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ALCOHOL AND THE CRIMINAL JUSTICE SYSTEM: CHALLENGE AND RESPONSE

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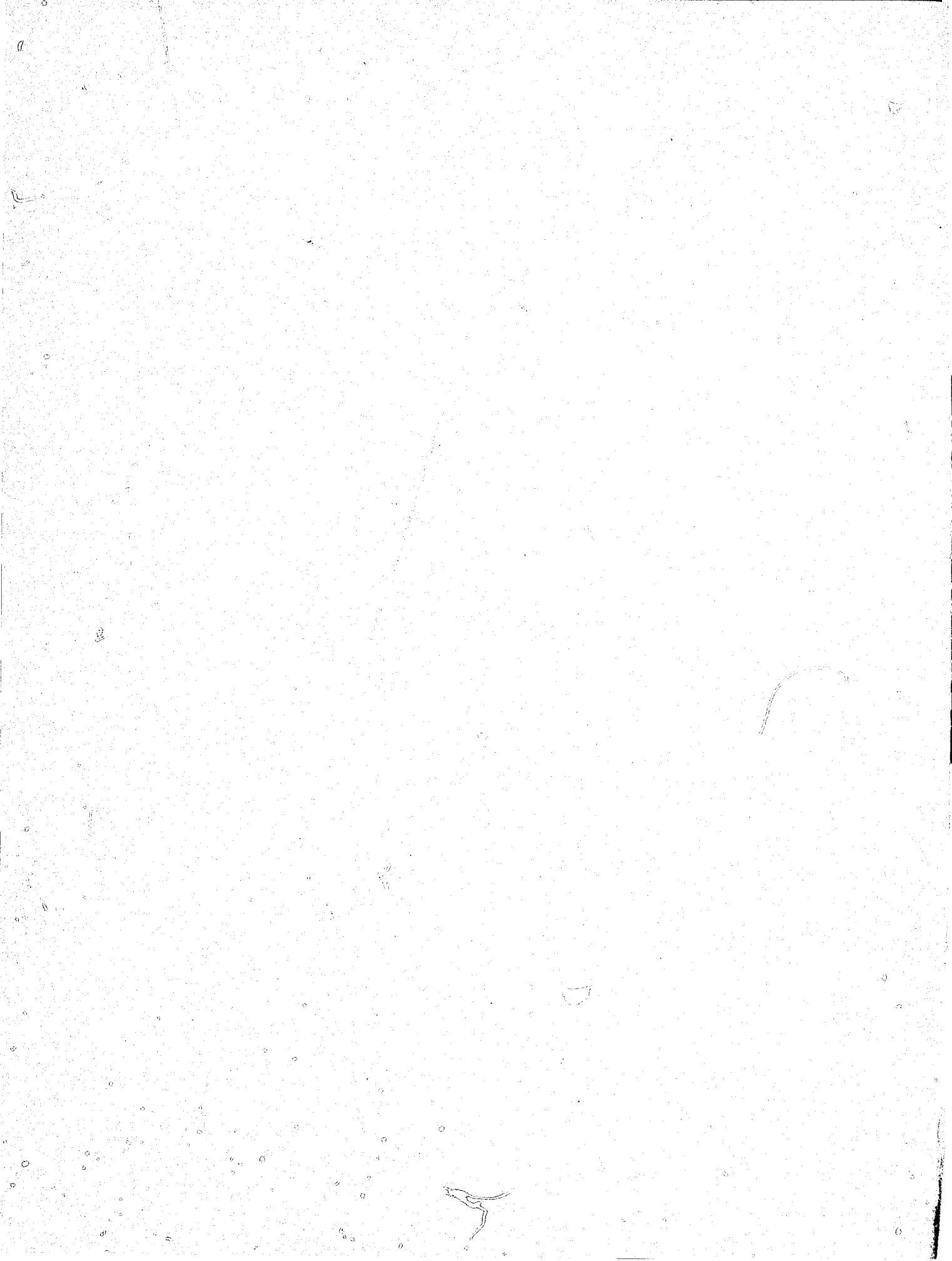

ALCOHOL AND THE CRIMINAL JUSTICE SYSTEM: CHALLENGE AND RESPONSE

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. . .With these kinds of guidelines, and with the opportunities we now see ahead, we can perhaps venture some real hope in a field that for too long has been marked by frustration. Through the processes now at work, the public itself may come to realize that our task is not to punish, but to heal. . .

John N. Mitchell, Attorney General
of the United States
December 9, 1971

PREFACE

This monograph, "Alcohol and the Criminal Justice System: Challenge and Response," has attempted to bring together information that might be useful to criminal justice personnel in planning programs and research in alcohol abuse.

Several states have repealed the legal sanctions against alcoholism, namely the District of Columbia, Maryland, Florida, Hawaii, Minnesota, Massachusetts and California. Other legislatures are considering the matter but many are still uncommitted.

The transition from considering alcohol abuse not a crime but an illness will not be an easy one. In those states where the new approach has been tried, unforeseen problems have arisen. However, the National Conference of Commissioners on Uniform State Laws have drawn up a Uniform Alcoholism and Intoxication and Treatment Act that can serve as a model to the states. The Commission is composed of a representative from each state and he is obligated to see that the act is introduced into the legislatures of his state.

Another major challenge in making the transition is that it will require close cooperation not only within the criminal justice system but among many unrelated agencies at the local level - the health care system, mental health experts, educators, welfare and anti-poverty groups, highway safety departments, the mass media and the public itself. In the report of the Cooperative Commission on the Study of Alcoholism, "Alcohol Problems: A Report to the Nation," Thomas F. A. Plaut sums up the Commission's optimism in this regard in the following way:

> The Commission proposes the formulation of a national policy on alcohol and it believes that such a comprehensive policy can be developed. The Commission recommends that an integrated conceptual approach be substituted for the current patchwork of actions. The extent and character of the proposed changes should not be underestimated. A thorough examination is needed of individual and group behavior. It should now be possible for professional workers and the American people generally to look at drinking patterns to examine their strengths and weaknesses and to move toward modifying types of drinking that are damaging and unacceptable. The

Commission believes that there is a substantial, if not conclusive, evidence that such modifications will reduce rates of alcoholism and other types of problem drinking.

These are sweeping proposals for broad social changes. Their scope is great and their demands severe. They ask that the public assume total responsibility for alcohol; that the painful and troubled experiences of Prohibition be put aside; and that current social freedoms surrounding alcohol use be critically examined and scientifically studied for their strengths and weaknesses. A major shift in social attitudes and policies is required to match the prevalence, the persistency, the complexity and the interrelatedness of alcohol problems.

CONTENTS

Chapter

I	ALCOHOL IN AMERICA	1
	A. Extent of Drinking in the U. S.	1
	B. Historical Basis for Present Attitudes Toward Alcohol Problems	2
II	DIMENSIONS OF THE PROBLEM WITHIN THE CRIMINAL JUSTICE SYSTEM	5
	A. The Public Inebriate	5
	B. Alcohol-Related Felonies	8
	C. The Drinking Driver	9
III	ALTERNATIVES TO THE CRIMINAL JUSTICE PROCESS	11
	A. St. Louis Detoxification and Diagnostic Evaluation Center	12
	B. District of Columbia Program	14
	C. The Vera Institute Bowery Programs	16
IV.	TREATMENT AND CONTROL OF ALCOHOL PROBLEMS	20
	A. Current State of Treatment for the Alcoholic	20
	B. Prevention of Drinking Problems	22
	C. Research Needs	23
V	SOURCES OF SUPPORT AND INFORMATION	26
	In Conclusion	28

CHAPTER I

ALCOHOL IN AMERICA

Extent of Drinking in the U.S.

While drug abuse problems have been stealing the headlines in the last decade, the average American increased his yearly consumption of hard liquor by half a gallon. In the 1950's Americans were drinking a gallon and a quarter of hard liquor; by 1969 that figure had increased to a gallon and four fifths.(1)

While these figures could mean simply that more Americans are drinking rather than that Americans who drink are drinking more, we have little cause for complacency; alcoholism as a disease is recognized as a national health problem second only to cancer and heart disease.(2) While the rate of alcoholism in the population appears to have remained relatively stable it is the second highest in the world and is surpassed only by that of France.

