can be committed. Then after that he can be recommitted, going through the same process exactly, for another 90 days and then another period of 90 days--a

total of 210 days in addition to the 7 days under the prior sections. That is the total amount of time that a person can be held under this Uniform Act. In other words, we are interested in treatment. If you can't treat him successfully within this period of time and wish to hold him for additional time, you must use some other provision of State law. There is a provision here, Section 14(i), that indicates quite clearly that we are interested in treatment because if, in fact, they find that further treatment will not be likely to bring about "significant improvement in the person's condition, or treatment is no longer adequate or appropriate" an incapacitated person should be discharged.

In addition, a man who is committed under this judicial procedure has the right to be represented by counsel; if he has no money, counsel is to be provided. We have the whole range of protection in this statute just as you do in a criminal procedure. Although this is definitely not a criminal proceeding, we want to protect the rights of the individual who is to be committed. The writ of habeas corpus is always available to an individual under this Act.

We are interested also in the individual while he is being held under one of these commitment provisions. For example, there is to be no mail censorship; the use of the telephone is to be assured to this individual under reasonable rules; he is to have opportunity to consult with his attorney and to have contact with his family and friends. All of these are assured in the Uniform Act.

I would suggest that this Uniform Act, first, eliminates drunkenness and public intoxication as crimes and takes this problem out of the hands of the police and puts it in the hands of people who are interested in treating these individuals. It allows or provides for a broad range of treatment of alcoholics. It always insists that the voluntary should be heard over the involuntary. It is true that no special medical treatment is provided. All we are giving here is a legal framework within which the best treatment can be offered. The regional approach is to be preferred over a broad statewide approach. In other words, an individual can best be treated at home or close to his home rather than at a facility miles away from his home. I believe that the rights of the individual are protected here. I think commitment provisions are extremely limited and then they are provided for treatment only.

Secretary Richardson some time ago indicated that he felt that this Uniform Act is desirable. He said:

> In my opinion, this Act represents one more example of the ability of our system to be responsive to change and to the needs of people and communities. I fully support their action. For too long, public intoxication has been the

> responsibility of the criminal justice system. This new Act removes public intoxication from the criminal justice system and creates safeguards as well as a new system for helping alcoholic persons as well as their families. The burden on police and courts will be alleviated. More importantly, human beings will be assured of receiving assistance and more effective services such as emergency medical treatment and appropriate follow-up care involving social, vocational, and rehabilitative services, medical and psychological services. In giving my full support to this Act, I intend to promote its adoption by the States as well as to promote the early initiation and expansion of more effective services for alcoholic persons. I have, therefore, instructed the director of the National Institute on Alcohol Abuse and Alcoholism, Department of Health, Education, and Welfare, to provide assistance to any State wishing to develop appropriate plans and services for full implementation of the Uniform Act.

The American Bar Association's House of Delegates meeting in New Orleans has recently approved this Uniform Act. The American Medical Association has approved it. I think it something that deserves serious consideration of citizens throughout the United States. The State of Washington had adopted the Uniform Act. We have had indications of interest in the Uniform Act from North Carolina, Washington, Wisconsin, Oklahoma, Illinois, and the Act has been introduced in the general assembly in Iowa. We have high hopes that it will be adopted in a number of States in the very near future.

PLENARY SESSION

RECOMMENDATIONS AND RESPONSES

PLENARY SESSION

REMARKS OF THE FEDERAL ADMINISTRATORS

W. Thomas Engram, Assistant Director of the Conferences and Institutes Division of the University of Maryland's Center for Adult Education, served as chairman of the final session and explained its purposes: to hear from representatives of the sponsoring agencies, to receive the reports and recommendations of the three workshop groups, and to offer the Federal administrators an opportunity to respond to the concerns expressed by the conference participants.

The administrators speaking at this point were:

Willard Y. Howell
Director, Office of Alcohol
Countermeasures
MHTSA

James Wilson
Associate Administrator
NHTSA

Kenneth S. Carpenter
Assistant Chief, Corrections
Programs Division
LEAA

Dr. Morris Chafetz, Director of the NIAAA, and John Wolfe, project officer of the conference, responded to recommendations and questions later in the session.

MR. HOWELL:

Three communities of interest are meeting here to focus on a single serious problem: alcoholism and alcohol abuse. We all need to remind ourselves that each of the three Federal agencies focuses its searchlight from a different angle. The NIAAA people are interested in alcoholism and alcohol abuse as a major health problem of the Nation. The NHTSA people see it as a highway safety problem of considerable magnitude. LEAA is concerned with alcohol as a root cause of public safety problems. Each agency must understand the interests and viewpoints of the others, so that efforts to alleviate the alcohol problem can be complementary rather than fragmented, duplicating, or, worse, contradictory.

Obviously in a conference like this, some people will feel that some material is not germane to their concerns. But the great thing to be gained by such a conference often comes from contacts and conversations outside the working sessions. Just getting people together and locking the door does lead to exchange of points of view.

NHTSA, NIAAA, and LEAA are three of the newest Federal agencies. To some degree, they're all still in the formative stage. They've not become solidified. They'd like to think they have not gotten into a rut as deep as some of the agencies that have been around longer. They see themselves as being still flexible. So, hopefully, the recommendations that come from this conference can be accepted by the respective administrators, and something can be done about them.

NHTSA traces its history back about five and a half years to two laws passed by the Congress: the Motor Vehicle Safety Act passed in the fall of 1966, which created a motor vehicle safety agency headed by a Presidential appointee; and a sister act, the Highway Safety Act, passed at the same time, which also created an agency. These two agencies were melded into a single bureau, which recently has been upgraded to an administration. There are two operating line departments--one which regulates the safety of motor vehicles manufactured in Detroit and elsewhere, and the other concerned with the general field of highway safety. Each is headed by an associate administrator.

We have with us today the associate administrator who heads up the highway and traffic safety aspects of the agency, James Wilson. He was in effect drafted from the State of California where he built up a tremendous reputation as a highway safety engineer. It gives me great pleasure to introduce Mr. Wilson.

MR. WILSON:

NHTSA is happy to be a sponsor and a participant at the conference. I want to thank all of you who came from so far--and some of you who came from near--for participating in this very important activity. If this conference results in an improvement in the quality of government and perhaps a more responsive tone to society's needs, then it will have been a success. As Mr. Howell has mentioned, we have somewhat different points of view in dealing with the various problems of alcohol abuse and alcoholism, but all of these points of view and all of the solutions to the problem if they are successful, and I believe they will be successful, can certainly improve the quality of life in the United States.

As Mr. Howell also mentioned, we are creatures of two highway safety pieces of legislation. During the hearings in 1965 and 1966 someone had the forethought to propose including in the Highway Safety Act the mention of the term "alcohol and alcohol-related crashes." Certain aspects of the testimony got into the law itself. Congress required that the agency make a study of alcoholism or alcohol-and-driving.

The study was completed and filed with the Congress in 1968, and out of that grew a national emphasis program and alcohol countermeasures.

The first active year was in 1970, when we initiated 9 alcohol safety action programs around the country, followed in 1971 with 20 additional projects and in 1972 with 6, for a total of 35. In addition to these projects, the grant-in-aid program, that is administrated under the Highway Safety Act and is a matching grant program with the States, carries with it a mandate to include heavy emphasis on alcohol-and-driving countermeasures. This, of course, is only one of the priority programs in the Department of Transportation, but in my opinion is probably the one which, if successful, will do a great deal to bring about a reduction in the fatality rate and the number of fatalities on the highways.

The Secretary has mandated to us that he wants to see the death rate--that is, the mileage-death rate--lowered to 3.6 by 1980. This is a realistic goal; I think we are going to make it. We have just now concluded the preliminary data for 1971, and it appears to us that the mileage-death rate is approximately 4.7 and has been going down for the last couple of years. I think we can reach the 3.6 figure. In addition, the Secretary has said that the number of traffic fatalities must be lessened and must be cut in half by 1980. This is a much tougher goal to reach. Perhaps we won't reach it, but I believe striving for a goal just out of reach may force us to work just a little bit harder in order to come near the goal. We can't do this, we can't meet the goal, without addressing the problem of the alcohol involvement in traffic crashes and that is why we are here. And as we see our role, we must control the drinking and driving of the American citizen and keep him from driving while he is under the influence. We look upon the NHTSA's program as part of the detection system for other programs to work. We are looking at highway safety as a system. We are also trying to look at the drinking-and-driving problem as a system. Without the cooperation and assistance of HEW and other Federal agencies, this program cannot be a success. That is why we are here today--to see if we can't make a success out of it.

MR. CARPENTER:

Although it is a little late to be welcoming anybody to the workshop, I certainly am pleased to bring you greetings from the Law Enforcement Assistance Administration. LEAA is a relatively young agency in the Federal government. We were established by Congress in 1968 to improve the country's criminal justice system. As we have gone about our business the past few years, we have found that we have had many programs funded in the States and local communities which do involve the individual who has a problem of alcohol abuse or alcoholism. So it certainly is very appropriate that we work with the other agencies in this workshop.

LEAA has had, I think, a good deal of experience in working with other Federal agencies, inasmuch as we find that the Federal dollars that are available for programs are going to be much more effective if they can be stretched with those of other Federal agencies and local money. So consequently we have worked with the Department of Health, Education, and Welfare in many interagency ventures, and we are happy to have had this opportunity to work with the National Highway Traffic Safety Administration.

In addition, it is most fitting and appropriate that we have our regional representatives here at the workshop. Along with other agencies, LEAA is strengthening its regional structure. Frankly, with reorganization this past summer, practically our total program has gone into the regions. So the strength of our organization does lie with our regional staff and also with the staff of the State Planning Agency Councils and their respective regional staff and councils. It is that type of structure which is going to mean a difference as to whether programs get off the ground or not. So I am looking forward to the report from the various workshops, and I hope that I am going to be able to bring back to the administrators of LEAA issues and recommendations by which we hope to be able, in sharing with our regional staff and our State planning council staffs, to resolve many of the questions which have been discussed at this workshop.

