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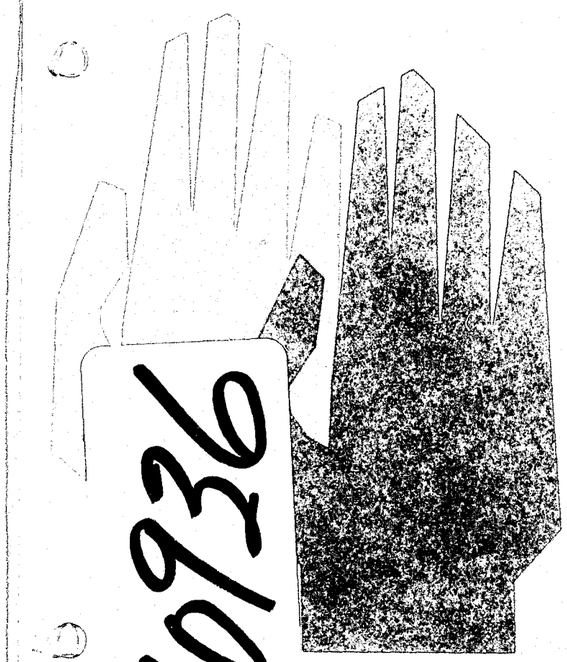
Grant #284 (S. 093)

THE ST. LOUIS DETOXIFICATION and DIAGNOSTIC EVALUATION CENTER



LEAA PROJECT REPORT

THE ST. LOUIS DETOXIFICATION AND DIAGNOSTIC EVALUATION CENTER

Project Summary

Final Project Report

Final Evaluation Report

Submitted to

Law Enforcement Assistance Administration
U. S. Department of Justice

by

St. Louis Metropolitan Police Department
St. Louis, Missouri

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A C K N O W L E D G E M E N T S

This research was made possible by a grant from the Office of Law Enforcement Assistance of the United States Department of Justice to the St. Louis Metropolitan Police Department.

It is impossible for us to express adequately deep gratitude to the many agencies and individuals who have made this project possible. Nevertheless, special mention can be made of just a few of those who represent some of the general support given through special contributions that they made.

---- The State administration under the guidance of Governor Warren E. Hearnes; George A. Ulett, M.D., Director of the Missouri Division of Mental Diseases; Ronald J. Catanzaro, M.D., Director of the Missouri Alcoholism Program; Ivan W. Sletten, M.D., Director of the Missouri Institute of Psychiatry of the University of Missouri Medical School; and the Governor's Advisory Council on Alcoholism under the chairmanship of Nicholas Veeder.

---- The administration of the St. Louis Metropolitan Police Department under the leadership of the Board of Police Commissioners through its previous President, Colonel Edward L. Dowd, and his successor Colonel I. A. Long; Colonel Curtis Brostron, Chief of Police; Captain Frank Mateker, Director, Planning and Research Division; and those members of the Planning and Research Division staff who labored so competently and industriously to insure the success of the project.

---- The Social Science Institute of Washington University under the guidance of its Director, David J. Pittman, Ph.D.; its consultant to the project, Laura E. Root, M.S.W.; and former Patrolman James Weber, who conducted the patient evaluation research for the project.

---- The Sisters of Saint Mary under the guidance of Mother Mary Josetta, S.S.M., Mother General of the order, and Sister Eugene Marie, S.S.M., former Hospital Administrator of St. Mary's Infirmary.

---- The Governmental Research Institute of St. Louis, under the guidance of its Director, Victor Brannon, Ph.D., and Grant Buby, Assistant Director, for its valuable and constant counsel.

---- Those community agencies and resources which were so helpful in augmenting the work of the Center, with a special

word of appreciation to Alcoholics Anonymous and Al-Anon, as well as the Lutheran Church, Missouri Synod, for their provision of a Chaplain and numerous volunteers.

---- The various elements of the news media who provided a continuing and sympathetic portrayal of the development of the Center. Particular mention should be made of Miss Marguerite Shepard of the St. Louis Globe-Democrat for her feature writing, and of Miss Pat Williamson of KSD-TV and Gary Robinson of KMOX-TV for their documentary specials on alcoholism.

---- The public at large - both lay and professional - whose warmhearted support and generous contributions of time and money aided so much the on-going operation of the Center.

---- The entire staff of the Center whose energy and loyalty made possible the implementation of the effective total treatment approach.

---- Finally and perhaps most important, the patients treated at the Center who gave as much as they received towards the total success of the project and the development of an increasing body of knowledge about the disease of alcoholism.

Joseph B. Kendis, M.D.
Medical Director

Michael Laski
Project Co-Director

ST. LOUIS DETOXIFICATION AND DIAGNOSTIC EVALUATION CENTER

PROJECT SUMMARY

BACKGROUND

The disease of alcoholism - the third largest public health problem in the nation - is an extremely significant one in that there are an estimated 6.5 million persons in the United States with a serious alcohol problem. Of that number 1.5 million are chronic addictive alcoholics and other Americans are addicting at the rate of 200,000 per year. These individuals are found in all segments of our society, at all class and all occupational levels.

The skid row or "public intoxicant" constitutes an estimated eight percent of the chronic addictive alcoholic population. That this segment is a major problem is attested to by the fact that they account for approximately two million arrests annually across the country. A large number of these actions involve the repeated arrest of the same man, reflecting the familiar pattern of the "revolving door" alcoholic - intoxication, arrest, conviction, sentence, imprisonment, release, intoxication and rearrest.