On the other hand, other countries have had far worse problems. London, in the 18th century, for example, when its population was less than a million, consumed eight million gallons of gin in a year. The streets, as depicted by the art and the literature of the time, were packed with drunks and alcoholics. However, the problems of the time could not be blamed on alcohol but rather on the depressing circumstances in which most Londoners lived during that period.(3)

Approximately 70 percent of adult Americans drink and 40% are regular drinkers (at least once a month).(4) Thus, 80 million adults are regular users of alcohol. To this must be added the teen-age drinkers which vary from 30% in Michigan and Utah to 80% in New York.(5) Since it is usually illegal for persons under 21 to drink, these figures are not ordinarily included. However, since the majority of adults drink, it would seem unrealistic to expect teen-agers to abstain.

There are various estimates of the number of alcoholics in America ranging from 4 million (the Department of Health, Education and Welfare, 1966) to 18 million (Dr. Morris Chafetz, Director of the National Institute of Mental Health Alcoholism Program, 1970).(1) Alcoholics have an accident rate twice that of non-alcoholics and their life span is approximately 12 years less. The ratio of male to

female alcoholics in the U. S. is 5.5 to 1 and the proportionate ratio of white to black is 1.6 to 1.(6)

It is popularly supposed that the poor drink more than the rich. However, only 54 percent of the people with incomes of $3,000 or less drink as compared to 87 percent of those whose annual income is $10,000 or more.(3)

There are also regional, religious and ethnic differences in drinking patterns. Persons living in urban areas drink more than those in rural areas. The southern and mountain states have the lowest rates—33 to 55 percent while the Northeastern states have the highest—88 percent. Baptists have one of the lowest drinking rates (48 percent) and Jews and Catholics the highest (90%).(3) However with regard to alcoholism, Jews have the lowest and Catholics the highest rates of all groups.(8) Some Protestant groups of course such as the Mormons and the Seventh Day Adventists forbid drinking and this lowers the rate of the total Protestant group.

Most writers on the subject tend to feel that drinking behavior, as all behavior, is learned. The fact that Jews drink more but seldom become alcoholic is explained by the ceremonial use of alcohol in the Jewish religion. The Jewish child early becomes familiar with alcohol and he does not think of it as something taboo to be used later in rebellion or escape from life's problems.

Historical Basis for Present Attitudes Toward Alcohol Problems

The Eighteenth or Prohibition Amendment has the unique distinction of being the only Amendment in the American Constitution that has ever been repealed. The strong public reaction against this most disastrous and unpopular experiment to "legislate morals" has been suggested as one reason for the delay in any comprehensive approach to the alcohol problem.(8) However, as Dr. Plaut points out, the passage of time since the repeal of the Prohibition Amendment, the weakening of the Temperance Movement (a recent Gallup Poll has indicated that "dry" sentiment is at its lowest point since repeal- from 1/3 to 1/5 of the population), and the widening acceptance of social drinking make for a more favorable climate for the development of a more reasonable American alcohol policy.

The revenue derived from liquor taxes and from the sale of liquor in state stores, also creates a reluctance to do anything that might have the effect of reducing alcohol consumption. Federal alcohol taxes amount to close to $4 billion a year. Only individual and corporate income taxes exceed this amount as a source of Federal revenue.(8)

Another reason for the slow development of remedial programs is of course the feeling that the alcoholic cannot be helped. This point will be discussed in more detail later.

Despite the difficulties some change has been achieved. It is often assumed that what progress has been made has been initiated at the Federal level. However, the Law Enforcement Study Center in the Social Science Institute at Washington University takes exception to this attitude in the following excerpt from "Alcoholism and Law Enforcement":

> Beginning with the Oregon Alcoholism Program in 1943, American states and municipalities have been in the forefront of organizing governmental activities for alcoholism treatment, research education and prevention. As of today 45 states and the District of Columbia have identifiable funded alcoholism units at the state level. Despite varied patterns of organization, the American states have shown a strong awareness of the need for governmental involvement in alcoholism treatment and control. The same generalization is true for many local governments. Municipal alcohol programs - whether anchored in local health departments, hospitals, special commissions, boards of country commissioners or supervisors, in police, court or correctional authorities - have a significant role to play in alcoholism control activities. For example in developing new patterns of care for the public or "revolving door" alcoholic, almost all innovations in treatment have occurred at the municipal level - specifically in "court honor classes" for alcoholics in Des Moines and Denver; in short term correctional programs in Portland, Oregon, and Atlanta; in the police detoxification center procedures in St. Louis, Washington and Des Moines; in poverty programs in Boston; and in municipal hospital care programs in Boston and Cincinnati.
>
> In short, during the last 25 years almost all governmental activities in the field of alcoholism have occurred at the state or municipal level. It is a frequent criticism today that state and local governments have ignored their responsibilities and have abdicated them to the federal level. This is blatantly untrue for the field of alcoholism control, where the Federal Government had been minimally involved until 1966, when the National Center for the Prevention and Control of Alcoholism in the National Institute of Mental Health was created. (3)

From whatever vantage point one looks at the problem, there can be little doubt that the indiscreet and excessive use of alcohol results in much that is tragic in human society. The World Health Organization

in 1951 defined alcoholism as a disease and the American Medical Association followed five years later with their opinion that alcoholism should come under medical practice, that hospitals should make provision for the care of alcoholics and that medical interns should be trained in the treatment of alcoholics. Traditionally, problems resulting from drinking have been defined as crimes and considered the domain of the criminal justice system, but it has become increasingly clear that this method of taking care of alcohol abuse is not working and is all but paralyzing the criminal justice function. The time has come for a reappraisal of our methods and goals.

In considering the role of alcohol in crime and delinquency, it must be kept in mind that the problem is not with alcohol itself. As in the case of drugs, alcohol has a positive aspect in increasing appetite and relieving tensions. We are concerned with its excessive use by the public inebriate, the idiosyncratic reaction of some individuals to alcohol in the case of violent behavior, and with its indiscreet use as in the case of the drinking driver.

CHAPTER II

Dimensions of the Problem within the Criminal Justice System

It has been said (as it is said of drug abuse) that that portion of the problem to reach the courts is but the "tip of the iceberg." Although the two problems have much in common, alcohol-related arrests far outnumber narcotic drug-law violations and often are more serious in nature. While the heroin addict commits crimes against property - robberies, burglaries and larcenies - to get money to buy the illegal drug, alcohol is frequently associated with violent crimes against persons.

This section will be concerned with the public inebriate, alcohol-related felonies and the drinking driver. In order that the reader may consider alcohol-related offenses against a backdrop of all crimes, a page has been borrowed from the most recent Uniform Crime Reports (1970) and is reproduced on page 6.

The use and effects of alcohol are interrelated with criminal behavior in many ways. At least one-half (estimates differ) of the prison population have long histories of the excessive use of alcohol. The fact that studies of juvenile delinquents indicate that excessive drinking is much more prevalent among juveniles in trouble than among others of comparable age led the author of the Pennsylvania Task Force Report on Alcohol and the Criminal Justice System(11) to make the following statement: "The causes of alcohol abuse may also underlie criminal behavior." This may prove to be a very profound observation as research develops in this too long neglected area. Earl Rubington(7) has pointed out that between 30 and 40 percent of persons chronically arrested for drunkenness have histories of earlier criminal behavior. They are apparently double failures - they have failed in society and in their criminal careers.