REPORTS FROM THE WORKSHOPS

WORKSHOP I--KAY TANZOLA, MODERATOR

In Workshop I we were to concern ourselves with the violent and non-violent offender whose offense is related to alcohol. I think I can safely say that we gave some time to this subject, not full time, but we did concern ourselves with it. Our papers varied from one on youth, violence, and alcohol to one on new directions in meeting manpower needs, which brought forth a good deal of feeling toward the end of our sessions.

We agreed on certain conclusions and made recommendations which could help deal with the problems suggested in some of the conclusions.

First, I'll present a group of conclusions.

C-1. The three agencies sponsoring this conference have a common constituency. To symbolize this fact, someone suggested a Venn diagram (which most of us saw as the Ballantine beer trademark) of three interlocking circles. The overlaps on the diagram represent the common constituency.

C-2. The common constituency can be identified.

C-3. There is not now adequate coordination to deal with the common constituency.

C-4. At present, the common constituency is not being adequately treated.

To deal with this set of conclusions, we drew up these recommendations:

R-1. Operating people (judges, police, etc.) should be sensitized to alcoholics, alcoholism, and treatment programs.

R-2. Treatment programs should be oriented to the individual rather than categorized.

R-3. There should be a joint and systematic exploration by the three agencies of treatment and management techniques, independent of the point where individual cases are found. Example: all agencies should be involved in development and evaluation of all treatment modalities--education, social milieu, etc. as well as psychomedical.

Now back to the conclusion:

C-5. The target group is now inadequately represented at the problem-defining and planning level.

Our recommendation to deal with this conclusion:

R-4. Operational management systems should be based in, designed by, and implemented by the local communities.

Final conclusion:

C-6. Existing social values and attitudes, abetted by the advertising media, reinforce beliefs in drinking as desirable and appropriate behavior.

To deal with the conclusion, our recommendation:

R-5. Efforts should be made to secure the cooperation of the advertising media in re-orienting advertising toward a different image of drinking.

And a final recommendation:

R-6. Working groups should be set up to study and make recommendations on unified information systems--technical, legal, philosophical.

Schematically, our conclusions and recommendations line up this way:

C-1. Common constituency.	R-1. Sensitize police, courts, etc.
C-2. Can be identified.	R-2. Individualized programs.
C-3. Not adequately coordinated.	R-3. Joint exploration of treatment and management techniques.
C-4. Inadequately treated.	R-4. Programs must be based in, designed by, and implemented by local communities.
C-5. Target group not involved in planning.	R-5. Secure cooperation of advertising media to re-orient advertising to different images of drinking.
C-6. Existing social values, abetted by advertising, reinforce belief in drinking as desirable and appropriate behavior	R-6. Working groups to study unified information systems.

WORKSHOP II--ANNE L. TWOMEY, RECORDER

Our group concerned itself with the public inebriate.

It is very difficult to give group reports that are of interest to others who haven't been present. And, as you well know from your own group sessions, you hop around from one thing to another. I must say that we had some frustrations. I think that we worked through some of these, but I am sure that there are going to be further frustrations as we move on in the program. However, I think sometimes frustrations prove to be motivating factors, and I know that our group felt we had learned a great deal from this conference in terms of what to do and what not to do in carrying on conferences at the regional level.

One area that our group was able to focus on seemed to come up over and over again; the problem of housing for public inebriates and the backup services that are necessary to go along with this housing. However, it was interesting to note that none of the Federal agencies had funding mechanisms with funds to support this part of the program. A person from HUD who happened to be in our group the first day was very helpful, but we need to look further into this.

We had six recommendations:

1. That there be a meeting of representatives of the three Federal agencies on a regional level to coordinate planning and programming within each State and that this meeting be brought to the attention of the Federal Regional Council at its regular meeting.

2. That the NIAAA take the initiative in setting up an ad hoc committee at the Federal level to review and correlate existing Federal legislation relating to the public inebriate, to determine the overlap and gaps in legislation, and to publish the results and disseminate the information to various agencies responsible for these programs.

3. That special priority be given by the Federal funding agencies to meeting the range of housing needs for the public inebriate as part of a comprehensive program for alcoholics.

4. That NIAAA convene a meeting of representatives of State-designated alcoholism agencies for the purpose of establishing guidelines for effective coordination within each State and maximum involvement and cooperation with local alcoholism agencies and programs.

5. That we support the recommendation to follow this conference with similar conferences at the regional level.

6. That in conferences of this type, representation from HUD, Labor, Federal Highway Administration, OEO, and SRS be included.

WORKSHOP III--MELVIN PERSONETT, RECORDER

Workshop III concerned itself (at least to a great extent) with the drinking driver. We travelled from youth and alcohol through prevention by way of public education and on to rehabilitation of the ones whom we wish had gotten help in the first place. We heard four papers read on those subjects. Although some of us were surprised that more disagreement was not reached, it possibly proves that we are after the same goal.

We have one all-encompassing resolution and several specific resolutions. We recommend that: all governmental and private sector agencies, including professional and public organizations concerned with the alcohol problem should be responsibly interrelated to effect a reduction in alcohol in each individual citizen.

This will have an impact on the role of alcohol in crime and accidents on the highways, in the air, in industry, and in the home, as well as on the health and welfare of the individual.

Interrelation must be based on a systematic analysis of the state of the art of safety programs, enforcement programs, prevention programs, and treatment programs from the research and administrative points of view. By describing the activities of each organization in terms of unemotional objective goals and the values on which these goals are based, cooperative and coordinated action under a master plan could be achieved. Such a plan can be both scientifically and politically acceptable. The Federal model can be emulated on the State and community levels.

Workshop III suggested that the following programs be implemented:

1. A regional coordinating committee regarding coordination of public education materials coming from the regional offices.

2. A regional report and evaluation system for this public education--an advisory committee more than a censor in regard to films and other types of education.

3. We feel that there is a need for research information collection and analysis dissemination at the national level from an interagency group; in other words, a periodic state-of-the-art report from the three agencies represented here.

4. On the regional level there should be an exchange of at least the summaries of each agency's State plans as related to alcohol. We feel that there should be dissemination of relevant laws under which the agencies work, defining especially overlapping programs.

5. There should be an outgrowth of this conference to have regional meetings of public and private agencies concerned with the problem of alcohol on a structured basis.

6. There should be a standby group of consultants in order to guarantee continuation of ongoing programs from one area or one period of time to another.

7. There should be more development of coordinated programs between the different agencies.

8. Each Federal agency should furnish a fact sheet containing all of the alcohol-related information that they have gathered, all that was mentioned in one of the other resolutions, the overlapping laws, codes and so forth, a sort of unified brochure for the information of all interested agencies.

9. We feel that there should be an interagency planning group to insure that the plans of one agency are not in conflict with the plans of another agency, so that we have a common direction rather than uncoordinated programs.

10. Finally, we hope that there is some planning in the future for funding of these regional meetings and the other requests that we made.

RESPONSES OF THE ADMINISTRATORS

MR. CARPENTER:

I think the last session of the workshop this afternoon has been brought into a very important focus by the recommendations of several of the reports for developing on the regional level coordinated planning, exchange of State plans, and funding potential. The participants have been able to get into a beginning discussion of these matters. Then, returning to their regions, they will be able to work with and through their regional councils.

Also, at least as far as LEAA is concerned, it would seem very important for our regional staffs to give our staff in Washington some ideas as to how we can be helpful to them in providing whatever data they feel is going to be essential to get some of these programs off the ground.

MR. WILSON:

Some of the reports seemed to indicate that you feel there is no coordination of programs related to alcoholism and alcohol abuse. But there certainly has been considerable coordination going on at the Washington level. All three of our secretaries have certainly laid it upon us, you might say, to coordinate our activities, and I am sure that a certain amount is going on.

With regard to the point raised about trying to reduce the amount of alcohol consumption, NHTSA is not trying to do that. What we are trying to do is separate the drinking and the driving. We are not putting on any campaign to reduce the amount of alcohol consumed. Our primary mission is to save lives by keeping the drinking driver from behind the wheel.

I guess we have a common constituency, although I think we are all working on different segments of that constituency. From our point of view we have a constituency we call the "problem drinker driver." We don't see the skid row person who might have an alcoholism problem and doesn't own a car as being part of our constituency, a minor technical point. I believe there is another constituency too that maybe we would not be addressing and that is the alcoholism that takes place in the home. A lot of women who have an alcoholism problem don't drive. So I think we have this broad-based constituency, but most of us are working on different segments of it for corrective purposes.

DR. CHAFETZ:

I will direct my remarks into just a couple of areas. I think the thing that I sense in the remarks of my colleagues and from the plenary working sessions is a plea for cooperation and coordination. I suspect that one of the things about a common constituency and a common goal is that in our desire to help a lot of people, simplistic ideas sometimes are proposed for complex problems. It is a neat trap that we all get into. I would suggest, for example, that coordination and cooperation are like motherhood. We always talk about them, but we don't engage in them very often. One of the beauties of this kind of conference and the statements that I have heard is that I sense a sincere commitment to coordination and cooperation. I know we have had both at the Federal level. I suspect, as Mr. Wilson has indicated, that it has been going on perhaps in a less formal sense at other levels; and we have a responsibility to enhance this in this common purpose.

One of the recommendations of one workshop called for reduction of the consumption of alcohol, and another group recommended something about the advertising community. Somebody else then suggested that we sensitize judges and other people about the parameters of alcoholism so that we can respond to this. I might point out to you that information and education that we talk about are quite different, are quite separate. For example, some of you have not been aware of the fact that in our special report to Congress we pointed out that there is no correlation with the rates of consumption of alcoholic beverages and the incidence of alcohol problems. As a matter of fact, Finland just changed its distribution laws; the rate of consumption in one year increased by 47 percent, and they have no evidence that that has led to any increase of alcohol problems. In the report we also point out that between the years of 350 B.C. and 25 B.C. there were serious alcohol abuse and alcoholism problems. And to our knowledge there was no advertising industry, there was no affluence, there was no urbanization, and certainly there was no liquor trade. So that I think instead of our looking for gimmicks, we have to recognize that whatever our system, whatever our program, whatever our goals, whether at the Federal planning level or the regional level, we are still dealing with people and that is where the real gut issues lie.