In an effort to cope with this problem, Colonel Edward L. Dowd, former President of the Board of Police Commissioners for the St. Louis Metropolitan Police Department, and David J. Pittman, Ph.D., Sociologist and Director of the Social Science Institute of Washington University, with the assistance of many other key persons, developed the plan for a detoxification center. Their initial planning was based on a number of observations, including the following:

1. There is a growing acceptance of the fact that alcoholism is a disease and should be treated as such - a concept reinforced by recent court decisions.

2. Clinical results from some European countries and also from the Alcoholic Treatment and Research Center in St. Louis give indication that the public intoxicant can benefit from and respond to treatment.

3. There are very few services of any kind available in communities for the public intoxicant.

4. From the standpoint of the police, the "revolving door" alcoholic takes the police officer away from other duties for a disproportionately large amount of time.

5. Empirical evidence indicates that repeated jailing is neither a deterrent nor a successful rehabilitation technique for the public intoxicant.

On the basis of these observations, a proposal was designed and submitted to the Office of Law Enforcement Assistance, United States Department of Justice, to establish a 30 bed unit within the facilities of St. Mary's Infirmary offering medical treatment and supportive social and rehabilitative services. In October, 1966, a grant of $158,781 was received from OLEA and four weeks later the Center was in operation - the first such unit sponsored by a Police Department in the Western Hemisphere.

Broadly stated, the goals of the experiment were twofold:

1. To determine to what extent this process might effect a time saving on the part of the police and indirectly upon the court and the penal institution.

2. To determine what rehabilitative effect a short-term treatment approach might have on the life style of the chronic public intoxicant and to what extent his "revolving door" pattern could be altered.

METHOD OF APPROACH

As implied earlier, one of the primary expectations of the demonstration project was that it would put the police officer back in service more quickly than was possible under the prior procedure of handling the public intoxicant through the criminal process. Under that existing procedure the arresting officer must convey the public inebriate to a City Hospital, await medical examination and possible treatment, take him to the Prisoner Processing Division for booking and detention, determine if he is wanted by a police agency for a previously reported crime, prepare a report, and apply for a warrant (in another building). If the warrant is issued and the offender pleads not guilty the officer must later appear in City Court.

Under the Center experimental program this procedure was revised so that the officer merely conveyed the inebriate to the Detoxification Center, helped him into the building, filled out an admitting form, checked by telephone to see if the subject was wanted on a prior charge, and returned to his patrol assignment.

Because the Center's 30 bed unit was inadequate to service all nine police districts of the City, the decision was made to

limit intake to those three districts that included the inner city and immediately adjacent areas. Therefore it was only in these three districts that the innovative procedure was used. It should be noted, however, that these target districts, while constituting only 37.4 percent of the City population, accounted for 81.8 percent of the drunkenness arrests in 1966.

The other primary expectation of the Demonstration Project was that a short-term treatment approach might have some positive impact on the "revolving door" pattern of the chronic public intoxicant. The gist of this approach was to hospitalize the public intoxicant at the Center for seven days, essentially on a voluntary basis, treating him through a variety of therapeutic techniques. These included medical examination and treatment, counselling and evaluation (social/vocational/employment), group therapy, work therapy, didactic lectures and films, socio-drama, and Alcoholics Anonymous. Paralleling these therapies, aftercare plans were worked out with him in regard to housing, employment and further treatment if necessary and desired. The purpose of the procedure is: to "dry out" the public intoxicant, build him up physically, begin the process of social rehabilitation, and return him to the community under circumstances favorable to his efforts toward increased sobriety.

It was anticipated - and subsequently borne out- that the community aspects of the total treatment approach would be the most difficult because of negative attitudes toward alcoholics and especially the public intoxicant, the lack of appropriate facilities, and a dearth of workers knowledgeable in the field of alcoholism. As a first step to meet this situation, thirty community health and welfare agencies were invited to the Center for a tour and orientation. Fifty-five people from twenty of these agencies responded and indicated their willingness to support the endeavor. This general session was followed up by individual, personalized contacts with each of these agencies, as well as with some who did not attend, to attempt to strengthen their knowledge and commitment, and to crystallize the details of an on-going working relationship. During this process a few agencies indicated they were "not really equipped" to work with the public intoxicant. Later on in the operation of the Center still other agencies indirectly indicated the same position by neither accepting nor acting upon referrals. Nevertheless this approach did yield essentially what we were seeking - a nucleus of facilities and staff persons in a variety of agencies which represented <u>effective</u> referral resources for the public intoxicant upon discharge from the Center.

An interesting though tangential development in the relation-

ship between the Center and the broader community is reflected in the fact that as our operation became more widely known its potential as a training site was noted by university faculties. As a result at one point seventeen students were placed with us from four universities, representing five disciplines - psychiatry, social work, nursing, sociology and psychology. An indication of the keen interest of the national and even international community was the fact that we have received visitors and inquires from almost seven hundred persons representing over forty states and six foreign countries all posing the same questions: "How did you get started?" "How do you operate?" "What results are you getting?" "How do we go about setting up one just like this?"

EFFECT ON LAW ENFORCEMENT AGENCIES

The data relative to the impact of the Detoxification Center on the Police Department, the City Court and the Medium Security Institution (Workhouse) were compiled and analyzed by the Planning and Research Division of the St. Louis Metropolitan Police Department from files and reports from those three agencies. Findings for this aspect of the research were arrived at essentially by comparing relevant figures from 1966 with those from 1967.