The Public Inebriate

"Two million arrests in 1966 - one of every three arrests in America - were for the offense of public drunkenness. The great volume of these arrests places an extremely heavy load on the operations of the criminal justice system. It burdens police, clogs

—Total Arrest Trends, 1969–70

[4,222 agencies; 1970 population 137,267,000]

Offense charged	Number of persons arrested											
	Total all ages			Under 15 years of age			Under 18 years of age			18 years of age and over		
	1969	1970	Percent change	1969	1970	Percent change	1969	1970	Percent change	1969	1970	Percent change
TOTAL	5,628,997	5,922,688	+5.2	551,762	554,908	+.6	1,447,635	1,504,402	+3.9	4,181,362	4,418,286	+5.7
*Criminal homicide:												
(a) Murder and nonnegligent manslaughter	11,172	11,942	+6.9	156	180	+15.4	1,100	1,302	+18.4	10,072	10,640	+5.6
(b) Manslaughter by negligence	3,111	2,700	−13.2	37	35	−5.4	255	219	−14.1	2,856	2,481	−13.1
*Forcible rape	13,936	14,116	+1.3	560	596	+6.4	2,898	2,986	+3.0	11,038	11,130	+.8
Robbery	76,213	83,691	+9.8	9,142	9,395	+2.8	25,934	28,275	+9.0	50,279	55,416	+10.2
*Aggravated assault	110,694	115,232	+4.1	6,030	6,420	+6.5	18,647	19,509	+4.6	92,047	95,723	+4.0
Burglary—breaking or entering	247,368	261,690	+5.8	63,460	60,499	−4.7	133,984	136,018	+1.5	113,384	125,672	+10.8
Larceny—theft	502,945	567,728	+12.9	140,145	144,259	+2.9	267,555	289,053	+8.0	235,390	278,675	+18.4
*Auto theft	122,802	118,251	−3.7	19,787	17,763	−10.2	72,039	66,175	−8.1	50,763	52,076	+2.6
Violent crime [1]	212,015	224,981	+6.1	15,888	16,591	+4.4	48,579	52,072	+7.2	163,436	172,909	+5.8
Property crime [2]	873,115	947,669	+8.5	223,392	222,521	−.4	473,578	491,246	+3.7	399,537	456,423	+14.2
Subtotal for above offenses	1,088,241	1,175,350	+8.0	239,317	239,147	−.1	522,412	543,537	+4.0	565,829	631,813	+11.7
Other assaults	251,306	282,500	+4.5	17,797	19,556	+9.9	44,839	48,758	+8.7	206,467	213,742	+3.5
Arson	8,270	8,537	+4.0	3,635	3,423	−5.8	5,184	5,159	−.5	3,086	3,438	+11.4
*Forgery and counterfeiting	35,622	39,811	+11.8	825	655	−20.2	4,027	4,246	+5.4	31,595	35,565	+12.6
Fraud	59,692	66,465	+11.3	915	674	−26.3	2,990	2,882	−3.6	56,702	63,583	+12.1
Embezzlement	6,065	7,531	+24.2	45	59	+31.1	246	310	+26.0	5,819	7,221	+24.1
Stolen property; buying, receiving, possessing	44,669	56,061	+25.5	4,705	5,076	+7.9	14,230	16,801	+18.1	30,439	39,260	+29.0
Vandalism	103,694	102,224	−1.4	50,006	46,645	−6.7	75,996	73,370	−2.8	27,698	28,354	+2.4
Weapons; carrying, possessing, etc	87,939	95,204	+8.3	3,956	4,223	+6.7	15,138	15,937	+5.3	72,801	79,267	+8.9
Prostitution and commercialized vice	47,979	48,127	+.3	94	100	+6.4	976	1,097	+12.4	47,003	47,030	+.1
*Sex offenses (except forcible rape and prostitution)	49,811	46,163	−7.3	4,283	3,721	−13.1	10,823	9,660	−10.7	38,988	36,503	−6.4
Narcotic drug laws	227,661	327,792	+44.0	7,933	9,621	+21.3	56,187	73,139	+30.2	171,474	254,653	+48.5
Gambling	77,885	82,470	+5.9	259	208	−19.7	1,671	1,592	−4.7	76,214	80,878	+6.1
Offenses against family and children	47,912	46,607	−2.7	163	232	+42.3	788	702	−10.9	47,124	45,905	−2.6
*Driving under the influence	335,549	375,784	+12.0	75	81	+8.0	3,621	4,054	+12.0	331,928	371,730	+12.0
*Liquor laws	201,612	194,712	−3.4	5,862	5,940	+1.3	67,671	66,583	−1.6	133,941	128,129	−4.3
*Drunkenness	1,390,965	1,364,125	−1.9	4,929	4,658	−5.5	41,277	36,999	−10.4	1,349,688	1,327,126	−1.7
*Disorderly conduct	565,967	543,927	−3.9	40,362	40,212	−.4	115,642	115,308	−.3	450,325	428,619	−4.8
*Vagrancy	103,448	95,502	−7.7	1,925	2,038	+5.9	11,022	11,892	+7.9	92,426	83,610	−9.5
All other offenses (except traffic)	640,564	724,433	+13.1	77,106	79,416	+3.0	198,750	212,573	+7.0	441,814	511,860	+15.9
Suspicion (not included in totals)	92,847	62,464	−32.7	5,367	5,550	+3.4	20,764	18,182	−12.4	72,083	44,282	−38.6
*Curfew and loitering law violations	98,375	96,342	−2.1	25,567	24,841	−2.8	98,375	96,342	−2.1			
Runaways	155,770	162,961	+4.6	62,003	64,379	+3.8	155,770	162,961	+4.6			

[1] Violent crime is offenses of murder, forcible rape, robbery and aggravated assault.

[2] Property crime is offenses of burglary, larceny and auto theft.

*Crimes Frequently Alcohol-related

lower criminal courts and crowds penal institutions throughout the United States."

Task Force Report: Drunkenness 1967 (9)

The largest problem, quantitatively, facing the criminal justice system concerns the arrest and incarceration of men for public drunkenness, vagrancy, loitering and related crimes. It should be noted that the above figures refer to arrests, not individuals, for the public inebriate is a chronic offender and may be in and out of jail many times in a year. The "revolving door" cycle affects the homeless alcoholic in particular. He is caught in the cycle of intoxication, arrest, conviction, confinement, release, and return to the street where the cycle begins all over again because he cannot control his drinking.

Who are these men? A 10-day study of all men picked up for intoxication in the 6th police district in Philadelphia (10) revealed the following:

1. General Characteristics. The men had a median age of 50 years. 80 percent lived alone and 18 percent were homeless, 58 percent were unemployed. One-sixth reported that they had been arrested more than 50 times, usually for intoxication.
2. Drinking History, Patterns and Problems. Because of drinking, 56 percent of the men had lost employment, and 36 percent had been hospitalized for drunkenness. Two-thirds were spree drinkers and more than two-thirds (72 percent) drank to alleviate hang-over effects. 37 percent reported having experienced delirium tremens. About half (48 percent) said they were alcoholics and even more (58 percent) wanted help for their drinking problems.
3. Medical Findings. Chronic alcoholism was diagnosed to be almost certain in 62 percent, probable in 17 percent, suspected in 14 percent and not present in only 6 percent of those who were drunk. Hospitalization was found to be an urgent need for 10 percent of the men and was required, though not urgently, for about one-third.

Cities differ in their policies with regard to the type of alcoholic who is arrested. It is assumed that the above sample in Philadelphia is fairly typical for most cities. The Vera Institute program (Manhattan Bowery Project) offers assistance to those men who are so obviously intoxicated or debilitated that they are unable to take care of themselves in the street. A survey of the first two hundred patients admitted to

their detoxification center revealed many serious medical ailments including: cardiovascular diseases (90 percent), pulmonary diseases including tuberculosis (63.5 percent), chronic organic brain syndrome (35.5 percent), and schizophrenia (33 percent).(11)

Can one wonder that these men are unable to help themselves? It has been remarked that what the skid-row alcoholic needs is a Blue Cross Card. However, health insurance companies apparently do not provide coverage for the treatment of alcoholism, for the following is one of the recommendations of the Cooperative Commission on the Study of Alcoholism:

> The financial barriers that often impede the hospitalization of problem drinkers should be removed. These include the present policies of private insurance companies, Blue Cross and Blue Shield, public welfare programs and federally supported or subsidized medical care programs that often exclude such patients from hospital and medical care plans.(8)

The two million annual arrests do not represent the total amount of time the police spend on this problem. Police officers in many communities, especially small towns and suburban areas, may take a man home, call a taxi for him or notify relatives to come for him. If he is picked up, he may be held until sober without charge. It is only when the inebriate is homeless, poor, and appears vagrant that an arrest is the probable outcome. It has been estimated that the apprehension of drunkards costs the Philadelphia police 90,000 man-hours annually.

The cost to the nation of handling two million annual arrests has been estimated at $100 million(3), and since no treatment is provided in the jail, the inevitable revolving door phenomenon is continued year after year. It is indeed a high cost for a system that is an abysmal failure.

Alcohol-Related Felonies

Public drunkenness is, of course, a misdemeanor. The "crime" is the behavior resulting from the excessive use of alcohol. Of all alcohol-related crimes the public inebriate is the most pathetic.

But alcohol also plays a large part in violent crime. In some individuals (who are frequently over-controlled but irascible) alcohol depresses inhibitions and releases the underlying violence and aggression.