PARTICIPANT:

I would like to ask Dr. Chafetz one more question on what I think is a sensitive issue and perhaps one that is tough to deal with. That is the question of why we don't do something to get FCC to cut liquor advertising off the air. Dr. Chafetz, I thought your words at your press conference the other day were extremely well chosen. I wonder if you could go into the subject just a little more fully, because it is a problem to us, and it must be even more of a problem to you. What do we do about advertising?

DR. CHAFETZ:

I am glad to respond to that question. I think the proposal to regulate liquor advertising is gimmickry, a simplistic response to a complex issue. For example, in the smoking and health situation, the figures have shown that as advertising for cigarettes has gone off the air, the production and consumption of cigarettes have gone up. Now I think that one of the things that that points out is that sometimes our expectations are very high in the wrong direction. I happen to believe that human beings behave and respond to more complex inputs than just advertising stimuli. I believe the advertising industry can make us switch brands of cigarettes if we are already smoking, but I am not convinced that the advertising individuals make you and me smoke cigarettes in the beginning. I think they may switch our brands; I don't think they tell us how to behave beyond that.

Now as to the alcohol issue, as I pointed out in the press conference, the cigarette smoking, the labelling, the advertising thing, came from an Act of Congress. There is no such Act of Congress on the books vis a vis alcohol. As our findings from our first report to Congress brought out to our available knowledge, the occasional moderate use of alcohol is not detrimental to health. I think that it would be beyond the responsibility of what we know historically to take a stand unless we know what we are taking a stand on.

PARTICIPANT:

The people up there on the platform seem to indicate that there is a lot of high-level coordination between your various agencies on these common problems. It might be well in the future to publicize that coordination to people out in the boondocks because at least from my viewpoint it's not visible.

PARTICIPANT:

In order to cut a lot of red tape who created the idea of this triumvirate and this conference, and what were the desires of that person or that agency, and what do you hope us to do in the future?

MR. CARPENTER:

LEAA and NIMH have had a number of standing committees, inasmuch as we have many interrelated concerns such as juvenile delinquency, drugs, alcoholism. Our committees have been meeting and, in the process of our discussions, we felt that if we were really to do any good in the field we were going to have to, first of all, get some data as to just where we stand on issues of research and demonstration about a lot of the questions concerning alcohol abuse and alcoholism. We decided that it would be important to call researchers together so that we really would know just where we are as far as current findings go. Secondly, we knew that if we were going to do anything about such findings, or at least as

far as our agency was concerned, we were going to have to do something on the regional and local level because LEAA is largely a block grant program where the bulk of our monies goes into the States, and if anything was going to be done somehow we had to involve people on that level. Consequently, in addition to gathering the data, we wanted to have something develop on the regional and State basis, which meant pulling in our regional people. For this reason we did think that to have communication between those who knew what was going on and what the findings were and those who could do something about it (our regional people), getting together would be extremely helpful. As for where we go from here, if anything is going to be done, it is going to have to be implemented back home. Consequently, we thought that a workshop like this could give those of you back in the boondocks, as somebody said, the kind of information that you might need concerning alcohol abuse and alcoholism, so that you in turn could set up some type of activity within your communities, either state-wide or region-wide, which would in turn bring this information to the problem in terms of the facts as well as the kind of programs which have proven to be helpful in resolving many of the issues that we are talking about today.

DR. WOLFE:

I came on the scene about six months ago when I came to join the Federal bureaucracy, and I attended the first planning meeting about a month later. I don't know how long the group had been meeting, but they were still asking, "Well, what are we going to do at this conference?" We spent another month trying to decide what we were going to do. I am impressed by the way history repeats itself. It repeated itself, I think, at this conference as it relates to what the planning committee did. I heard the comments around several of the rooms: What are we doing here? Is what we are doing really worthwhile? Are these topics really important and germane to what's happening out there? This is the same process we went through at the committee level. I don't know why I don't accept it that people will do what they are going to do. I think that's one reason why the structure of this conference was not any tighter than what it was. The various papers that were presented, although they appeared categorical, certainly were not, because all of these things are interrelated. They cannot be separated out except for discussion purposes. Leaving the structure loose puts a great deal of responsibility on the members of the conference within the workshops. That part of it was intentional, and I hope it did create some anxieties among some of you. As Anne said, perhaps out of the anxieties and frustrations comes a motivation to do something. Somebody was asking about the coordination at the Federal level. I think the mere fact that these three agencies got together with a committee, to pull this together, was in itself something of a historical mark. That was not an easy process for the people involved. In other words, there was a great deal of argumentation, bloodletting, disagreement about what the topical areas should be, how the workshop should be set up, and on and on. I hope you have the same kinds of experiences at the regional level because I think there is where growth can occur. If we are afraid

of that kind of conflict and consultation and headaches, then we are just really kind of fooling ourselves.

> Editor's Note: At this point and elsewhere suggestions were made regarding the contents of the proceedings of this conference. See the concluding section of this session.

DR. WOLFE:

In floating around to the various workshops and listening to the reports, I heard two charges; one was to the regional people, that they can develop various kinds of workshops within their regions to pull together the various agencies and even broaden representation past the three agencies represented at this conference, such as HUD, SRS, and others. The second charge is to the Federal agencies. We have a charge now. Whether we knew it or could articulate it before this conference is individually determined. The charge is that a common core of knowledge needs to come out of the central office, that the state of the art should somehow be disseminated by the central office people, that information on legislation should be pulled together by the central office. It makes me feel good that that kind of specific charge has been made. There also has been a comment that the regional office people be more involved in some of the decision making. Out of these recommendations I think there have been some very specific charges to the Federal level and the regional level. The regional level people will have to disseminate that on down to State and local levels.

MR. HOWELL:

I would just like to add a couple of comments. First, we speak about the Federal government. Of course, we represent one branch of the Federal government; we represent the Executive Branch, some relatively small pieces of it. The Federal government as we all know has the three co-equal branches--judicial, legislative, and executive. We in the Executive Branch get our charge from the Congress. This is first grade civics stuff, I know. We carry out the laws that are passed by the Congress. Part of your criticism or comment about a lack of overall direction, I think, probably pertains to such questions as: Should there be additional legislation? Should there be other agencies or outfits charged by the people's elective representatives in the Congress to do other things than we are doing? In transportation, particularly in highway safety, we think we have a going program. It is moving. Our regional administrators, I think, sometimes feel they get too much direction from Washington. Everybody here knows the old story of the three blind men and the elephant. One touches the trunk and says it is a snake, one touches the leg and says it is a tree. This old story is rather applicable here. We in the safety thing reach out and feel this alcohol abuse problem, and we say it is a bunch of dead bodies on the road. The

people in mental health and alcoholism and alcohol abuse reach out and touch the elephant, and they see it as a bunch of sick, disturbed individuals. The law enforcement people perhaps reach out and touch the elephant and see it in terms of a cause of crime in our society. So one purpose of this conference, at least, is to get an idea what the whole elephant is.

PARTICIPANT:

We get plenty of general direction from Washington. Basically, what seems to be overlooked here is that most of these programs emanate from the States. Now on the regional level we have the Federal Regional Council. But on the State level there is obviously room for improvement. I think that is basically the way we are going to have to start if we are going to make any improvement on the State level. We have done about as much as we can do within the dictates of the law that has been given to us by Congress. Congress has laid out the road map for the problem. . .but that is what we have to do. I think if we are going to improve our operations we are going to have to start on the State level, rather than at the top. It has to come up from the bottom.

DR. CHAFETZ:

I would like to respond to your remarks because I think you have raised a very crucial issue. Many of you have heard me say that money lends respectability and is an impetus to action. In our formula grant authority PL 91-616 that created the National Institute on Alcohol Abuse and Alcoholism, we have required in the guidelines that are being promulgated with the help of a variety of the constituent people in this country who helped us draw up the guidelines. One of the requirements of the State plan is that it have indication of a cooperative endeavor, a working relationship with other agencies that are dealing with this wide range of alcoholism programs. I think that if this is implemented as we intended it to be, I think it may help the other agencies in their State relations to re-enforce it.

The law requires that a State agency be designated by the governor to handle the alcoholism funds (the formula grant funds) and prepare the plans for the State, a single State agency. It was our belief that we should not, from our wisdom of Washington, dictate to each State where that responsibility ought to lie. So consequently it may be in public health; it may be in welfare; it may be in mental health. We did not think that we should dictate a kind of universal for the whole country. We believe that, in a mutual relationship, not all of the wisdom is in Washington and not all of the wisdom is in the localities. If we really are committed to this problem, there has to be a working together; and we did not try to dictate which agency should have it.

MR. BERLINER:

I am a little reluctant to identify myself because I am here by command performance. I was told that the Bureau of Prisons ought to be represented and since we just started our first formal alcoholism program, and I have the dubious distinction of being its director, I seem the logical candidate.

I do have some trepidation about making these remarks because I am a Johnny Come Lately. It's like spending two weeks in Russia and coming back as an expert. My initial observation is that we need to broaden the base for any future planning meetings because of what seemed to me the relative lack of representation of behavorial scientists at this conference--sociologists, social psychologists, etc. It seemed to me that the discussion was overweighted on the clinical side. We repeatedly talked about diagnosis and treatment, which to me is the way of conceptionalizing the problem of alcoholism as a medical one. In my view, this is reductionism or oversimplification, in Dr. Chafetz' terms. My own bias is that, like tuberculosis, alcoholism is a social problem with a medical aspect. I acknowledge that as a bias, but I plead for broadening the base in terms of bringing in other disciplines so that we can look at this problem from other aspects.