Police Time

In studying the data on arrests of the drunkenness offender in the three target police districts in 1966 it was learned that the average time expended by the arresting officer was 95.8 minutes. The equivalent figure in 1967 when the Detoxification Center was used was 47.7 minutes or a reduction in time of 50.2 percent.

This figure does not represent the entire saving of police time, however, since it relates only to the arresting officer and not to other Department personnel involved in booking, processing, etc. In an earlier time survey, the results of which were included in the Grant Proposal for this demonstration, it was found that the total amount of police time involved in the handling of a single drunkenness offense was 190 minutes. With that figure as a base, the reduction to 47.7 minutes through the use of the Center's procedure becomes even more significant.

City Courts

In analyzing the information obtained from the Clerk of the City Courts for the calendar years of 1966 and 1967, it was learned that there was a drop in the number of Drunk On The Street cases from 409 to 268. This represents a decrease of 34.5 percent.

It should be noted for both of these groups that the same percentage (67 percent) were found guilty in each year. That aspect was examined because it could have been a factor in the number of persons sentenced to the Workhouse.

Medium Security Institution (Workhouse)

From data supplied by the Workhouse it was found that 204 persons were committed in 1966 and 125 in 1967 for the charge of Drunk On The Street, a decrease of 38.7 percent in commitments. Similarly, it was learned that a total of 3,325 inmate days in 1966 and 1,941 inmate days in 1967 were served by persons committed on a charge of Drunk On The Street. This reflects a 41.6 percent reduction of inmate days for that charge.

EFFECT ON PATIENTS

Those aspects of the analysis of the program's effect on patients related to the treatment dynamics and the referral system were evaluated by staff members of the Detoxification Center. The final portion - follow-up evaluation of patients - was based on a study conducted under the auspices of the Social Science Institute of Washington University.

Prior to an examination of the effects of the treatment program there must of course be some cognizance taken of the general characteristics of the patient population being treated. During the calendar year of 1967, a total of 1,120 patients were admitted to the Center while 1,122 were discharged. Since their stay was voluntary they did have the option of leaving "against medical advice" before the completion of their seven days. Only 100 (nine percent) exercised that option which, in our judgement, demonstrated the voluntary acceptance by the public intoxicant of the treatment offered.

Of the 1,122 patients discharged in 1967, the great majority were male (93 percent), white (84 percent), with a median age of 48 years. Sixty-two percent were either separated, divorced or widowed and 22 percent had never been married. Only 14 percent were currently married and living with their families. Forty-eight percent had an eighth grade education or less, and only 11 percent continued beyond high school. With regard to occupational background, 51 percent were unskilled laborers, 25 percent were semi-skilled and 12 percent were elderly and/or disabled. With regard to "repeat admissions", it is interesting to note that the 1,120 admissions represented 674 individual patients seen during the year. Of that number, 464 were hospitalized only one time while less than one-third (210) were hospitalized two or more times.

Treatment Dynamics

The long-range results of the treatment program are outlined later in this report under Patient Follow-Up Study. One dramatic index of the effectiveness of the treatment observable during hospitalization was the fact that since the Center opened there has been only one mild case of delirium tremens. Other physiological improvements were notable: tremors disappeared, appetites returned, sleep was normal without sedation, physical strength and stamina returned, related medical complications cleared up or markedly improved, the ability to think and articulate clearly showed excellent improvement, and any existing hallucinosis disappeared.

From the psycho-social point of view the patients' response to and interaction with one another and the staff improved day by day, and the majority showed increased insight into their disease and a somewhat more realistic approach in attempting to cope with it.

Patient Referral

The approach used in developing a patient referral system was described earlier in this report. Without citing all of the

elements of that system, several examples reflect the direction taken: the State Division of Welfare has assigned a worker "on call" to work immediately with patients potentially eligible for assistance, a relatively effective and speedy referral channel has been effected with the alcoholism units of the Mental Health Center and State Hospital, and the assignment to the Center by the Lutheran Church of their Coordinator of Ministry to Alcoholics has opened doorways to the Church Community.

Many other agencies have been helpful - Salvation Army, Missouri Employment Service, the local Poverty Program, a half-way house, etc. But the fact still remains that for the most part there are far too few facilities to meet the needs - half-way houses, domicilary facilities, sheltered workshops, etc. - and too few interested and knowledgeable agencies to accept and carry out referrals. Nor is that picture all one-sided. Of those patients judged to be in need of housing and/or employment during 1967, one-half of them (49 percent) refused referral help offered them. Without a doubt, many of those refusals stemmed from the fact that what was available was not sufficiently appropriate for the situation, although one must recognize that some simply did not choose to change their life pattern at that point in time. But one must also be cognizant of the fact that most of these men have been without help for many years, and it would be unrealistic

to expect them to accept enthusiastically the first hand offered.

Patient Follow-Up Study

The findings reported in this section stemmed from a study of 200 male patients (160 actually located) made through interviews conducted an average of four months after discharge. Five areas were evaluated - drinking, employment, income, health and housing. Using a pooled rating score that reflected a composite of all five indices, it was found that 50 percent of the patients demonstrated significant overall improvement. The following table shows the breakdown of the total sample according to each of the five categories:

	Markedly Improved	Remained Same	Deteriorated
Drinking	47%	50%	3%
Employment	18%	76%	6%
Income	16%	71%	13%
Health	49%	42%	9%
Housing	15%	82%	3%

As an additional indicator of a change in life style for this sample of chronic police case inebriates, their "before-and-

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after" arrest records were examined. The findings revealed an average of 1.0 arrests for intoxication in the three months prior to treatment as compared to an average of only 0.3 after treatment. The latter figure represents arrests plus readmissions. On another index, 46 percent had been arrested for drunkenness in the three months prior to their first admission while only 13 percent had been arrested in the same period after discharge.