In a study of 588 homicides Marvin Wolfgang has reported that in 64% of the cases alcohol was a factor and in the majority of these alcohol was present in both offender and victim. This survey also showed that the bulk of criminal homicides in Philadelphia occur on week-ends - the period when most drinking is done. Alcohol was found to be present in 70% of the homicides occurring on Friday, Saturday, and Sunday while in only 50% of homicides committed between Monday and Thursday. Bensing &

Schroeder(13) found that 62% of homicides in the greater Cleveland area took place on the 3 days of the week end. Other studies have reported 84% of all homicides as occurring on the week-end.(12)

Wolfgang has also reported an association between the method of inflicting death and alcohol. More stabbings occurred with alcohol present than in other methods of homicide. Of 228 stabbings 72 percent involved the presence of alcohol. Beatings with fist, feet, or blunt instrument ranked second with 69 percent of the 128 cases involving alcohol. Of 194 shootings only 55 percent involved the presence of alcohol.

Robbery is the only one of the four index crimes designated as violent in which alcohol shows only a minimal involvement. Alcohol was found present in the offender in only 7 percent of 892 robberies in Philadelphia where an offender was arrested(12). The Violence Commission concludes that the robbery offender is an individual who rationally plans his act, as compared with the offender in the other major violent crimes who often acts more passionately and impulsively.

Although in general alcohol appears to be more related to crimes against the person than to property crimes, there is some evidence to suggest alcohol as a secondary factor in bad-check writing and petty theft etc. because chronic alcoholics have no jobs and need funds. The Task Force on Drunkenness quotes the results of a questionnaire given to 2,325 men in California prisons. Twenty-eight percent of all the men claimed they were intoxicated at the time they committed the offense for which they were imprisoned; 50 percent of those committed for car theft; one-third of those in for manslaughter, assault, sex offenses, forgery and bad checks; and 10 percent of those convicted on narcotics charges.(9)

There are, unfortunately, no national statistics on alcohol-related violent crimes. On the basis of several small studies the Commission on Violence(12) has concluded that at least 24 percent of the four violent index crimes are alcohol-involved. Referring back to page 7 (the Uniform Crime Reports Total Arrest trends for 1969-1970) the reader will note that crimes of violence numbered 224,981 cases in 1970. Twenty-four percent of this figure is approximately 54,000 cases - an appreciable figure equivalent to the number of traffic fatalities each year. If we were to add 50 percent of the car theft (59,125), 33-1/3 percent of forgery (13,270) and 10 percent of those arrested on narcotics charges (32,779) this figure comes close to 160,000 arrests.

The Drinking Driver

It is well known that alcohol plays a part in many automobile crashes. The use of alcohol by drivers and pedestrians leads to some 25,000 deaths and a total of at least 800,000 crashes in the United States annually. Alcohol-related deaths constitute 50% of all fatal auto accidents. Drivers believed to have been killed as the result of the action of others have not usually been drinking. In such cases

80 percent of the victims have no alcohol blood content.(12)

It has been estimated that the cost of traffic accidents in 1965 (in the form of insurance, medical expenses, property damage, and wages) is approximately $9 billion(3).

According to the Alcohol and Highway Safety Report to Congress by the Secretary of Transportation, 1968, only the 1 to 4 percent of drinking drivers having 0.10 percent or higher blood-alcohol concentrations were responsible for 48 to 57 percent of all fatal single car crashes. Thus, although the heavily intoxicated drivers are only a small percentage of those on the road, they account for at least one-half of the fatal accidents.(12)

Studies of drivers involved in fatal accidents show that such drivers have histories of rage, depression, paranoid tendencies, suicidal proclivities, violent behavior, prior accidents, personal problems and alcoholism. An unpublished California study in 1965 showed that drivers who were killed in single vehicle crashes and who had high blood-alcohol concentrations also exhibited high arrest rates for violent crimes compared to a group with low blood-alcohol concentrations.(12) Other studies on violent offenders in prisons have shown a high proportion of reckless driving convictions although this finding has not been related to alcohol.(14)

Another interesting finding with regard to highway fatalities is that drinking pedestrians as well as drinking drivers are a major cause of traffic deaths. Nearly one-third of the pedestrians killed in District of Columbia traffic accidents for a recent three-year period had been drinking(1). Sixteen of them were killed in 1970 while trying to cross a street against a red light or in the middle of a block.

Conclusion

As one considers these three categories, the public inebriate, alcohol-related felonies and the drinking driver, a pattern begins to emerge. They are obviously not unrelated. It may be that we are looking at the same people at different stages of their alcoholic careers. One is reminded of the observation of the Philadelphia Task Force Report quoted earlier that the causes of alcohol abuse may underlie criminal behavior.

To recapitulate what has been covered in Chapter II, the reader should again refer to the 1970 Uniform Crime Report table on page 6. By actual count, crimes directly associated with alcohol total 2,294,608. As we have seen alcohol-related felonies approximate 160,000. Driving under the influence accounts for 375,784 arrests. These figures total 2,830,392 arrests out of 5,922,688 - or roughly 50 percent of all arrests.

CHAPTER III

ALTERNATIVES TO THE CRIMINAL JUSTICE PROCESS

The President's Commission on Law Enforcement and Administration of Justice Task Force Report on Drunkenness made several recommendations with regard to alcohol-related problems. They were briefly as follows:

1. Drunkenness should not in itself be a criminal offense. Disorderly and other criminal conduct should remain punishable as separate crimes.
   The recommendation requires the development of adequate civil detoxification procedures.
2. Communities should establish detoxification centers as part of comprehensive treatment programs.
3. Communities should coordinate and extend after-care resources, including supportive residential housing.
4. Research by private and governmental agencies into alcoholism, the problems of alcoholics, and methods of treatment, should be expanded.
   Consideration should be given to providing further legislation on the Federal level for the promotion of the necessary coordinated treatment programs.(9)

As we have seen previously the concept of alcoholism as an illness had been growing steadily for over twenty years. It is now generally agreed that the traditional way of handling the problem is outmoded, expensive, and futile but the methods for handling it are still in the experimental stages and there is still some disagreement as to what exactly should be done. The San Francisco Committee on Crime, for example, (15) while regarding it as a public health problem, feels that drunkenness should be taken out of the criminal process entirely, without the expense of attempts at complete medical rehabilitation and cure. Their chief recommendation is for residential centers for alcoholics.

To date most rehabilitative studies have focused on the problem of the public inebriate. The problems of the alcoholic felon and the drinking driver have been given only brief attention.

The three largest experiments in dealing with the public inebriate have been in St. Louis, Washington, D.C., and in New York and will be

dealt with briefly in this chapter. Raymond T. Nimmer of the American Bar Association has recently reported his evaluation of these projects in his book "Two Million Unnecessary Arrests" (11) and we are heavily indebted to him for the information presented here.

The St. Louis Detoxification and Diagnostic Evaluation Center

The St. Louis project has the distinction of being the first operative detoxification program in the United States. It was begun toward the end of 1966 under a one-year grant from the Office of Law Enforcement Assistance (the predecessor of the present Law Enforcement Assistance Administration-LEAA). Its budget was $200,000 and its caseload 1600 cases per year.

Prior to the inception of the program the St. Louis police force followed a policy of de-emphasizing public drunkenness, and arrest rates were low. In 1964-65 arrest rates in St. Louis did not exceed 4000, while in Washington, D. C. for the same year, 40,000 arrests were made (the cities are roughly comparable in size).

The three major goals of the program were to provide medical assistance, to facilitate rehabilitation of the patients, and to reduce public expenditures. Since the arrest rate was already low the program is somewhat difficult to evaluate. The program did demonstrate the needs of the derelict inebriate and the failure of the law enforcement approach to reach everyone in need of medical attention.

The program consisted of a seven-day stay at the treatment center. The men arrested were given the chance of becoming patients at the detoxification center or being processed through the courts. Few chose to be prosecuted or to leave the facility without permission.

After admission the patients were given a medical examination and if serious ailments were found, were transferred to a local hospital or mental health center. The patient was showered, deloused if necessary and assigned to a bed. He would remain in bed for two days and would receive vitamins, forced fluids, tranquilizers and a high protein diet. He would be urged to participate in physical therapy and a psycho-therapy program which included socio-drama, group therapy, lectures and counselling.