It seems to me that we need to be aware that there is another very important dimension of the problem; namely, the social factors that influence drinking habits, driving habits, and violence which portray them as normative, even desirable, behavior. This comes now as a response to one of Dr. Chafetz' remarks.

Cigarette advertising has been turned off with respect to one of the media, but cigarette advertising comes through loud and clear in the other media. So I don't really think that observation, Dr. Chafetz, is fully pertinent. We are still being bombarded with ideas concerning the alleged virtues of cigarette smoking. I agree that there is a lot more to the problem than the activities of the advertising media. I sound defensive because this is one of the proposals that I fought for. It may be simplistic to say: Deal with the advertising media and try to influence them to modify their practices. I agree that there is a lot more to the problem than the activities of the advertising media, but you have to start somewhere. I do believe that as long as our society considers certain behaviors as functional--that is, as providing goods and services which people want--then crime, alcoholism, and highway deaths will simply be a cost factor which society is apparently willing to bear. Are we brave enough to say that we cannot make substantial inroads on the problems under consideration until we can find other ways of defining adulthood than by drinking and smoking; of defining masculinity in other ways than by fast driving; problem solving in other ways than by pushing people around? I am also aware that every society known to us is using mind-altering substances. The question is: How do we fulfill the needs served

by these substances without paying what we can all agree are the prohibitive costs of our present practices? I leave the mike with a question not an answer.

DR. WEISMAN:

I am Max Weisman of Maryland. I have a tendency to say I don't want to engage in a polemic with my colleague Dr. Chafetz, but I do feel that I must introduce a voice of caution in accepting statements that sound categoric and coming from eminent authorities when there are controversial aspects to such statements. I simply would like to present evidence that is accumulating that it is necessary to confirm with more careful and more extensive scientific investigation, that alcohol is a toxin, that the literal term intoxication is appropriate, and that investigations by men like Rubin and Lever in Sinai, have shown that even moderate amounts of alcohol consumed in social drinking do harm liver cells, that there is fatty drop degeneration even on a small consumption of alcohol. I would like to introduce another bit of caution that we may eventually get to the stage as more evidence accumulates, that bottles of whiskey will have statements that "this is dangerous to your health," if only to this extent, and possibly we may arrive at a stage in the history of our society when liquor ads will be banned from television and other mass media advertising. This is simply something for us to bear in the background and recognize that more research is needed. But we should maintain an open attitude, not making any decisions at the present stage. I am thoroughly in agreement with Dr. Chafetz on that point. But we should recognize that those of us like myself who continue to drink and certainly those who still continue to smoke, are possibly acting in a way that may represent a certain degree of irresponsible behavior in the future.

DR. CHAFETZ:

Rubin was part of the task force that prepared our report. I am familiar with the work of Lever and Rubin and the deposition of fat in the liver. I point out that Isselbacher and a number of other crucial investigators have discounted that. I also point out that studies in alcohol use and alcoholism are such that you can find a study that will confirm anything that you want to believe. I am saying that at this point in time there is no conclusive evidence that would support our saying that small amounts of alcohol are detrimental to health. Now there is no question in my mind, and I so stated it at the press conference, that copious prolonged use of alcohol is seriously detrimental to health. I couldn't care less whether people in America gave up drinking or not. I am going on the historical evidence that when they were given the opportunity to give it up they didn't take it. During prohibition there was no advertising about alcohol in any media and apparently people were consuming it like mad. I believe that many of us in responsible positions get carried away with our omnipotence that we are going to change

the behavior of people, we are going to control them. I don't happen to believe that. All I am saying is: Given that people are going to behave a certain way, let's try to give them alternate pathways so if they choose to go that way they don't destroy themselves and society.

SUGGESTIONS ON THE REPORT OF THE CONFERENCE

At various points in the final session specific suggestions were made as to contents of the conference proceedings. Several materials proved to be needed sooner than a printed proceedings could be provided, and these requests were met by sending out packets of information materials to the participants.

In response to other requests, the appendix contains brief descriptions of the objectives and operations of the three sponsoring agencies prepared by their staffs. A list of regional and some State personnel follows. Also included in the appendix is an abbreviated program of the conference and a roster of those who participated.

APPENDIX

LAW ENFORCEMENT ASSISTANCE ADMINISTRATION

LEAA began operations in the fall of 1968. Congress, in Title I of the Omnibus Crime Control and Safe Streets Act, set these goals for LEAA:

> "To assist State and local governments in reducing the incidence of crime, and to increase the effectiveness, fairness and coordination of law enforcement and criminal justice systems. . ."

Specifically, LEAA:

- Encourages State and local governments to develop comprehensive law enforcement plans based on specific needs and problems in each locality;
- Awards Federal funds to State and local governments for programs to improve and strengthen law enforcement;
- Encourages research and development directed toward the improvement of law enforcement and the reduction of crime.

State and local governments bear the primary responsibility for law enforcement. The LEAA program was designed to honor this principle. Most of LEAA's budget is awarded in block grants to States, which set their own priorities and devise their own programs.

PLANNING

With the help of a block planning grant from LEAA, each State annually draws up a law enforcement plan in cooperation with its city and county governments. The plan must be comprehensive; that is, it must contain programs to improve the entire criminal justice system--police, courts, and corrections; it also must provide for adequate assistance to high-crime areas.

The plan is prepared by State planning agencies, which were created in each of the 55 jurisdictions eligible for LEAA assistance. To insure local involvement in the planning process, each State must make at least 40 per cent of block planning funds available to local government units.

(This requirement may be waived in States where the bulk of responsibility for law enforcement rests with the States rather than with local governments or where adherence to the 40 percent formula would not contribute to the efficient development of the State plan.)

GRANTS FOR LAW ENFORCEMENT IMPROVEMENT

When the comprehensive plan is approved by LEAA, the State receives its block action grant to implement the specific improvement projects.

LEAA also awards action grants directly to States, cities, counties, and other recipients. These discretionary grants represent 15 percent of the total action grant budget. LEAA uses discretionary grants for projects with national implications and for special problem areas such as urban crime. A major portion of LEAA discretionary funds has gone to the Nation's largest cities to help them deal with pressing crime problems.

For most action programs, the Federal share may be up to 75 percent of the cost of the project with States providing the remaining 25 percent. LEAA will pay up to 50 percent of the cost of construction projects; the Federal share for correctional facility construction (Part E grants) may be up to 75 percent.

States are currently required to make at least 75 percent of the block action grant available to local governments. As of July 1, 1972, this will be modified to require that funds passed through to localities must be in proportion to local expenditures for police, courts, and corrections.

LAW ENFORCEMENT EDUCATION

LEAA also awards funds to colleges and universities which in turn provide grants and loans for college study by law enforcement professionals and students preparing for criminal justice careers. Approximately 10 percent of the Nation's uniformed police have attended college courses through LEAA assistance, and thousands of preservice students have received tuition loans under the program.

RESEARCH

The National Institute of Law Enforcement and Criminal Justice, LEAA's research and development branch, awards funds for creation of innovative crime control programs, equipment and techniques.

OTHER PROGRAMS

LEAA also has an information and statistics program which is developing needed information about the operation of the criminal justice system.

LEAA's technical assistance program provides expert advice and help to States and localities in all areas of criminal justice operations.

LEAA ORGANIZATION

The agency is directed by an Administrator appointed by the President with the advice and consent of the Senate. The Administrator is executive head of LEAA and exercises all administrative powers including appointment and supervision of personnel. There are two Associate Administrators, also appointed by the President and subject to Senate approval. Policy decisions and the award of grants and contracts require the concurrency of the Administrator and at least one Associate.

LEAA underwent a major reorganization in 1971 designed to cut red tape and enable States and localities to receive needed funds more rapidly.

The present organizational structure is the result of an intensive study of LEAA by a task force of governmental and administrative experts. Administrator Jerris Leonard, shortly after being named to head LEAA, appointed the task force on March 29, 1971, and directed it to recommend ways to make the agency more effective. In announcing the reorganization on May 18, 1971, the Administrator said:

> A great deal has been accomplished by the LEAA program in less than 3 years. A nationwide crime control program is a reality, and it is a reality in every State, where the States are carrying out programs in cooperation with their cities and counties.
>
> But my candid feeling is that the LEAA program has not done enough; that it has weaknesses which have been a brake on progress; and that major changes must be undertaken now. That is my view; it is the task force's view.

Basically, the reorganization streamlined LEAA. The agency was restructured into eight offices reporting directly to the Office of the Administrator. Five offices are staff functions: Audit, Inspection and Review, General Counsel, Civil Rights Compliance, and Office of Public Information and Congressional Liaison. Three are line function offices

dealing with all other LEAA operations: Criminal Justice Assistance, National Institute of Law Enforcement and Criminal Justice, Operations Support.

The reorganization created a new Office of Inspection and Review, responsible for planning and evaluation of LEAA programs.

The Office of Criminal Justice Assistance (OCJA) replaced the Office of Law Enforcement Programs (OLEP). OCJA administers all planning, action, and discretionary grant programs. It reviews grant applications and provides technical assistance to States. Under the reorganization, much more authority was given to the regional offices to make LEAA more responsive at the grass roots level to the needs of State and local governments. Final review for nearly all types of grants is placed in the regional offices which were increased from seven to 10. (See map showing location of regional offices and their addresses.)

The Office of Criminal Justice Assistance also took over responsibility for the Law Enforcement Education Program. Much of the authority in awarding academic assistance grants will be decentralized to the regions.

The Institute was restructured to broaden its research functions, expand dissemination of information, and encourage more transfer of technology from the laboratory to the field.

Information and statistics programs were reorganized, with statistical research now located in the Institute and systems analysis capabilities in the Office of Criminal Justice Assistance (to provide systems development assistance to States) and in the Office of Operations Support (as a service unit for LEAA).