TRAINING PROGRAMS

An obvious requirement for the Center's successful operation was that all concerned parties were knowledgeable about alcoholism and the treatment of the public intoxicant. This includes the police officer since treatment literally begins when he makes his first contact with the potential patient. Police recruits began receiving orientation lectures on alcoholism in 1962, and this program has since been expanded to a six-hour lecture-film-discussion sequence, most of which is given by Dr. Joseph B. Kendis, Medical Director of the Center. This sequence includes an overview of alcoholism, the physical, psychological and social changes related to drinking, how to handle the intoxicant, and a step by step demonstration of the policeman's role in the overall operation of the Center.

The treatment staff, of course, is given a much longer and more intensive period of training, including the four day Alcoholism Education Program under the direction of Laura E. Root of the Social Science Institute of Washington University. In addition she and Dr. Kendis give continuing on-the-job training covering the medical, pharmacological, psychological and sociological aspects of the disease through the use of didactic lectures, films, reviews of the literature, discussion, group therapy sessions, individual consultation, and demonstrations. Prior to the opening of the Center the entire staff had three weeks of intensive training followed by six more weeks, when only a limited number of patients were accepted so the staff could develop expertise in treatment techniques.

TREATMENT SITUATION FOR THE PUBLIC INTOXICANT

In the past the chronic police case inebriate has been neglected and/or punished for displaying his drunkenness in public. Many spent most of their lives in jail even though every indication was that the "revolving door" process - intoxication, arrest, conviction, sentence, imprisonment, release, intoxication, and rearrest - had a deteriorating rather than a rehabilitating effect upon the individual. Unfortunately, with a few exceptions, this situation has changed very little.

In most communities - large or small - the jail cell or drunk tank is the basic "treatment facility" and, if the offender is fortunate, he may be given coffee as his "medication".

In view of these circumstances, it becomes almost academic to attempt to determine how many of the persons handled by the Detoxification Center could have been treated as patients in a regular, unsegregated hospital facility. If the attitude of hospital personnel concerning alcoholism and the public intoxicant were positive rather negative, if they were knowledgeable in the treatment of the alcoholic, if sufficient beds were made available, and if ability to pay were not a factor, then it is quite likely that the vast majority of the Center's patients could have been treated in such a facility.

Concerning the relative merits of the specialized versus the detoxification facility being integrated in a regular hospital, our judgment would be that detoxification can take place in either setting but that the separate facility within a hospital or mental health facility is preferable in that it allows for a staff specifically trained and experienced in the work, a more effective utilization of appropriate therapies, more comprehensive diagnostic evaluations and recommendations, and the assumption of the "clearing house" role. This conclusion notwithstanding, each community

must make that judgment based on its own needs and resources.

CONCLUSIONS

On the basis of the Detoxification Center experience it would seem clear that an investment in this type of operation could be expected to yield a number of positive results: a significant number of police man-hours could be re-deployed into more crucial assignments, a substantial saving of City Court time could be devoted to more serious and appropriate cases, and an easing of crowded conditions in the Workhouse by virtue of having fewer drunkenness offenders could occur.

With regard to the chronic public intoxicants who were treated, it can be anticipated that half of them would show marked improvement for a relatively sustained period of time; and that they would be apprehended far less frequently by the police, thereby releasing a portion of the officer's time.

How much "return on the investment" accrues to the community as individual public intoxicants become contributing members of society - assets rather than liabilities - is an imponderable that we cannot document. But it is there - we have witnessed it - and it is substantial!

TABLE OF CONTENTS

I. INTRODUCTION AND BACKGROUND

The disease of alcoholism - the third largest public health problem in the nation - is an extremely significant one in that there are an estimated 6.5 million persons in the United States with a serious alcohol problem. Of that number 1.5 million are chronic addictive alcoholics and other Americans are addicting at the rate of 200,000 per year. These individuals are found in all segments of our society, all class levels, all occupational and ethnic groups as well as in the majority of religious groups.

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the St. Louis Metropolitan Police Department, and David J. Pittman, Ph.D., Sociologist and Director of the Social Science Institute of Washington University, with the assistance of many other key persons, developed the plan for a detoxification center. Their initial planning was based on a number of observations, including the following:

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Broadly stated, the goals of the experiment were twofold:

1. To determine to what extent this new process might effect a time saving on the part of the police and indirectly upon the court and the penal institutions.

2. To determine what rehabilitative effect a short-time treatment approach might have on the life style of the

chronic public intoxicant and to what extent his "revolving door" pattern could be altered.