The center was centrally located initially at St. Mary's Infirmary, which provided a convenient and friendly location. However, when the grant expired the program obtained state funding and was moved to the St. Louis State Hospital, which necessitated an hour's driving time to deliver patients and return. The hospital was also in a middle-class residential area which seemed to the police officers unfitting for derelict men. There were also difficulties with regard to patients being refused admission.

The patrolmen reacted against the center, not only because of its inconvenient location and the fact that drunk arrests had never had a high priority in St. Louis but also because they were skeptical that the

program really rehabilitated. This latter may have been the price of overemphasizing the curative potential of the new system.

A study of 200 patients made through interviews (by patrolmen) four months after discharge showed the following:

(1) 19 percent of the group had abstained from drinking following discharge for at least 4 months.
(2) 47 percent had shown "marked improvement" in drinking patterns.
(3) 49 percent had shown "marked improvement" in health.
(4) 15-18 percent had shown "significant improvement" in housing, income, and employment.(17)

For a group of men who were chronically ill and addicted these results could be regarded as showing a fair degree of success. However, when the St. Louis patrolmen were interviewed by Mr. Nimmer's staff, they were generally antagonistic and many indicated that they would no longer use the center.

The other objective of the project was of course to reduce expenditures within the criminal justice system. The projected savings to the system for 1967 were reported as $64,000. Since the project cost $200,000, no reduction could be demonstrated.

Raymond Nimmer sums up the value of the St. Louis project in the following way:

> The St. Louis detoxification program is often cited as a demonstration of the proposition that the criminal process can be reformed via the police initiated detoxification scheme. It is more accurately described as a demonstration of the difficulties which inhere in this approach to reform. At the very least, it suggests the desirability of taking a careful look at the police practices in the jurisdiction and if necessary, taking affirmative action to make them relevant to the goals of the program. If the goals are viewed as servicing the needs of all indigent public inebriates, the police practice can decisively frustrate the achievement of the goal. On the other hand the more limited approach, which sees the service population as including only those who have been picked up by the police, makes little sense where pickups are made on criteria unrelated to the service needs of the subject.
>
> The St. Louis experience suggests several steps in shaping police practices. Perhaps most important is the factor of convenience. Even under the best of circumstances, police will regard the skid row man as a secondary concern and will be influenced by the time required

to process a pickup. Also, the system must make itself congenial and inviting to the patrolman. Finally, it is vital not to over-promise and under-perform since this will merely fuel the skepticism of the patrolman about a medical-rehabilitation approach. (11)

The District of Columbia Detoxification Program

The Easter v. District of Columbia decision in 1966 held that chronic alcoholics could not be convicted under the public drunkenness statutes. Prior to this time, arrests for drunkenness had been heavy (averaging 40,000 annually from 1957 to 1965) for as the Nation's Capital it was felt that the streets should be kept clear of undesirables, and the police accepted their role in this objective. This system cost the city $3 million dollars annually and 5% of police time. Half of the expense ($1.5 million) resulted from incarceration costs, because arrest for public drunkenness carried a 30-day sentence.

After the Easter decision there was a good deal of confusion in the interpretation of what the police role should be in the new state of affairs. At the same time, riots and public concern over violence tended to give public intoxication a low priority. All this resulted in fewer arrests, and public inebriates were being left on the streets.

The first detoxification center was funded by the Office of Law Enforcement Assistance shortly after the Easter decision but was not implemented by the Public Health Department until eighteen months later. It was first located in the basement of the D. C. General Hospital, where 25 beds were made available. It was relocated in April, 1968 to a newly constructed 60-bed facility. The District of Columbia Alcoholic Rehabilitation Act was passed later in 1968 and authorized a broad rehabilitation network for alcoholics. A center for women was also opened in the D.C. General Hospital in 1971.

The Washington project differs from the St. Louis in several respects:

(1) It emphasizes nursing care and makes no effort toward rehabilitative therapy and counselling, relegating rehabilitative efforts to other agencies via referral.
(2) Fifty-five percent of the patients are released after one day and the remainder after three days of treatment with a resultant low average per patient cost and a minimal deprivation of the patient's liberty.
(3) The District of Columbia program admits self-referred patients on an equal basis with police admissions and the rate of self-admissions is high. Except with respect

to their residence (most walk-ins live in the vicinity of the center) and arrest record (walk-ins have fewer arrests) the self-admitted and police-admitted groups have similar characteristics. The high rate of self-admissions suggests that an open door may be a feasible strategy to reach the derelict.(11)

The project has had many difficulties. There is a vast difference between the way the patrolmen interpret the new system and the way in which it is interpreted by the public health system and the way the reform elements within the criminal justice system see it. There has been no attempt to instruct patrolmen in their role. No course on detoxification is offered at the police academy and the public health personnel have shown no interest in implementing such a course.

The program has been evaluated by a research team from George Washington University. The team felt that the program has demonstrated that a nursing care service is feasible and economical, but notes that the program makes inadequate provision for patients after release in terms of shelter, clothing, and food, and that the program is ineffective in keeping patients long enough for complete withdrawal from alcohol.

Of the patients in the evaluation sample who volunteered for treatment, 43 percent left before their treatment term was finished. The effort at referral to other agencies was also largely unsuccessful. Only 16 men handed in referral cards to the Alcoholic Rehabilitation Clinic (ARC) out of a total of 1,282 men referred.

The total cost of the program has been roughly estimated at $1.7 million per year. Previously the cost to the criminal justice system was $3 million, half of which was spent on the costs of incarceration. The detoxification center eliminates this expense by releasing each patient within 3 days of his admission.

Raymond Nimmer sums up the District of Columbia experience in the following manner:

> The theme of strained relationships between the police and the detoxification program occurs in both St. Louis and Washington leading to the suspicion that it may be a chronic condition of police-initiated systems. Especially difficult to counteract is the apparent tendency of the police to treat detoxification pickups as a low priority concern -- to be avoided if possible and to which little time or effort should be devoted. In a contemporary context in which public concern for violent crime is high, the low priority stance is probably irremediable. Thus, a police initiated process, it would seem, must either accept the fact that many prospective patients will be ignored or should take steps to make police admissions convenient and speedy for the officers.
>
> The Washington process suggests the feasibility of

opening the treatment program for self-admissions. Over 50 percent of the center's patients are in this category and the high rate of self-admissions suggests that a pick-up process, whether or not police initiated is not the the only strategy available to provide care while an inebriate sobers up. Accepting self-admitted patients can be a technique for ameliorating the effect of police practices that leave prospective patients on the street.

The per-patient-day and per-patient-term costs of a detoxification process are not absolutes, but can be manipulated by modifying the services that are provided. The Washington process is much more efficient than the St. Louis Model - twenty dollars a day for one to three days vis-a-vis forty dollars a day for four to seven days. The extent to which the Washington program deals less adequately with the medical needs of its patients or the rehabilitative concern of the state is not clear. It is not possible therefore, to make the balancing assessment necessary to determine whether a program which reaches more patients for less cost is, in the long run, preferable to the effort of reaching few men at high cost. In the short run, however, the less expensive program more clearly meets a realistic assessment of available funds.

Finally, the enormous cost and time savings recorded in the District of Columbia support two observations concerning the efficacy of obtaining similar economies elsewhere, not by implementing a detoxification program but through a large cut-back in the number of police contacts with the men. First, the D. C. experience provides physical evidence of the obvious proposition that a lower level of contacts will involve lesser costs. Reduction from forty thousand to six thousand was largely responsible for the enormous saving in the District; a reduction from forty thousand to zero would produce even larger gains. Second, the D. C. experience demonstrates that a large reduction can be feasible even in a city whose populace was thought to be highly interested in clean streets. Nothing in our observations indicates that a similar acceptance would not occur if the police contacts were still labelled arrests. (11)

The Vera Institute Programs

The Vera Institute programs in the Bowery differ from both the St. Louis and Washington projects in that the objective was explicitly defined as meeting the needs of the skid row men.

The Manhattan Bowery project was begun in 1968 with a budget of $635,800 made up from federal, state, and local funds. The financial responsibility for the project was eventually assumed by the Department of Mental Hygiene and the City's Community Mental Health Board.