LEGISLATIVE AMENDMENTS

In 1970, Congress amended the Omnibus Crime Control and Safe Streets Act. The new provisions were designed to improve LEAA operations and increase the agency's effectiveness. Among the important provisions:

- Cities must now be represented on regional planning boards, as well as on State planning boards.
- Planning funds must be passed along to "major cities and counties" to help them develop input for State plans.
- The kinds of buildings and facilities which can be funded with block or discretionary grants were broadened to include local correctional facilities, narcotic treatment centers and "temporary courtroom facilities in areas of high crime incidence."

- Two new areas which could be funded by both block and discretionary grants were added: Community-based delinquency prevention programs and criminal justice coordinating councils for units of local government over 250,000 population.

- The Federal matching share on block action and discretionary projects was raised from 60 to 75 percent, and starting in fiscal 1973, the local share of the match must include 10 percent of the total cost in appropriated money, rather than goods or services.

- The requirement that no more than a third of any block action or discretionary grant could be used for compensation of personnel was modified to mean only "police and regular law enforcement personnel," and the existing exemption for personnel involved in training projects was broadened to include "research, development, demonstration or other short-term projects." Since discretionary grants cover short-term projects, salaries involved would ordinarily not be subject to the one-third limitation.

- State plans must indicate adequate assistance will be given to areas characterized by "high crime incidence and high law enforcement activity"--in other words, the cities, and particularly the larger cities.

- Beginning in fiscal 1973 States will be required to provide one quarter of the non-Federal matching funds for local projects.

- New language is provided for the reallocation of block grant funds in the form of discretionary grants when a State fails to gain LEAA approval of its plan.

- New language allows LEAA to reclaim block grant funds unused by a State and distribute them to other States.

- New regional as well as national training programs and workshops are authorized.

- A new part E provides significant additional funding in the corrections area. Starting in fiscal 1972, this money will total at least 20 percent of the total available for block and discretionary grants. Particular emphasis is placed on community-based corrections, and programs as well as facilities will be funded. Federal funds will provide 75 percent of the cost of all projects.

- Starting in fiscal 1973, the percentage of action funds passed through to local units will be based on their expenditures for police, courts, and corrections. In other words, if local goverments pay 90 percent of the cost of criminal justice operations in the State, they can receive 90 percent of the State's action funds.

FUNDING

In its first 3 years, LEAA funding totaled $860 million. LEAA's first year appropriation--fiscal year 1969--was $63 million. In fiscal year 1970, the budget grew to $268 million. A total of $530 million was appropriated for the program in fiscal year 1971.

The fiscal year 1972 budget of $698.4 million is more than 10 times the size of LEAA's original budget. Funds will be allocated as follows: $35 million for planning grants; $413.6 million for block action grants; $73 million for discretionary grants; $97.5 million for correctional improvement grants; $30 million for law enforcement education; $21 million for research and development; $9.7 million for information and statistics programs; $7 million for technical assistance and training, and $11.5 million for administration.

TOTAL LEAA FUNDING/FISCAL YEARS 1969-71

Block action grants	$547,400,000
Discretionary grants	106,400,000
Planning grants	66,000,000
Block corrections (Part E) grants	25,000,000
Discretionary corrections (Part E) grants	22,500,000
Law Enforcement Education Program	47,000,000
National Institute	18,000,000
Administration and advisory committees	14,500,000
Information and statistics	5,000,000
Technical assistance	5,000,000
Transferred to other agencies	3,200,000
TOTAL	$860,000,000

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

INTRODUCTION

The problem of alcoholism was first given concentrated Federal attention in 1966 when the National Center for Prevention and Control of Alcoholism was established within the National Institute of Mental Health to develop and administer Federal support programs in the area of alcoholism. In July 1970, in response to the growth of interest in alcohol problems and the need for an expanded alcoholism effort, the Center was elevated to Division level within NIMH. Federal alcoholism programs reached a new status and achieved a further impetus when, on December 31, 1970, President Nixon signed into law one of the most important pieces of legislation ever enacted in the field of alcoholism--the "Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970." In addition to establishing the National Institute on Alcohol Abuse and Alcoholism within NIMH, the major provisions of the Act include:

- Establishment of a National Advisory Council on Alcohol Abuse and Alcoholism to make recommendations to the Secretary on policy relating to Federal alcoholism programs, and to review grant awards in this area.

- Authorization of formula grants to the States and project grants to organizations and institutions.

- A requirement that comprehensive State health plans under Section 314(d) of the Public Health Service Act include services for the prevention and treatment of alcohol abuse and alcoholism, commensurate with the extent of these problems within the State.

- A mandate for an alcoholism treatment and rehabilitation program for Federal employees, to be conducted by the Civil Service Commission in

cooperation with the National Institute on Alcohol Abuse and Alcoholism, and for the Institute to foster similar programs in State and local governments and in industry.

- Prohibition of discrimination by hospitals receiving aid under the Act in regard to admitting alcoholics for treatment.

NIAAA ORGANIZATION

NIAAA is a part of the National Institute of Mental Health, which is a component of the Department of Health, Education, and Welfare's Health Services and Mental Health Administration. The Institute is headed by a director who is appointed by the Secretary of Health, Education, and Welfare. The Office of the Director exercises control over three divisions, each representing a significant program emphasis of the Institute. These are the Division of Research, the Division of State and Community Assistance Programs, and the Division of Special Treatment and Rehabilitation Programs. An additional division has become operational, the Division of Prevention, which makes NIAAA the only entity throughout the health agencies of the United States to have such an organizational unit. This is indicative of the emphasis NIAAA intends to place in this area. Each of the divisions carries out appropriate training activities related to its missions and program goals. Ten regional coordinators work with the associate regional health directors for mental health in the implementation of NIAAA programs and policies on a nationwide basis.

POLICIES AND PROGRAMS

The present director of the National Institute on Alcohol Abuse and Alcoholism, Dr. Morris E. Chafetz, has stated the direction that the Institute will follow in its effort to reduce the enormous toll taken by alcoholism and alcohol abuse upon our society today:

> The planning and program structure in every area is being guided by its relevance to meeting two paramount goals which have been adopted for the National Institute: (1) to mobilize, strengthen, and expand all existing resources for the treatment and rehabilitation of alcoholic persons at the community level, and (2) to develop the most effective methods of preventing alcoholism and problem drinking.

To achieve these objectives, the NIAAA fosters, develops, conducts, and supports broad programs of research, training, development of community services, and public education through a wide range of Federal assistance programs.

RESEARCH

Since alcoholism is the product of a complex interaction of biological, psychological, and social factors, hope for developing a better understanding of its causes, natural history, and treatment lies in a wide range of research in all relevant disciplines. Through a program of research grants, the NIAAA encourages and supports basic and applied investigations in universities, medical schools, and other institutions. Demonstration projects are also supported to develop and evaluate new techniques, approaches, and methods for the treatment and prevention of alcoholism and the rehabilitation of alcoholic persons and problem drinkers.

Among the research categories and topics of interest supported by the Institute are the following: (1) studies to provide knowledge in support of prevention, treatment, and training programs, including investigations of the basic physiological, biochemical, and pharmacological effects of alcohol; (2) studies of sociocultural factors and drinking practices, including longitudinal and survey studies of practices, attitudes, and alcoholism development; (3) studies leading to the development and evaluation of education programs for the general public and high-risk groups; (4) studies of the treatment process, including prediction and measurement of treatment response, improvement of detoxification procedures, and new psychotherapeutic, pharmacotherapeutic, and sociotherapeutic approaches.

The Institute also operates an intramural research program at Saint Elizabeths Hospital, NIMH National Center for Mental Health Services, Training, and Research, Washington, D. C.

Funds allocated for research grant programs in fiscal year 1972 total more than $7.5 million. This represents an increase of nearly 30 percent over fiscal year 1971 expenditures.

TRAINING

The major objective of the training program of the NIAAA is to increase the supply of manpower to treat and eventually prevent alcohol abuse and alcoholism. A high priority has been set on funding programs to introduce and include information about alcoholism in the curricula of schools of medicine and other physical and mental health disciplines.

Other training program objectives focus on development of alcohol specialists to take leadership roles in training, research, public education, and administration, as well as on alcoholism training to enable hospital staff, private practitioners, and counselors to function in both clinical and coordinating roles.

Training grant proposals are evaluated on the basis of their relevance to the goals of the NIAAA. The favored training programs include those which enhance the capacity and effectiveness of the Institute's programs in research, treatment and rehabilitation services, and prevention programs, as well as in treatment and control activities aimed at drinking drivers, alcoholic employees, American Indians, and chronic drunkenness offenders. Training priorities are kept flexible to accommodate changing program emphases.

Training grants in fiscal year 1972 were increased more than 200 percent over the previous fiscal year to better than $4 million.

PREVENTION

The National Institute on Alcohol Abuse and Alcoholism places high priority upon programs of public education as a key method of reducing alcohol problems in the United States through prevention. The public information and education program of NIAAA has the following objectives: (1) to develop public recognition of alcoholism as an illness for which the afflicted individual needs help and can be helped; (2) to encourage the health system to accept alcoholism as a medical-social-behavioral problem and to treat the alcoholic person with the same attention and consideration as any other patient; (3) to develop public awareness of the properties of alcohol, its effects on the body and behavior, and of the distinctions between responsible and irresponsible drinking attitudes and practices; (4) to produce a new national environment regarding the use and misuse of alcoholic beverages, with an eventual reduction in the rate of drunkenness, problem drinking, and alcoholism. To meet these objectives, a variety of educational materials, including films, television and radio spot announcements, newspaper and magazine advertisements, publications, and curriculum guides are being developed for use by the mass media, community groups, and schools.

TREATMENT AND REHABILITATION

The results of the Institute's research and training programs are directed, ultimately, at improving treatment and rehabilitation services. Under the Alcoholic and Narcotic Addict Rehabilitation Amendments of 1968 and 1970 to the Community Mental Health Centers Act, Federal grants are authorized for local communities to develop and expand such services for

the treatment and prevention of alcoholism. Several different grant programs are used by NIAAA to further its goal of aiding State and community efforts to provide effective and comprehensive treatment and rehabilitation services for alcoholic people and problem drinkers.