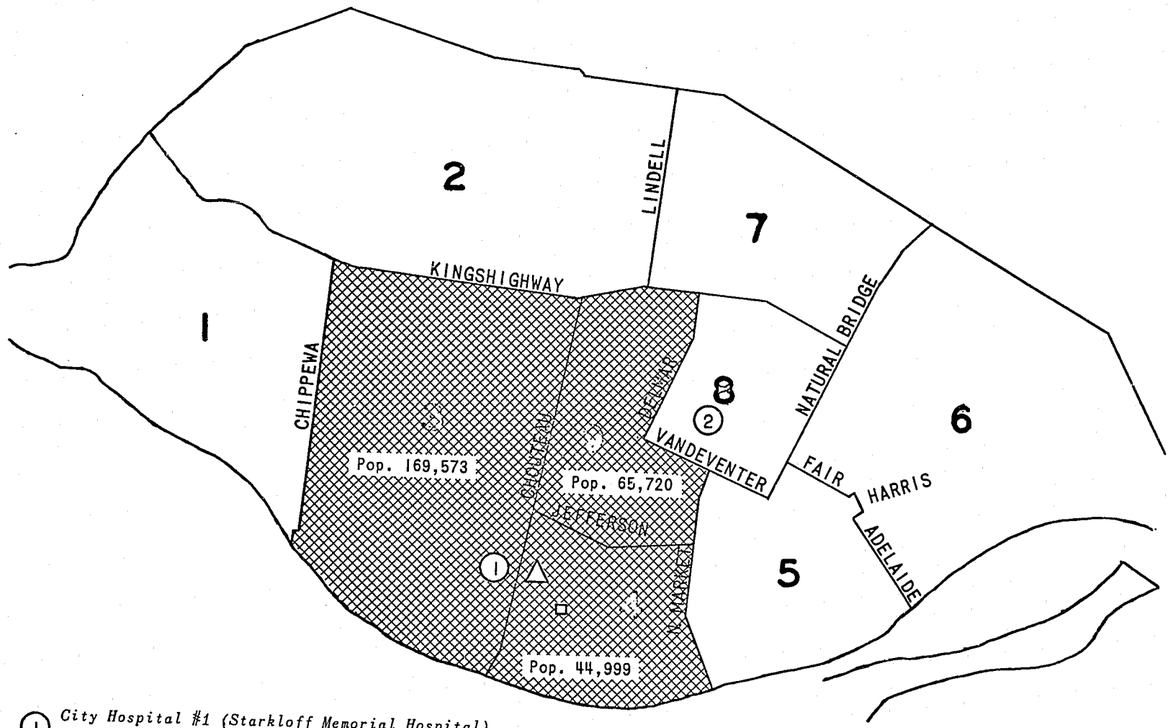
Under the guidelines of the project, only the person who was picked up by the police for being "Drunk On The Street" could be admitted to the Center. He would remain approximately seven days during which time a variety of therapeutic techniques would be employed starting with medical diagnosis and treatment and including counseling and evaluation (social/vocational/employment); group therapy; work therapy; self-government; didactic lectures and films; socio-drama; Alcoholics Anonymous, etc. Paralleling this treatment approach, aftercare plans would be worked out with him with regard to housing, employment and further therapy if deemed necessary. The purpose of the procedure: to "dry out" the public intoxicant, build him up physically, begin the process of social rehabilitation, and attempt to return him to the community under circumstances favorable to his efforts toward sobriety.

The first patients were brought to the Center on November 18, 1966, by officers of the Fourth Police District. On November 25, 1966, the service of the Center was extended to the Third Police District, and on March 6, 1967, it was

again extended to also include public inebriates encountered by officers in the Ninth Police District.

The following page is a map of the City indicating the confines of the three police districts involved and the location of the Detoxification Center, City Hospitals, and Police Headquarters Building. These three districts accounted for 81.8 percent of the City's drunkenness arrests in 1966 while constituting only 37.4 percent of the total population of the City.

It is within this developmental framework that the evaluation of the impact of the Detoxification Center is made - first upon the several law enforcement agencies and secondly upon the public intoxicants themselves.



(1) *City Hospital #1 (Starkloff Memorial Hospital) 1515 Lafayette Avenue*
(2) *City Hospital #2 (Homer G. Phillips Hospital) 2601 North Whitter Street*
□ *Police Headquarters Bldg.. (Including Fourth District, Prisoner Processing Division and Planning and Research Division) 1200 Clark Avenue*
△ *St. Louis Detoxification and Diagnostic Evaluation Center 1536 Papin Street*
⊠ *Districts serviced by Detoxification Center*

Pop. - Population as indicated by Police District

Population of City of St. Louis 750,036 - per 1960 Census

II. EFFECT OF THE DETOXIFICATION CENTER ON THE JUSTICE PROCESSES

One of the primary expectations of the demonstration project was that it would put the police officer back in service more quickly than was possible under the prior procedure of handling the public intoxicant through the criminal process. It is necessary, therefore, to examine the two procedures, taking into account not only the time of the arresting officer and other related personnel but also other variables such as number of arrests, warrants, etc. Further, one cannot overlook the potential ramifications of the project on related law enforcement agencies such as the Court and the City penal institution. This section is devoted to a discussion of the measurable impact of the Center on these three agencies.

A. St. Louis Metropolitan Police Department

Procedures

To determine the time saved by a police officer who admits a public intoxicant to the Detoxification Center for remedial medical and social treatment of an illness, rather than processing the inebriate as a

criminal, a description and comparison of the two procedural methods is necessary.

When a public intoxication offender comes to the attention of a police officer in the Third, Fourth or Ninth Police District, the officer, after determining that the Center has room, conveys him directly to the Detoxification Center. After physically assisting in admitting the subject into the building, the officer fills in an admitting form and a City Court Summons for the charge of "Public Drunkenness" and verifies that the subject is not wanted by any police agency for a previously reported offense or bench warrant issued by a judge. He then returns immediately to his patrol assignment. Appendix A contains a Special Order of the Chief of Police which details the police procedure for Detoxification Center admissions, the admitting form and the City Court Summons.

It is to be noted that although the offender is actually placed under arrest and issued a summons to appear in City Court, the summons is voided and no record is kept in the Department's Record Section of the subject's arrest or admission to the Center.