The three original premises on which the program was based, after an initial study of the situation in the Bowery, were:

1. That there was an urgent need for emergency street rescue services for the homeless alcoholic.
2. That such services should be tied to existing long-term rehabilitation programs; and
3. That all efforts and services should operate on a voluntary basis.(11)

Rescue teams consisting of a recovered alcoholic and a plain-clothes police officer offer assistance only to those men who are so intoxicated or debilitated that they are unable to care for themselves. Patrols are made in unmarked police vehicles and care is taken to avoid the appearance of an arrest.

Although the St. Louis and Washington programs also use the term "voluntary", coercion is present. However, the degree to which a semiconscious person can make decisions for himself might also be questioned. In any event 60 percent of the men approached accept the services of the center. The center also accepts self-referrals, but limits this kind of patient to 25 percent of the total. Eight or nine men are picked up on an average day.

Vera's services include a detoxification center, an after-care outpatient program and an emergency medical clinic, all of which are housed in the Municipal Men's Shelter.

On admission, a physician conducts the initial screening; individuals having no serious medical problems are showered and placed in beds in the detoxification center. A thorough medical examination is given. They remain in the acute ward for 3 days and are given treatment to ease the withdrawal from alcohol. On the third day they may be moved to the recuperative ward where recreation is available.

Each case is assigned a social worker and a history is taken and plans made for his care after leaving the center. After the plan is discussed by a committee of physicians, psychiatrists, and nurses, a referral plan is suggested. If the patient is willing, the caseworker contacts the outside agencies. The most frequently used resources are State Hospital rehabilitation units, psychiatric wards in general hospitals, a city-run camp for homeless men or the project's own after-care clinic. About 47% of the patients do not accept referrals.

The medical clinic on the first floor of the shelter is run by staff from St. Vincent's Hospital and is funded by the New York City Bureau of Social Services. It was developed by the Vera Foundation to provide medical care to Bowery men regardless of whether or not they are intoxicated.

The medical clinic is operated in much the same fashion as the detoxification center, i.e., patients are brought in by a rescue squad. However, they are held only long enough to provide treatment (3 or 4 hours) and the rate of voluntary acceptance is higher. Only 14 percent of 4,717 men approached in the first year refused help.

The Bowery projects emphasize their "service" orientation and the programs have not been formally evaluated. However, Raymond Nimmer's summation of his inquiry into the Vera projects is as follows:

> The Vera programs were not wed at the outset to the idea that the service problem involved providing care for intoxication. Rather the issue was explicitly viewed as a skid row service problem and only after a survey of needs was the desirability of a detoxification program accepted and the program implemented. The explicit recognition that the concern was with services for skid row permitted a flexibility in Vera's outlook and facilitated the creation of a second system - the medical clinic - which is not limited to alcoholics and inebriates.
>
> Both of the Vera units employing a pickup operation utilize civilian rescue squads. In each case the rescue squads function to locate and bring in patients who fit the objectives of the program. Unlike St. Louis and Washington pickups, no systematic exclusion of skid row men occurs that is unwarranted by the objectives of the program.
>
> The rate of voluntary acceptance of assistance is substantially different between the center and the medical clinic. This suggests that the acceptance rate will vary according to the type of services provided. It is not clear what factors influence the rate but considerations such as the length of treatment, emphasis on rehabilitation and quality of service suggest themselves. The issue deserves inquiry because if an expected 60 percent acceptance rate is considered too low and precludes the use of a civilian squad in a voluntary format, modifications in services leading to a higher rate of acceptance might make the voluntary model acceptable to policy makers. (11)

We have not yet arrived at the ideal solution for handling the problem of the public inebriate. The problem will exist as long as skid row exists and the final solution to skid row is not in sight.

It seems inevitable that the service part of the problem must be absorbed by the health care system despite the fact that the three experimental projects described above were initiated by the criminal justice system. Federal funding is necessarily a temporary procedure and a permanent plan is called for.

Relieving the burden on the criminal justice process can be considered as a separate issue and this has been suggested. It is possible to simply not arrest the public inebriate. He would probably be little worse off than he is under the present system.

Although our society is built up around a myriad of interrelated phenomena it is managed by many separate systems. It would seem that instead of emphasizing the disparate nature of these systems, closer integration and cooperation is essential if we are to solve the problems. Within the criminal justice system other concerns (apart from drunkenness) are badly in need of scrutiny by the personnel from other fields and the reverse is of course also true.

With regard to the public inebriate some guidelines are possible:

1. A centrally-located facility where walk-ins are possible is preferable to an isolated center such as a state hospital. Such an arrangement ensures the voluntary nature of the admission, cuts down on the expenses of the pick-up squad and is preferred by police.
2. If a pickup squad is used, then the procedure must be voluntary. Although the compulsory removal of an inebriate is generally regarded as appropriate, in a state that has officially declared alcoholism to be an illness, not a crime, the legal basis for compulsion does not exist. Involuntary treatment is also unacceptable from the medical point of view.
3. Civilian rescue teams are probably preferable to patrolmen. However, if police are used they must be trained to recognize illness and psychosis.
4. A general medical clinic such as that established by Vera will apparently bring in more men than a detoxification center per se.
5. Welfare rules and health insurance company policies must be changed to allow for treatment for alcoholism.

In all this nothing has been said about dealing with the drinking driver or the violent individual with an alcohol-related problem. The 1 to 4 percent of drivers responsible for 48 to 57 percent of fatal car crashes no doubt is comprised of many alcoholics. Methods need to be devised to reach this group.

Alcohol-related violent behavior has received little attention and it is generally considered that nothing can be done about this type of crime. However, it is a problem not unrelated to suicide (25 percent of suicides are alcohol-related) and the "crisis center" format might possibly be of some help. As research develops in this area the methods to deal with it may become clearer.

CHAPTER IV

TREATMENT AND CONTROL OF ALCOHOL PROBLEMS

Current State of Treatment for the Alcoholic

Strong feelings of pessimism still persist with regard to the treatment of the alcoholic. We have seen in the St. Louis experiment that overly-optimistic attitudes toward rehabilitation have produced skepticism and disinterest in the policemen having to deal with the problem. The question of whether or not such skepticism is justified should be seriously considered.

The following excerpt is taken from a publication of the Center for the Prevention and Control of Alcoholism (now the National Institute on Alcohol Abuse and Alcoholism). It appears under the heading "Chances of Recovery":

> In evaluating the future outlook of alcoholics many therapists divide patients into three broad groups.
> 1. The psychotic alcoholics. These are patients, usually in State Mental hospitals, with a severe chronic psychosis. They may account for five to ten percent of all alcoholics.
> 2. The Skid Row alcoholics. These are the impoverished "homeless men" who usually no longer have - or never did have - family ties, jobs or an accepted place in the community. They may account for three to eight percent.
> 3. The "average" alcoholics. These are men and women who are usually still married and living with their families, still holding a job - often an important one - and still are accepted and reasonably respected members of their community. They account for more than 70 percent of alcoholics.
>
> From the scanty information available it would appear that the prognosis for chronic psychotic and Skid Row alcoholics is poor and that less than 10 to 12 percent can obtain substantial aid from ordinary therapy. For the average alcoholic, the outlook is far more optimistic...(18)

These are discouraging words to anyone interested in the problem of the public inebriate. However, they form but one opinion and that admit-

tedly based on "scanty information." Recent studies have produced a somewhat higher rate of success. As reported earlier, 19 percent of the St. Louis study group remained abstinent for at least four months after discharge. A Boston halfway house program for skid row alcoholics reported 22 percent successfully rehabilitated (15). These figures, although higher, are still not particularly encouraging. It is possible that rather than complete cure or total abstinence the goals for skid row men should be based on improved health and better living conditions. Alcoholism is a chronic illness in the same sense as diabetes or mental illness and to refuse treatment to these conditions would not be tolerated. Suffering must be relieved to the extent that it is possible.

Addiction occurs in about 10 percent of alcohol users and takes from three to twenty years to develop. Addiction-producing drugs, on the other hand, produce addiction in 70 to 100 percent of users and the addictive process takes only two to four weeks.

The causes of alcoholism are not well understood. Theories are various and complex but it is generally agreed that anxiety or tensions play a part. The social milieu may also contribute by stimulating excessive drinking. Differences in metabolism may also be a factor.