Comprehensive staffing grants are used to pay for temporary periods a portion of the compensation of professional and technical personnel with some experience in the prevention and control of alcoholism who provide elements of comprehensive services. Funding may be available for a period of up to eight years, with the Federal share ranging from as high as 90 percent in Year 1 to 70 percent in Year 8, if the geographic area served has been designated by the Secretary of Health, Education, and Welfare, as a poverty area. Non-poverty area Federal assistance can average as much as 53 3/4 percent over an eight-year period.

Initiation and development grants are available to help with the start-up costs of new service programs. Funding under this grant program can include up to 100 percent of the cost involved, up to a maximum total of $50,000.

Additional grant programs, such as consultation/education grants and funds for surveys, field trials, and demonstrations, are available to sponsor a wide range of activities in the area of treatment and rehabilitation services. Some of the supported functions include: conducting surveys and field trials to evaluate the adequacy of programs for prevention and treatment of alcoholism with a view to determining ways and means of improving, extending, and expanding such programs; developing specialized training programs and materials, as well as in-service training and refresher courses; training personnel to operate, supervise, and administer services for the prevention and treatment of alcoholism; demonstrations of new, effective, or efficient methods of delivery of services to alcoholic persons; provision of vocational, educational, and social services related to the rehabilitation of alcoholic persons; leasing of space for the construction or establishment of alcoholism treatment facilities.

Community assistance funds are expected to total approximately $40 million in fiscal year 1972. Beginning with the 1972 fiscal year, community-level assistance has been augmented by a State-level program of formula grants. Funds allocated under this program total $30 million for the current fiscal year. Allocations are made on the basis of population, facility need, as indicated by population and comparison with existing resources, and financial need, as indicated by average per capita income. Allocations under the current formula range from a legal minimum of $200,000 for several States to a maximum of $2.4 million for California.

SPECIAL COLLABORATIVE PROGRAMS

The NIAAA is collaborating with other Federal, State, and local agencies to develop programs targeted at reducing and preventing alcohol-related problems in special population groups.

A major collaborative program with the National Highway Traffic Safety Administration of the Department of Transportation is aimed at reducing the number of deaths and injuries caused by drinking drivers. NIAAA is spending approximately $2 million this fiscal year in cooperation with NHTSA on such activities as an information campaign on the relation between drinking and driving hazards, to be coordinated with the general NIAAA education campaign, consultation and assistance in the development of the DOT community-oriented Alcohol Safety Action Program, and coordination of research funding.

Another special project concerns the NIAAA focus on the alcoholic employee. An estimated 10 percent of the Nation's work force are alcoholic persons and alcohol abusers. Based on existing programs in the field, more than half of these employees can be rehabilitated. Special project funding of nearly $4 million this fiscal year is being used to encourage the establishment of employee alcoholism programs in State and local governments and in private industry, to assist employees in establishing such programs, and to work with the Civil Service Commission towards the initiation of employee alcoholism programs in Federal agencies. Such programs will save the Federal government an estimated $300 million annually.

To combat the problem of alcohol abuse and alcoholism among American Indians where the problem has reached epidemic proportions, $3.3 million is being spent by NIAAA in the 1972 fiscal year. Research and education efforts, as well as collaboration with other Federal agencies concerned with Indian affairs, are being sponsored to reduce drinking problems among Indian groups.

To sponsor special projects related to the problem of chronic drunkenness offenders, $2.5 million has been funded by NIAAA. Although only 5 percent of the alcoholic population fit the "skid row drunk" description, they account for 40 percent of the annual arrests in the United States for non-traffic offenses. Handling this group within the criminal justice system costs more than $100 million a year, and yet does nothing to help alleviate the problem. The NIAAA is actively engaged in working with other agencies to find more practical and effective alternatives for handling chronic alcoholic offenders.

The NIAAA has also allocated $5.8 million this fiscal year to deal with alcohol problems in coordination with a number of agencies engaged in Federal poverty programs.

FUNDING

The fiscal year 1972 budget of $86 million for NIAAA programs and activities represents a six-fold increase in funding over the previous fiscal year, and a twenty-eight-fold increase as compared with the budget of the original National Center for Prevention and Control of Alcoholism. Of the current budget, a total of almost $80 million has been allocated for new and continuing grants, fellowships, and other forms of Federal assistance.

NIAAA BUDGET/FISCAL YEAR 1972

Research Grants	
New Awards	$2,659,000
Continuations	4,884,000
TOTAL	$7,543,000
Training Grants and Fellowships	
New Awards	$2,889,000
Continuations	1,200,000
TOTAL	$4,089,000
Community Assistance Grants	
Project Grants	$40,193,000
Formula Grants	30,000,000
TOTAL	$70,193,000
Public Information and Education	$ 750,000
Direct Operations	4,056,000
TOTAL FY 1972 BUDGET	$86,631,000

FACTS ON ALCOHOL ABUSE AND ALCOHOLISM
FROM
THE FIRST SPECIAL REPORT TO THE CONGRESS ON ALCOHOL AND HEALTH

SIZE OF PROBLEM

9 million persons with drinking problems

36 million American family members affected

SOCIAL COST TO THE NATION

50 percent of all traffic fatalities, as high as 28,000 annually

2 million arrests each year for public intoxication and related offenses (40 percent of the U.S. total of non-traffic arrests)

1/2 of all homicides are alcohol-related

10 to 12 years reduced life expentancy for alcoholic people

ECONOMIC COST TO THE NATION

5 percent of Nation's work force are alcoholic people

an additional 5 percent of Nation's work force are alcohol abusers

$10 billion in lost work time

$ 2 billion in health and welfare services

$ 3 billion in property damages, medical expenses, and overhead

NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION

In 1966 two acts dealing with highway safety were passed by Congress. These acts were the National Traffic and Motor Vehicle Safety Act of 1966 (P.L. 89-563) and the Highway Safety Act of 1966 (P.L. 89-564). Some of the provisions of the National Traffic and Motor Vehicle Safety Act included:

- The promulgation of Federal safety standards for motor vehicles and motor vehicle equipment,
- Checking on manufacturers compliance with standards,
- Establishing uniform tire quality grading system,
- Investigating possible safety defects,
- Conducting research, development and testing

The Highway Safety Act was also designed to accomplish several important functions such as:

- Aiding each State to develop and put into effect a coordinated, comprehensive highway safety program,
- Providing national standards for assistance to the States in development of highway safety programs based upon comprehensive plans,
- Coordinating the programs of the various States,
- Providing Federally supported research to improve the knowledge about highway safety,
- Providing for training of highway safety personnel,
- Matching State's expenditures on highway safety with Federal money to develop new and expanded programs.

The Act required that each State have a highway safety program approved by the Secretary and that such programs be in accordance with uniform standards.

Under the legislation, the Federal Government contributes financial assistance to supplement State and community safety efforts for approved programs which meet the following minimum requirements:

- The program must be managed by a State agency with adequate powers, equipment and organization as specified by the Secretary of Transportation.
- At least 40 percent of Federal funds apportioned to the State must be spent by its political subdivision.
- Total expenditures of the States for highway safety must not fall below the average level of fiscal years 1965 - 1966.
- There must be a comprehensive driver education/training program.

The above Acts in effect created two separate agencies concerned with highway safety under the Department of Commerce. These agencies were later transferred, as bureaus, to the newly formed Department of Transportation. In 1967 the two bureaus formed under the Department of Transportation Act of 1966 were merged by executive order into a single National Highway Safety Bureau (NHSB).

Until March 1970, the NHSB was one of the component agencies of the Federal Highway Administration (FHWA). At that time it became one of the operating administrations of the Department of Transportation by order of the Secretary. This administrative action was confirmed by law when the Highway Safety Act of 1970 was enacted in December, and the NHSB became the National Highway Traffic Safety Administration (NHTSA).

The Highway Safety Act of 1970 established the NHTSA as a separate Administration within the Department. Of additional significance was the authorization of two-thirds of the funding for the highway safety programs to come from the Highway Trust Fund rather than from General Funds.

While NHTSA's programs are directly responsive to the two laws already mentioned, activities of the Federal Highway Administration and its Bureau of Motor Carrier Safety also play an important role in the overall Federal effort in vehicle and highway safety, although the activities stem from different statutory authority.

NHTSA Organization

The NHTSA is directed by an Administrator appointed by the President with the advice and consent of the Senate. The Administrator is executive head of the NHTSA and is assisted by a Deputy Administrator, also appointed by the President and subject to Senate approval.

Under the Administrator and Deputy Administrator are five Associate Administrators, each concerned with a particular function within the Administration (i.e., Traffic Safety Programs, Motor Vehicle Programs, Research, Planning and Programming, and Administration.) Of these five functional areas, two of them directly reflect the two safety acts of 1966. These areas are the Motor Vehicle Programs (MVP) and Traffic Safety Programs (TSP) which reflect the provision of the National Traffic and Motor Vehicle Act (P.L. 89-563) and the Highway Safety Act (P.L. 89-564) respectively. The research portions of these acts are fulfilled primarily by the Research Institute which responds to the program requirements of both MVP and TSP.

Ten Regional Administrators also serve under the Administrator to operate the regional offices of the NHTSA.

Alcohol Countermeasures Program

One of the three priority projects within the NHTSA involves a program of several countermeasures to combat alcohol-related crashes. During 1970, after careful and lengthy study, the Secretary of Transportation recommended, and Congress approved, an Alcohol Safety Countermeausres Program to be handled by a special office within the NHSTA. The Office of Alcohol Countermeasures (OAC) was subsequently established under the Associate Adminstrator for Traffic Safety Programs and, in the implementation of the overall countermeasures program, has initiated Alcohol Safety Action Projects (ASAP's) in 35 States across the U.S. These multifaceted projects involve a systematic integration of a number of countemeasures in enforcement, judicial and educational areas. The primary objective is to identify the problem drinker and remove him from the road until his problem has been overcome by referral to treatment. A secondary objective is to deter the social drinker by a program of public education and strengthened enforcement.