Public drunkenness offenders arrested by a police officer in the six police districts not serviced by the Detoxification Center, as well as those arrested in the three participating districts when the Center is at capacity, are processed according to a procedure published by the Department in 1963 (see Appendix B-1). This written procedure requires that all public drunkenness offenders be conveyed to one of the two City Hospitals for a medical examination and treatment of any injuries prior to being forwarded to Prisoner Processing Division, located in the Headquarters Building at 1200 Clark Avenue, for booking on the charge of "Drunk On The Street" and confinement. The arresting officer then must prepare the Intoxicated Person Report (see Appendix B-2) and subsequently appear at the City Counselor's Office for an Information (Warrant) application. If the Information is issued, the subject is sent to City Court for trial.

Intoxicated persons removed from private property by the police where the owner or agent does not desire prosecution of the subject, but removal from the premises, are handled in the same manner as persons arrested for public intoxication with the exception being that the

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charge placed against the subject is "Protective Custody" and the subject is released within 20 hours of arrest. Consequently the arresting officer does not make an Information application and the subject is not sent to City Court.

From the description of the arrest procedure for public drunkenness offenders charged with Drunk On The Street, it can be seen that the arresting officer must convey the public inebriate to a City Hospital, await medical examination and treatment, convey the subject to Prisoner Processing Division for booking and detention, determine if the subject is wanted by a police agency for a previously reported crime, prepare the Intoxicated Person Report and apply for an Information at the City Counselor's Office, which is located in the Municipal Courts Building. If the Information is issued, the arresting officer will appear in City Court at the trial of the offender if he does not plead guilty. This involved procedure is circumvented when the arresting officer admits the public intoxication offender into the Detoxification Center and then returns to his patrol area.

Police Time

To learn the average time required by officers to handle an admission to the Center involving only one person per incident, a copy of each admission form filled in by the officer who admitted the subject was secured for all persons admitted from January 1, 1967 through December 31, 1967.

These admitting forms revealed that there were 1,120 admissions to the Center in 1967. Six-hundred and nine admissions came from the Fourth District, 348 from the Third District, 160 from the Ninth District and one each from the First, Fifth and Seventh Districts. Only 851 of the 1,120 admissions were used to develop data. The remaining 269 admissions were not used because many involved multiple admissions to the Center per incident and others contained incomplete data relevant to the time required to complete the assignment.

From these 851 admission forms, it was learned that it required an average of 47.7 minutes per each assignment involving a single admission to the Center.

It required officers assigned to the Third District an average of 49.6 minutes on 257 admissions, officers from the Fourth District required 43.1 minutes on 476 admissions, and the Ninth District officers required an average of 62.0 minutes on 118 admissions.

The reporting officers indicated that a district cruiser (conveyance) assisted in 331 of the 851 admissions.

The map on page eight indicates the location of the Center and its relation to the three districts.

A comparison of admittance forms revealed that the distance from the Center to the scene of the incident is a significant factor in determining the amount of time required to complete the assignment; however, the availability of a conveyance close to the scene as well as the physical condition of the subject and other factors could increase the time required to handle the incident.

To learn the number of persons arrested for drunkenness offenses in 1966 and 1967, a listing was prepared by the Computer Center of the Police Department indicating

by charge persons arrested for Drunk On The Street, Protective Custody, Drunk and Drinking in a Public Place. This listing indicated the date, time, district of arrest, subject's name, age, race, sex, as well as warrant status and complaint number of the police report indicating the circumstances of arrest.

Using the computer listing, the complaint numbers of all reports originating in the Third, Fourth and Ninth District concerning the arrest of persons charged with Drunk On The Street and Protective Custody were noted and a copy of each report was obtained. Since we are comparing drunkenness arrest time and Detoxification Center admission time, only reports where the drunkenness charge was the sole charge placed against the subject were used, and then only when the Intoxicated Person Report was the form used to record the incident.

On 243 assignments in the Third, Fourth and Ninth Districts under the aforedescribed circumstances and when the intoxicated person was charged with Protective Custody, the officers required an average of 95.5 minutes to complete the assignment.

On 67 assignments in the three districts when the subject was booked for Drunk On The Street, an average of 96.9 minutes was required to complete the assignment.

Combining the above two totals, we find that an average of 95.8 minutes was required in handling a total of 310 assignments.

Appendix C is a chart indicating at what time the officers of the three districts indicated that they received their assignments on the 851 Detoxification Center admissions and the 310 drunkenness arrests. As indicated on the chart, the peak time period officers encountered these intoxicated persons is between noon and 7:00 p.m.

From the admission reports reviewed on the 851 Detoxification Center admissions we have found as indicated earlier that it required an average of 47.7 minutes to handle an assignment of this type occurring in the Third, Fourth and Ninth Districts. The police reports on the 310 drunkenness arrests occurring in these same three districts indicate that an average of 95.8 minutes was required to handle an assignment of

this nature. It is thus apparent that an average of 48.1 minutes or 50.2 percent less police time was required in handling an assignment of this type.

Stating, however, that an average of 95.8 minutes is all of the police time required to handle an assignment involving the arrest of an intoxicated person would be erroneous.

The time expended by officers at Prisoner Processing in booking and handling these intoxicated persons during their period of confinement has not been taken into consideration nor has any consideration been given to the time used by supervisory officers and clerical personnel in processing the police report and arrest data. The time spent by the officer applying for an "Information" on persons arrested for Drunk On The Street as well as possible court time by the officer if an Information is issued has also not been taken into consideration. For these reasons, although it has been indicated that a reduction of 50.2 percent in police time was effected, the total police time saved would be far in excess of this figure.