The term alcoholism has been indiscriminately used to cover all types of problem drinking. As we have seen, problem drinking takes many forms even when considered within the limits of the criminal justice system. There have been many different attempts to refine the definition of terms with regard to alcohol. The Cooperative Commission on the Study of Alcoholism defines problem drinking as a "repetitive use of beverage alcohol causing physical, psychological or social harm to the drinker or to others". This is a broad definition which includes alcoholism, which is defined as "a condition in which an individual has lost control over his alcohol intake in the sense that he is consistently unable to refrain from drinking or to stop drinking before getting intoxicated".

Even within this narrower definition of alcoholism many stages have been described and individuals within the same phase differ greatly and different types of treatment and assistance are necessary.

For purposes of discussion the general treatment of alcoholism may be considered as of three types - emergency treatment for acute intoxication, inpatient care, and after care.

It is in the stage of acute intoxication that the police most frequently come in contact with the chronic alcoholic. The inebriate may be simply severely intoxicated, or in a comatose condition. The public inebriate in this condition may also be suffering from pneumonia, tuberculosis, contusions and even fractures. The treatment required to deal with acute intoxication may range from measures to deal with hepatic compensation, gastro-intestinal bleeding, fluid imbalance and deep coma, to simply the giving of food and a sheltered place to sleep off the effects of the excessive alcohol.

Delirium tremens, a withdrawal symptom which is marked by hallucinations (usually visual) and often extreme dysphoria, must be prevented.

Currently more men are "dried out" in jails than in all other kinds of facilities combined.(8) The literature on alcoholism abounds with lurid descriptions of the "drunk tank" - which is usually described as reeking with the stench of urine and vomitus from men unable to care for themselves in an overcrowded and unventilated cell. Every year most large cities have several deaths of intoxicated prisoners. However, it is generally agreed that the fault is not with the law enforcement agencies. Police and jail personnel do not regard these men as criminals. The fault lies with the community for not developing alternative methods to deal with the problem.

In the treatment situation, when the acute stage of intoxication is over, the patient usually requires some kind of medication to help him over the difficult early stages of getting along without alcohol. Tranquilizers are frequently used to reduce the anxieties and tensions which most alcoholics believe triggered their drinking bouts. Vitamins are administered as most alcoholics are deficient in this respect because they do not eat while they are drinking. Sometimes aversive therapy, i.e., the use of apomorphine (or emetine) which produces nausea, is given along with alcohol. A more popular method is the use of disulfiram (Antabuse) or citrated calcium carbimide (Temposil). These drugs also produce nausea and vomiting together with headache and flushing when alcohol is taken. Hypnotherapy and electric shock are also sometimes used in aversive conditioning. Psychotherapy usually in the form of psychodrama or group therapy is also used as a treatment modality.

Residential treatment is most frequently carried out in the state mental hospital. As many as 40 percent of all men admitted to mental hospitals in some states are given a diagnosis of alcoholism. Less than half are admitted on a voluntary basis. If a skid row man obtains admission to the mental hospital, he is usually not assigned to the alcoholism unit but is placed elsewhere in the hospital.

Outpatient care is provided usually by alcoholism clinics and psychiatric clinics. Currently there are approximately 130 alcoholism clinics in the United States.(8) Their approach is largely psychological although medication is dispensed in some. Their success rate is presumed to be better than that of the general psychiatric clinic. A great many patients also receive help from private physicians and of course from Alcoholics Anonymous groups.

As we have seen there is little that is new in the current treatment of the alcoholic. Since the field has been neglected for so long this is not surprising. To date few consistent physiological differences have been found between problem drinkers and non-problem social drinkers, but research has been uneven and sporadic.(8) New information is urgently needed on which to build better treatment methods.

Prevention of Drinking Problems

With the increasing consumption of alcohol in our population, the

presence of at least 5 million problem drinkers, and the relative ineffectiveness of treatment as "cure", it is obvious that treatment alone is not going to solve the problem. Even if treatment were improved and successful rehabilitation were guaranteed, it is obvious that there will never be enough therapists to treat the number of alcoholics in the population. Consequently, serious consideration should be given to prevention of the problem.

One approach to prevention might be to ban the sale of alcohol or to tax it so heavily that it is not easily available. But we have seen the results of such measures in the Whiskey Rebellion and in Prohibition. We have taken those routes and we know they do not work.

Although our knowledge with regard to the causes of alcoholism is far from perfect, we do have some clues that might be made use of in a preventative program.

We have seen that a large percentage of alcoholics attribute their excessive drinking to anxieties and tensions. It is possible of course that the alcoholic is basically a person who suffers more deeply than others from the strains of day-to-day living. However, the problem is so prevalent that a broad-side attack does not seem inappropriate. Hence, anything that can be done to improve the mental health of the community, such as providing "crisis" centers for various kinds of personal problems or improving the general public's understanding of the nature of human reactions in traumatic situations, would be beneficial. In a Utopian society where poverty were eliminated, opportunity were equal, where medical services were provided for all and where no one need feel alienated, it is doubtful that alcoholism would be a problem.

Other characteristics of drinking in America are the darkened bar where food is frequently not available and drinking for the sake of drinking is the keynote; the custom at parties of keeping liquor glasses perpetually replenished; and advertising which rarely if ever depicts drinking in a family situation but stresses "the men only" concept. All this could probably be changed if a concerted effort were made through the mass media, if the liquor companies could be influenced to change their approach in advertising and if all licensed premises could be prevailed upon to introduce food and other activities along with the drinking.

Young people need to be helped to adapt to a drinking society. We have previously seen that a large percentage of high school students drink despite the illegality of drinking for persons under 21 years of age. This does create a hypocritical situation that may breed contempt for law. Consideration should be given to changing the law to make it more compatible with the reality situation and to avoid the implication that drinking is a symbol of maturity.

Along with drug abuse information, alcohol education should be part of the curriculum. More particularly, alcohol-education should be part of all driver-education courses.

Research Needs

Because of the long neglect of the alcohol problem, special atten-

tion to this area is urgently needed. Research on alcohol, however, cannot be done in isolation because many of the issues are basic to other problems. For example the exact nature of addiction is of interest to drug abuse and in obesity as well as in alcoholism. When this is understood, it will probably be possible to develop drugs to eliminate a voracious craving for any substance.

It is not intended here to describe pharmacological and medical research needs in detail, but a few will be mentioned in passing.

1. Effective drugs are needed for the safe, rapid alleviation of hangover to break the drinking cycle of many alcoholics who drink to relieve hangover symptoms.
2. Better non-addicting drugs should be developed for the relief of emotional tension as substitutes for alcohol.
3. Further studies are needed for any chemical, physiological hormonal, metabolic, or other basic constitutional differences which may exist between problem drinkers and normal social drinkers.
4. More information is needed on the effect of specific foods, carbohydrates, fats, and proteins in protecting against dangerously high blood-alcohol levels.(I8)

In the psycho-social area research in the following areas is needed:

1. Longitudinal studies, beginning early in life, to determine the psychological, sociological, and cultural factors (as well as physiological) that may be related to alcoholism.
2. Better techniques need to be developed for psycho-therapy with alcoholics.
3. Further studies on low-and high-incidence cultural groups to determine in more detail differences which may be important for prevention.
4. Reliable methods need to be developed to accurately measure the incidence of alcoholism in geographical areas, vocations, races, age groups and other socio-economic categories.
5. Baseline information on the rates of problem drinking to better assess the effects of various educational and other approaches to prevention.

Within the criminal justice system the following studies are needed:

1. Studies of the impact of legal controls on drinking behavior.
2. The development of better statistical measures for more accurately reporting alcohol-related arrests and alcohol-related motor vehicle accidents.

3. Investigation of the feasibility of keeping an Alcohol-Incident record that could be used as a case-finding aid in studies of alcoholic criminal careers and as an aid to parole and probation officers.
4. Further studies of the role of alcohol in violent crime and in non-violent felonies.
5. Surveys of the attitudes of policemen, parole officers, and judges toward the alcohol-related offender to determine training needs and informational needs in disposition of cases.
6. Prison surveys to determine the extent and nature of service for the alcohol-related offender toward improving rehabilitation methods and treatment within the correctional system.
7. Intensive physiological, psychological, and sociological, as well as longitudinal, studies of juvenile delinquents who drink excessively. Such studies would provide a better understanding of the possible causes and course of alcoholic criminal careers as well as providing a basis on which to build better rehabilitation measures.

CHAPTER V

Sources of Support and Information

The impetus for Federal support for local and state efforts to combat alcoholism was given in March 1966 by President Johnson in his Health message to Congress:

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

The creation of the National Center for the Prevention and Control of Alcoholism was announced in October, 1966. It has since been reorganized on a broader base as the National Institute on Alcohol Abuse and Alcoholism.