A map showing the location of the 35 ASAP sites within the ten NHTSA regions and a categorical listing of the Countermeasures involved in such programs is also attached.

This countermeasures program is being carried out to the fullest extent possible in States and communities through:

Financial Support - Matching grants to assist States in their alcohol-highway programs, to train technicians, to develop facilities, and to improve record systems.

Research - To develop new and improved detection methods and devices, and more effective remedial measures.

Public Education - To make the public increasingly aware of the seriousness of the problem and that it is excessive drinking particularly by problem drinkers which underlies the alcohol safety problem, thereby fostering the establishment of community support for countermeasure programs.

Demonstration and Pilot Programs - Model community, or State projects to demonstrate the feasibility of various approaches funded by the Federal Government.

ALCOHOL COUNTERMEASURES

Alcohol in relationship to highway fatalities and injuries, and the safe and efficient mobility of vehicles, has been a problem since the early 1900's.

For upwards of three generations, the drunk-driver has been recognized as a social deviant by the medical profession, by law enforcement and safety authorities, and to a somewhat lesser extent, by the general public. Recently, studies have verified that it is the problem drinker-driver rather than the average social drinker who is responsible for the majority of drinking-driving fatalities.

Numerous proposals to resolve the dilemma of the alcohol-addicted driver have been made by the well-intentioned. Most recommendations were for punitive action.

Rehabilitation was seldom advocated as an incentive to the offender losing the driving privilege. This need was clearly demonstrated in the 1968 Alcohol and Highway Safety Report to Congress by the Secretary of Transportation.

Basically, the Report showed, through scientific research, that a small minority of the general population accounts for "a very large part of the overall problem."

The small minority constitutes problem drinkers who need help. Also included are others who, on occasion, drink to excess.

One of the principal solutions of the problem of the intoxicated driver is through Alcohol Safety Action Projects (ASAP's) becoming operational in 35 States. Another is a comprehensive national public education program designed to inform all citizens of the dangers inherent if the alcohol-involved driver is permitted to go unchecked.

Individuals who wish to become personally active in removing the menace of the drunk-driver from the highway may choose to become involved through an ASAP; or by contacting directly the Highway Safety Representative of the Governor of their State to organize a similar community project.

There are numerous Alcohol Countermeasures providing practicable methods for eradicating the continuing specter of tragic crashes caused by alcohol and other drug involvement.

While the countermeasures provide evidence of the program's general concept, it is not likely that all would be adopted to spearhead a local alcohol safety campaign. Interested citizens working together in a common purpose can activate parts of the program, for example: the augmentation of alcohol safety sections of high school driver education programs or court referral of convicted drinking-drivers to mandatory treatment. However, caution is necessary to insure a systems approach. For example, an enforcement crackdown which clogs court dockets will have only an interim effect.

By concentrating effort upon suitable Alcohol Countermeasures, every community in the nation may expect to reduce the primary hazard of the motor age alcohol-related highway deaths. Only then will a wish become a reality.

POTENTIAL ALCOHOL COUNTERMEASURES* (by Category)
(To be considered by States and Communities)

Enforcement and License Control:

Include alcohol safety material in driver license examinations and driver handbook.

Provide for special enforcement of drinking-driver laws.

Require pre-sentence investigation (by courts) of drivers convicted of driving while intoxicated (DWI).

Provide special surveillance of license-revoked drivers.

Authorize roadside screening tests.

Education

Develop mass media public information campaigns.

Develop speakers bureau program.

Augment alcohol safety sections of high school driver curricula.

Add sections on alcohol to primary school safety courses and to appropriate secondary school courses (Family Life, etc.)

Develop special driver improvement programs for offenders' schools.

[illegible] tests, and specify concentrations.

[illegible] implied consent for the tests.

[illegible] revocation if test is refused.

[illegible] screening, no breath testing equipment.

[illegible] assistance program in cooperation with government agencies.

[illegible] positions and procedures for the tests.

[illegible] qualifications for alcohol safety personnel.

[illegible] referral of problem drivers to treatment.

[illegible] medical advisory boards (MAB) for licensing agency.

[illegible] review of convicted DUI drivers before reinstating license.

[illegible] to require physical examinations of drivers they review.

[illegible] imprisonment for driving while license revoked, or for second DUI conviction within three years.

[illegible] of collision insurance if driver has blood alcohol concentration (BAC) above .10 percent.

[illegible] or revocation of license plates of vehicles owned by persons convicted a second time of drinking-driving; or

[illegible] special tags or registration certificates for these vehicles.

Prohibit the transfer of vehicles with special registration certificates.

[illegible] physical control of a motor vehicle while driver has 0.10 percent BAC or higher illegal per se.

Driver's Records

Require the license applicant to certify as to previous arrests and treatment for alcoholism.

Include in driver's record:

...alcohol-related traffic convictions from court records;

...non-traffic alcohol-related convictions;

...alcohol-related information from health agency records.

Flag vehicle records for cars owned by problem drinkers.

Include chemical tests in accident records.

Pedestrian Assistance

In areas of high accident risk or where drinking establishments are located, develop special pedestrian safety measures such as better lighting, speed limit reduction, special caution signs and rerouting of traffic.

Provide special patrols at identified pedestrian problem areas.

Coordinate treatment assistance for pedestrians.

Determine locations and times of day of accidents involving pedestrians who have been drinking.

*Do not all necessarily have the official approval of NHTSA.

REGIONS OF THE FEDERAL GOVERNMENT

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415/341-3401

Region X - (Washington, Oregon, Idaho)
David Head
Regional Administrator
LEAA - U.S. Dept. of Justice
130 Andover Building
Seattle, Washington 98188
206/442-1170

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Alabama

Alabama Law Enforcement Agency,
State Capitol,
Room 117, Public Safety Building,
Montgomery, Ala. 36104.
205/269-6665 (FTS 205/263-7521)

Alaska

Governor's Commission on the Administration of Justice,
Goldstein Building, Pouch AJ,
Juneau, Alaska 99801.
907/586-1112-thur Seattle FTS 206/583-0150

Arizona

Arizona State Justice Planning Agency,
Continental Plaza Building, Suite M,
Phoenix, Ariz. 85015.
602/271-5467

Arkansas

Commission on Crime and Law Enforcement,
1009 University Tower Building,
12th at University,
Little Rock, Ark. 72204.
501/371-1305

California

California Council on Criminal Justice,
1927 13th Street,
Sacramento, Calif. 95814.
916/445-9156

Colorado

Division of Criminal Justice,
Department of Local Affairs,
600 Columbine Building,
1845 Sherman Street,
Denver, Colo. 80203.
303/892-3331 (FTS 303/297-0111)

Connecticut

Governor's Planning Committee on
Criminal Administration,
75 Elm Street,
Hartford, Conn. 06115.
203/566-3020 or 246-2349 (FTS 203/244-2000)

Delaware

Delaware Agency to Reduce Crime
1208 King Street,
Wilmington, Del. 19801.
302/654-2411

District of Columbia

Office of Criminal Justice Plans and Analysis,
Room 1200,
711 14th Street N.W.,
Washington, D.C. 20005.
202/629-5063

Florida

Governor's Council on Criminal Justice,
104 S. Calhoun Street,
Tallahassee, Fla. 32301.
904/224-9871 (FTS 904/791-2011)

Georgia

Office of Crime and Juvenile Delinquency Prevention,
Bureau of State Planning and Community Affairs Office,
270 Washington Street S.W.,
Atlanta, Ga. 30304.
404/656-3825 (FTS 404/526-0111)

Guam

Office of Comprehensive Law Enforcement Planning,
Office of the Governor,
Government of Guam,
P.O. Box 2950,
Agana, Guam 96910.

Hawaii

State Law Enforcement and Juvenile Delinquency
Planning Agency,
1010 Richard Street,
Kamamalu Building, Room 412,
Honolulu, Hawaii 96813.
808/584-4572

Idaho

Law Enforcement Planning Commission,
State House, Capitol Annex No. 2,
614 W. State Street,
Boise, Idaho 83707.
208/384-2364

Illinois

Illinois Law Enforcement Commission,
Suite 600,
150 North Wacker Drive,
Chicago, Ill. 60606
312/793-3393

Indiana

Indiana Criminal Justice Planning Agency,
215 N. Senate,
Indianapolis, Ind. 46202.
317/633-4773

Iowa

Iowa Crime Commission
520 E. 9th Street,
Des Moines, Iowa 50319.
515/281-3241

Kansas

Governor's Committee on Criminal Adminstration,
525 Mills Building
Topeka, Kan. 66603.
913/296-3066

Kentucky

Commission on Law Enforcement and Crime Prevention,
Room 130, Capitol Building,
Frankfort, Ky. 40601.
502/564-6710

Louisiana

Louisiana Commission on Law Enforcement and
Administration of Criminal Justice,
P.O. Box 44337, Capitol Station,
Baton Rouge, La. 70804.
504/389-5987 (FTS 504/389-2233)

Maine

Maine Law Enforcement Planning
and Assistance Agency,
295 Water Street,
Augusta, Maine 04330.
207/289-3361 (FTS 207/622-6171)

Maryland

Governor's Commission on Law Enforcement
and Administration of Justice,
Executive Plaza, One, Suite 302,
Cockeysville, Md. 21030.
301/666-9610

Massachusetts

Committee on Law Enforcement and
Administration of Criminal Justice,
Room 1230,
80 Bolyston Street,
Boston, Mass. 02116.
617/727-5497 (FTS 617/223-2100)

Michigan

Office of Criminal Justice Programs,
Lewis Cass Building-2nd Floor,
Lansing, Mich. 48913.
617/373-3392

Minnesota

Governor's Commission on Crime
Prevention and Control,
Metro Square Building, Room 222,
7th and Roberts Street,
St. Paul, Minn. 55101.
612/224-6612