Arrest Statistics

The computer list indicated that 540 persons were arrested for Drunk On The Street in 1966, compared with only 215 so arrested in 1967. On the charge of Protective Custody, 1,068 were arrested in 1966 and 526 in 1967. For the charge of Drunk and Drinking in a Public Place, the number of persons arrested for Drunk in 1966 was 7 and in 1967 it was 6; arrests for Drinking in a Public Place amounted to 104 in 1966 and 49 in 1967.

Adults arrested for all four drunkenness charges in 1966 totaled 1,719 and 796 in 1967. It is apparent that there was a decrease of 923 persons arrested for drunkenness offenses comparing 1967 to 1966, or a decrease of 53.7 percent.

The annual reports of the St. Louis Police Department indicates that 1,733 persons were arrested for drunkenness offenses in 1966 and 805 in 1967 (the difference of 14 in 1966 and 9 in 1967 is caused by the addition of juveniles in the annual report figures which are not included in the computer listing).

These 1,733 and 805 persons indicated as arrested or taken into custody in 1966 and 1967 for drunkenness offenses represent cases where the drunkenness offense is the charge of the highest severity. In 1966, the total number of drunkenness offense charges amounted to 1,799 and in 1967 this figure amounted to 864. This difference in figures occurs because one person could be arrested and charged with several offenses but his arrest would only be indicated in the persons arrested category as being charged with the crime with the highest severity, thereby not being indicated as a drunkenness arrest.

Appendix D is a chart comparing 1966 and 1967 drunkenness arrests and Detoxification Center admissions by monthly and annual totals. Appendix E is a chart comparing 1966 and 1967 drunkenness arrests and Detoxification Center admissions by district annual totals.

Informations (Warrants) Issued

As indicated earlier, the computer listing of persons arrested for drunkenness offenses also indicated the warrant status. A review of those cases involving

an arrest for the charge of Drunk On The Street revealed a warrant issuance rate of 65.3 percent on a City-wide basis in 1966, and 84.4 percent in 1967. The issuance rate on cases involving the Third, Fourth and Ninth Districts was 65.1 percent in 1966 and 83.1 percent in 1967.

It is apparent that there was no decrease in Information issuance from 1966 to 1967 which could have resulted in fewer cases appearing on the docket of the City Courts. In reality the issuance rate on Informations for the charge of Drunk On The Street increased 19.1 percent for the entire City, and 18 percent in Districts Three, Four and Nine.

Appendix F is a chart indicating prosecution statistics for the charge of Drunk On the Street in 1966 and 1967.

B. City Courts

In order to learn what effect the Detoxification Center had on the City Courts in 1967 concerning the number of persons appearing on the charge of Drunk On

The Street, monthly computer listings showing the final dispositions on all cases tried in the City Courts were secured from the Clerk of the City Courts for the calendar years of 1966 and 1967.

A summary of these listings revealed a total of 409 such cases receiving a final disposition in 1966 and 268 in 1967. It is thus evident that there was a reduction of 141 such cases, or a 34.5 percent decrease.

From these listings it was learned that 277 persons or 67.7 percent were found guilty in 1966 and 181 persons or 67.5 percent were found guilty in 1967. These figures comparing 1966 and 1967 reveal no significant change in the percentage of persons found guilty, which could have affected the percentage of persons sentenced to the Workhouse.

It is to be noted that although a 34.5 percent <u>decrease</u> was indicated on the docket of the City Courts, this decrease was effected with an <u>increase</u> of 19.1 percent in warrant issuance rate.

Appendix G is a chart indicating the final

dispositions on all of the 409 cases in 1966 and the 268 cases in 1967 that appeared on the dockets of the Courts for persons charged with Drunk On The Street, as indicated by monthly totals abstracted from the computer listing.

C. St. Louis Medium Security Institution (Workhouse)

From data supplied by the St. Louis Medium Security Institution (Workhouse) it was found that 204 persons were committed in 1966 and 125 in 1967, for the charge of Drunk On The Street, for a decrease of 38.7 percent in commitments.

It was also learned that a total of 3,325 inmate days were served in 1966 and 1,941 inmate days served in 1967 by persons committed on the charge of Drunk On The Street. This indicated a decrease of 1,384 (41.6 percent) inmate days. As indicated earlier, the decrease of 38.7 percent in commitments and 41.6 percent in inmate days was effected by an increase of 19.1 percent in the warrant issuance rate. Since there was no appreciable change in the percentage found guilty by the Courts, this 19.1 percent increase could easily

have had an effect on both commitments and inmate days by limiting their reduction percentage.

Appendix H is a chart indicating by monthly totals the number of persons committed to the Workhouse in the years 1966 and 1967 on the charge of Drunk On The Street.

Appendix I is a chart indicating the monthly totals of inmate days served at the Workhouse in 1966 and 1967.

D. Summary and Conclusion

The following statements summarize our findings relative to the impact of the Center on law enforcement agencies:

A substantial reduction of police time required to process a public drunkenness offender has been achieved. The average time required to complete an assignment of this type was reduced from 95.8 minutes to 47.7 minutes or a reduction of 50.2 percent in police time and this reflects only the time saved by the arresting officers, not other related Department personnel.

A significant reduction in the number of public drunkenness cases appearing on the docket of the City Courts has also been achieved. In 1966, a total of 409 such cases had a final disposition rendered while in 1967, there were only 268 cases, indicating a decrease of 34.5 percent.

We have also found a reduction in Workhouse confinements on persons sentenced for the charge of Drunk On The Street, from 204 in 1966 to 125 in 1967 indicating a 38.7 percent decrease. The number of inmate days has also decreased from 3,325 in 1966 to 1,941 in 1967 for a reduction of 41.6 percent.