The Cooperative Commission on the Study of Alcoholism, established in 1961, had visualized a permanent structure, an "Interdepartmental Committee" on the basis that problem drinking could not be controlled unless the accompanying problems are also dealt with. The "other" alcohol problems are of course such issues as "the unwillingness to examine American drinking patterns, disagreement about what constitutes acceptable and unacceptable drinking behavior, the relation of alcohol use and criminal behavior, drinking and driving, laws and regulations regarding conditions of sale (including hours, minimum age, prices and so on), the relationship between advertising and drinking practices, and the Skid Row subculture." Participation in such a committee was viewed as follows:

> Elements of the Federal government that should participate in an Interdepartmental committee include the Department of Health, Education, and Welfare; Transportation (Traffic Safety); Agriculture (Wine Industry); Defense (both because it has more problem drinkers than

any other Federal agency and because it runs a very large liquor business of its own!); Labor (dealing with problem drinking in work settings); Housing and Urban Development (Skid Row); Treasury (Alcohol and Tobacco Tax Division of the Internal Revenue Service); plus independent agencies such as the Veterans Administration, Office of Economic Opportunity, Civil Service Commission, Federal Trade Commission and the Federal Communications Commission.

The Law Enforcement Assistance Administration had not been created at the time of this report and has not been included in this list of agencies interested in various aspects of the alcohol problem. Since that time, informal liaison has been established among various government departments, including the Department of Justice. However, complete collaboration is difficult because of the diverse nature of the problems and the fact that the various aspects of the alcohol problem have for so long been viewed in isolation from each other.

Despite these difficulties, some collaborative efforts are being made. A conference on "Alcohol Countermeasures Public Information Seminar" was recently held at the University of Michigan. It was sponsored by the Allstate Foundation of the Allstate Insurance Company, the Insurance Institute for Highway Safety, Licensed Beverage Industries, Metropolitan Life Insurance Company, National Highway Traffic Safety Administration of the U.S. Department of Transportation, National Institute on Alcohol Abuse and Alcoholism of the U.S. Health Education and Welfare Department, Occidental Life Insurance Company and the United States Brewers Association. Despite a reporter's comment (19) that "The people directly involved, public officials, and private companies and individual citizens, walk gingerly around the problem as if they were treading on thin-shelled eggs", even to bring such diverse elements together to consider the problem is a somewhat remarkable feat.

Another conference jointly sponsored by the National Institute on Alcohol Abuse and Alcoholism, the Law Enforcement Assistance Administration, and the National Highway Safety Administration will be held in February 1972, to consider the problems of the public inebriate, alcohol-related felonies and the drinking driver. It is hoped that this meeting will provide an opportunity for free exchange of information among participants concerning effective and humane alternatives for handling alcohol abusers. Regional representatives of all three Federal agencies will be present and the proceedings of the conference will be printed and disseminated to the regions.

Apart from Federal government resources, support for research in alcohol problems has been given by the Christopher D. Smithers Foundation (which recently contributed $10 million to the Roosevelt Hospital in New York City for treatment and rehabilitation of alcoholics), the Ford Foundation, American Heart Association, the Board of Christian Social Concerns of the Methodist Church, the Nutrition Foundation and the United

States Brewers Association and the Wine Advisory Board, an agency of the California State Department of Agriculture.

The Rutgers Center of Alcohol Studies (located at Yale from 1940 to 1962) is a center for research, education, post-graduate training, demonstration, documentation and publication. Its Quarterly Journal of Studies on Alcohol is probably the most authoritative publication in the field.

The World Health Organization is a source of information on the problems of alcohol from an international perspective.

The National Council on Alcoholism (originally the National Committee for Education on Alcoholism) was founded in 1944 as a national voluntary health organization. There are many local alcoholism committees or councils across the country and they serve as a very large group of potential volunteers.

The North American Association of Alcoholism Programs (NAAAP) is composed of administrators of government-supported programs for treatment, education and research in alcoholism. It was organized in 1949 and established a full-time central office in Washington, D. C., in 1963. Over thirty-five states operate such programs.

Alcoholics Anonymous was founded in the 1930's and has had a great impact in changing public attitudes toward alcoholism. It has been one of the first and most outstanding of the self-help groups and has been of great importance in leading the way in the rehabilitation of problem drinkers and is still a valuable resource. Al-Anon and Al-Ateen are companion organizations designed to give support to the spouses and children of alcoholics. There are more than 650 Alcoholics Anonymous groups in American prisons and jails.(20)

Mention should also be made of the Salvation Army and the Volunteers of America who have provided substantial amounts of care to skid row inhabitants.

This is not intended as an exhaustive list of all possible sources of help. Only those with the more specific interest in the problem have been mentioned.

In Conclusion

In looking back at the Total Arrest Trends table on page 6 it will be noted that almost all crimes showing a decrease from 1969 to 1970 are alcohol-related. Although it is not wise to put too much credence in small shifts in arrest rates, this is a trend that has been apparent since 1960.

It seems to be a possibility that the decrease in arrests for public drunkenness and related offenses may be due to the increasing numbers of public inebriates being diverted from the criminal justice system into treatment facilities. With decreases in at least a few of the felony categories that have some relationship to alcohol - e.g., manslaughter

by negligence, car theft, and sex offenses, the hope is born that when treatment and education with regard to alcohol problems become more general, the results will be reflected across the broad spectrum of crime.

REFERENCES

1. Graham, Donald E., Liquor Consumption, Related Problems are Increasing. Washington Post, February 7, 1971.
2. Chafetz, M.E. and Demone, H.W., Sr., Alcoholism and Society. New York Oxford University Press, 1962.
3. Gillespie, Duff G., Alcohol, Alcoholism and Law Enforcement. Washington University, St. Louis, 1969.
4. Mulford, H.H., Drinking and Deviant Drinking. U.S.A. 1963, Quarterly Journal of Studies of Alcohol, 25:634-650, 1964.
5. Maddox, G.L., Teen-age Drinking in the United States, in Pittman D.J. and Snyder C.R. - Society Culture and Drinking Patterns New York: John Wiley and Sons, Inc., 1962.
6. Hollister, Burr C., Alcoholics and Public Drunkenness: The Emerging Retreat from Punishment, Crime and Delinquency. National Council on Crime and Delinquency, Vol. 16 #3, 1970.
7. Rubington, Earl, Types of Alcoholic Offenders. Federal Probation, March, 1969.
8. Plaut, F.A., Alcohol Problems: A Report to the Nation. Report of the Cooperative Commission on the Study of Alcoholism. Oxford University Press, New York, 1967.
9. Task Force Report: Drunkenness. President's Commission on Law Enforcement and Administration of Justice, Washington, D.C., U.S. Government Printing Office, 1967.
10. Pennsylvania Crime Commission Task Force Report: Alcohol and the Criminal Justice System, 1969.
11. Nimmer, Raymond, Two Million Unnecessary Arrests. American Bar Foundation, Chicago, 1971.
12. Crimes of Violence: A Staff Report to the National Commission on the Causes and Prevention of Violence. U.S. Government Printing Office, Washington, 1969.
13. Bensing, R.C. and Schroeder, O., Homicide in an Urban Community. Charles Thomas, Springfield, 1960.
14. Ervin, Frank R., Massachusetts General Hospital Department of Psychiatry, Verbal communication.
15. A Report on Non-Victim Crime in San Francisco - Part I Basic Principles, Public Drunkenness. The San Francisco Committee on Crime, April 26, 1971.
16. Manhattan Bowery Project. First Annual Report, April 1969.
17. St. Louis Detoxification and Diagnostic Evaluation Center. St. Louis Metropolitan Police Department, St. Louis, Missouri, U.S. Government Printing Office, Washington, D.C.
18. Alcohol and Alcoholism, National Clearinghouse for Mental Health Information, Publication No. 1640 Revised, 1969.
19. Friedlander, Paul J.C., How Do We Handle Drunk Drivers? New York Times, December 26, 1971.
20. Roth, Loren H., M.D., et al, Prison Adjustment of the Alcoholic Felon, Quarterly Journal of Studies on Alcohol, Rutgers University, New Brunswick, New Jersey, Vol. 32 No. 2, June, 1971.

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