Mississippi

Division of Law Enforcement Assistance,
345 North Mart Plaza,
Jackson, Miss. 39206.
601/354-6525 or 6591 (FTS 601/948-2460)

Missouri

Missouri Law Enforcement Assistance Council,
P.O. Box 1041,
Jefferson City, Mo. 65101.
314/636-5261 (FTS 816/374-7000)

Montana

Governor's Crime Control Commission,
1336 Helena Avenue,
Helena, Mont. 59601.
406/449-3604

Nebraska

Nebraska Commission on Law Enforcement
and Criminal Justice
State Capitol Building,
Lincoln, Neb. 68509.
402/471-2194 (FTS 402/475-2611)

Nevada

Commission on Crime, Delinquency
and Corrections,
Suite 41, State Capitol Building,
Carson City, Nev. 89701
702/882-7118

New Hampshire

Governor's Commission on Crime
and Delinquency,
3 Capitol Street,
Concord, N.H. 03301.
603/271-3601 (FTS 603/669-7011)

New Jersey

State Law Enforcement Planning Agency,
447 Bellevue Avenue,
Trenton, N.J. 08618.
609/292-5800 (FTS 609/599-3511)

New Mexico

Governor's Policy Board for
Law Enforcement,
P.O. Box 1628,
Santa Fe, N.Mex. 87501
505/827-2524

New York

State of New York, Office of Planning Services,
Division of Criminal Justice,
250 Broadway, 10th Floor,
New York, N.Y. 10007
212/488-3880 (FTS 212/460-0100)

North Carolina

North Carolina Department of Local Affairs,
Law and Order Division
422 North Blount Street,
Raleigh, N.C. 27602.
919/829-7974 (FTS 919/755-4020)

North Dakota

North Dakota Combined Enforcement Council,
State Capitol Building,
Bismarck, N.D. 58501.
701/224-2594

Ohio

Ohio Law Enforcement Planning Agency,
Department of Urban Affairs,
50 West Broad Street, Room 3200,
Columbus, Ohio 43215.
614/469-5295 (FTS 614/369-5295)

Oklahoma

Oklahoma Crime Commission,
820 N.E 63rd Street,
Oklahoma City, Okla. 73105.
405/521-3392

Oregon

Executive Department, Law Enforcement Council,
306 Public Service Building,
Salem, Ore. 97310.
503/378-3514

Pennsylvania

Pennsylvania Criminal Justice Planning Board,
Federal Square Station,
P.O. Box 1167,
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Puerto Rico

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Rhode Island

Governor's Committee on Crime, Delinquency,
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Tennessee

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730 Littlefield Building,
Austin, Tex. 78701.
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Utah

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Room 304 State Office Building,
Salt Lake City, Utah 84114.
801/328-5731 (FTS 801/525-5500)

Vermont

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703/770-6193

Virgin Islands

Virgin Islands Law Enforcement Commission,
Box 280, Charlotte Amalie,
St. Thomas, V.I. 00801.
809/774-6400

Washington

Law and Justice Planning Office,
Planning and Community Affairs Agency,
Office of the Governor,
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206/753-2235

West Virginia

Governor's Committee on Crime
Delinquency and Corrections.
1706 Virginia Street East,
Charleston, W. Va. 25311.
304/348-3689 or 348-3692

Wisconsin

Wisconsin Council on Criminal Justice,
State Capitol
Madison, Wis. 53702.
608/266-3323

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Governor's Planning Committee on
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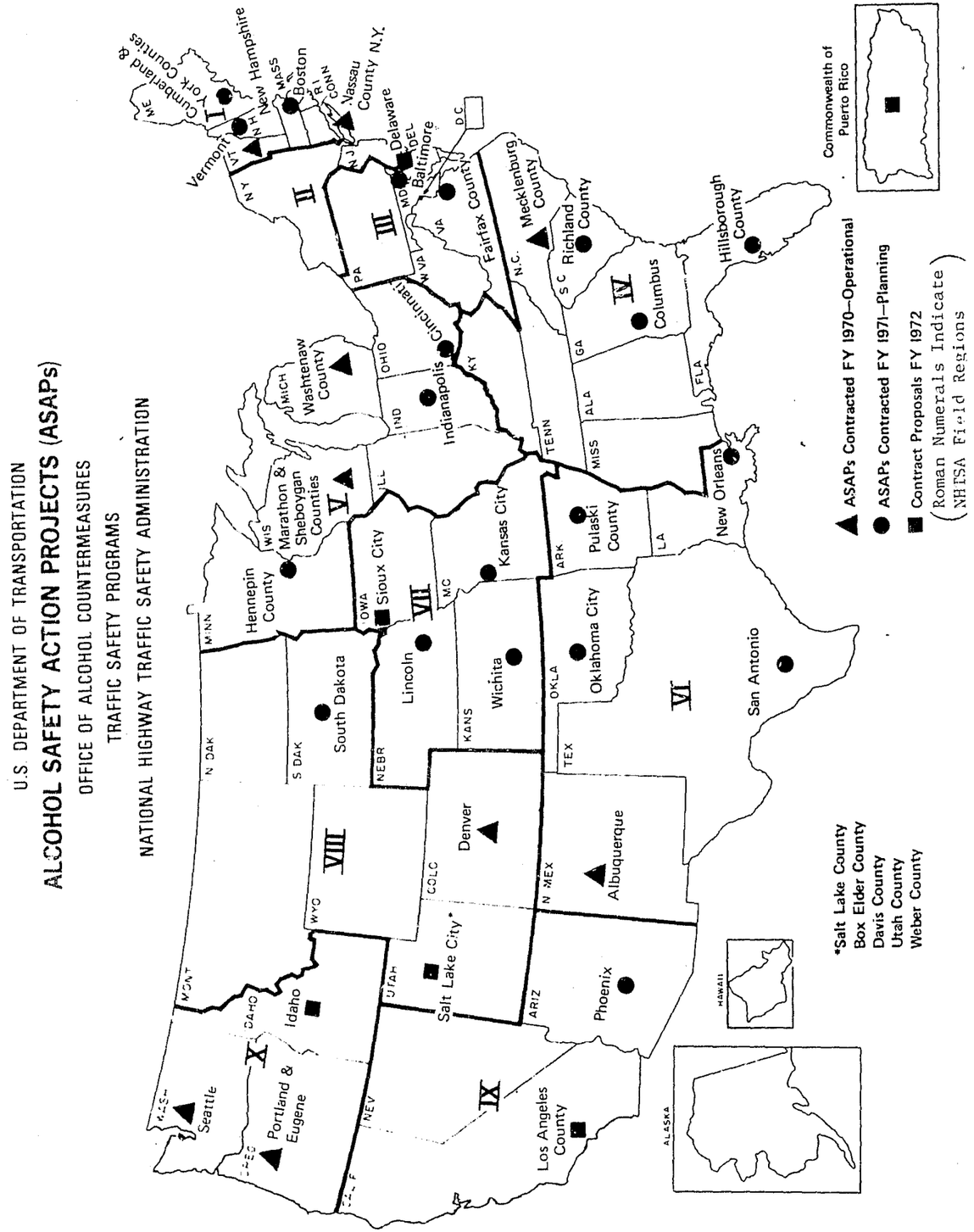

PROGRAM OF THE CONFERENCE

MONDAY, FEBRUARY 21

6:00 p.m. Registration - Lobby
7:00 Dinner - Ft. McHenry Room
8:30 Orientation to Conference Objectives
Discussion of joint planning, programming, funding and coordinating of joint conference
9:30 Briefing meeting for Panelists, Moderators, Recorders and Staff - Room A

TUESDAY, FEBRUARY 22

8:45 a.m. Three Workshops: First Session

Workshop I - Room A
The Violent and Non-violent Alcohol-related Offender
"Youth, Violence and Alcohol"
Steven Burkett

Workshop II - Room B
The Public Inebriate
"Housing and Treatment of the Public Inebriate
Irving W. Shandler

Workshop III - Room C
The Drinking Driver
"Youth, Alcohol and Collision-involvement"
Richard Zylman

11:30 Summary and revision of reports on first session (in each workshop)

12:00 p.m. Luncheon - Ft. McHenry Room
Speaker: Allan Vestal
"The Uniform Alcoholism and Intoxication Treatment Act"

1:30 Second Workshop Session

Workshop I - Room A
"Criminality and Psychiatric Illness: The Role of Alcoholism"
Samuel B. Guze
"Exploring Some Common Ground Relative to Alcohol Abuse"
Lyle D. Filkins

Workshop II - Room B
"The Public Inebriate and the Highway Transportation System"
Kent B. Joscelyn
"Two Million Unnecessary Arrests"
Raymond Nimmer
Workshop III - Room C
"Prevention and Deterrence through the Mass Media"
James W. Swinehart
"Analysis of the Value of Motion Pictures in Alcohol Education"
Alexander Sareyan

5:00 p.m. Summary and revision of report on second session
5:30 Adjourn

5:45 Reception - Ft. McHenry Room
6:30 Dinner - Ft. McHenry Room

WEDNESDAY, FEBRUARY 23

8:45 a.m. Third Workshop Session
Workshop I - Room A
"The Alcoholic Offender: Manpower Needs for the Future"
Frank Ervin
Workshop II - Room B
"Meaningful Employment for the Public Inebriate"
Joseph Walsh
Workshop III - Room C
"Can Communities Re-educate Drinking Drivers?"
Harold Sackman

11:15 Summary and revision of workshop reports and recommendations for presentation to Directors and Joint Conference members

12:00 p.m. Luncheon - Ft. McHenry Room

1:30 Plenary Session: Workshop reports and recommendations to the Joint Conference - Ft. McHenry Room
2:30 Directors' Press Conference - Ft. McHenry Room
3:15 Ten Regional Meetings for Initial Planning for Regional Joint Conferences on Alcohol Abuse and Alcoholism (Meeting locations to be announced)
4:30 Conference Evaluation
5:00 Adjourn

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