In 1966, a total of 1,719 persons over 17 were arrested for drunkenness offenses, while in 1967 only 796 persons in this category were arrested, indicating a reduction of 53.7 percent. It must be remembered that this figure refers only to those cases handled as drunkenness arrests and does not include the 1,120 cases that were admitted to the Detoxification Center. This decrease in the number of cases going through the arrest process also reflects a time saving on the part of the two City Hospitals since, had the Center not

been available, they would have been handled at those facilities.

Although we have shown the reduction of police time in processing a public drunkenness offender, it is impossible to show the reduction of police assignments that can be effected by the rehabilitation of the chronic alocholic contacted by the police.

Because of the chronic inebriate's unkempt appearance, he is frequently the cause of many additional police assignments due to his public presence even when he is not intoxicated. Also, because of his general poor health many assignments for sick cases, accidental injuries, and victims of assaults are handled by police in which the chronic alcoholic is the victim. Rehabilitation of the alcoholic will then lessen his police contact and need for services.

As indicated above, the City Hospitals are the medical facilities used by the chronic alcoholic when he is ill or injured. Officers handling cases involving "Sudden Deaths" of these persons frequently find a long list of treatments and admissions when investigating

the medical history of these persons. Rehabilitation of the public inebriates would also reduce the work load of the City Hospital involving treatment of these persons.

If the Detoxification Center were later to be used for intoxicated persons in the entire City rather than in just the three police districts indicated, a larger facility will be necessary. From the number of times that an officer has been given a negative answer as to there being room at the Center prior to conveying an alcoholic to their facilities, it is felt that for every two persons admitted to the Center the admittance of one person has been refused. To accommodate this group plus those from the other six districts, it is felt that a facility of about 50 or 60 beds would be required if public drunkenness offenders from the entire City were referred to the Center.

III. EFFECT OF THE DETOXIFICATION CENTER TREATMENT PROGRAM ON THE PATIENTS

A. Evaluation of Treatment Dynamics

The various components of the treatment regime have been described in detail in earlier reports and are touched on again in Appendix J. This regime includes in part the following: an effective handling of the public intoxicant on the part of the police in bringing him quickly to the Center; proper medication; good nutrition; reality-oriented group therapy; individual counseling; task and recreational therapy; Alcoholics Anonymous, etc. All facets of this total treatment approach must be integrated by a staff of firm but kind and understanding individuals functioning as a team.

The long-range results of this treatment can be measured primarily through noting the patient's functioning after he returns to the community. This aspect of the evaluation is discussed in another portion of the report. The more immediate results of the therapeutic regime can be observed during the seven day

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period of hospitalization.

One dramatic index of the effectiveness of the treatment is the fact that since the Center opened we have had only one mild case of delirium tremens. Other physiological improvements are notable: tremors disappear; appetites return; they sleep normally at night without sedation; physical strength and stamina return; related medical complications such as polyneuropathy or gastritis clear up or markedly improve; the ability to think and articulate clearly shows excellent improvement; and, any existing hallucinosis disappears.

From the psycho-social point of view, the patient's response to and interaction with one another and the staff improves day by day. The majority show increased insight into their disease and a somewhat more realistic approach in attempting to cope with it.

Finally, one must recognize what one means by "success" in treatment. We must keep in mind that alcoholism is a chronic disease and there are bound to be relapses. However, if something we may have done for or with one of our patients keeps him "dry" longer

than he had been before (even though he may have had a "slip"), he has now had a "positive" experience and as time goes along he will be much more likely to come to a meaningful decision that total sobriety for him is the preferable way of life.

B. Evaluation of the Patient Referral System

In developing a patient referral system our approach had to be governed by a number of factors. Paramount amoung these was the fact that we were opening a new agency - a "first of its kind" - providing a unique type of service to a clientele who for the most part had never received treatment before and who had a disease that traditionally had been neglected and rejected by most members of the helping professions. Given this set of circumstances, we expected - and subsequently found - that we would not only have to inform agency personnel about the existence and services of our Center, but would also have to do a substantial amount of educating about alcoholism and dealing with attitudes about the public intoxicant. To initiate the implementation of our approach, 30 community health and welfare agencies were invited to the Center for a tour and

orientation session. Fifty-five people from 20 of these agencies responded and indicated their willingness to support the endeavor.

This general session was followed up by individual, personalized contacts with each of these agencies, as well as some who did not attend, to attempt to strengthen their knowledge and commitments and to crystallize the details of an on-going working relationship. During this process, a few agencies indicated they were "not really equipped" to work with the public intoxicant. Later on in the operation of the Center, still other agencies indirectly indicated the same position by not accepting or not acting upon referrals.

Nevertheless this approach did yield essentially what we were seeking - a nucleus of facilities and staff persons in a variety of agencies who represented effective referral resources for the public intoxicant upon discharge from the Center. We will not attempt to list these resources here; they were dealt with fully in the first and second quarterly progress reports. However, several developments have been of particular significance in the general development of an effective

referral system. The State Division of Welfare assigned a caseworker available "on call" to work immediately with those patients potentially eligible for some type of public assistance. The relatively recently organized Eastern Missouri Alcoholism Coordinating Committee has been very effective in assisting with the expediting of referrals from the Center to the Malcolm Bliss Mental Health Center and the St. Louis State Hospital. The creation by the Lutheran Church, Missouri Synod, of the position of Coordinator of Ministry to Alcoholics and the assignment of a Chaplain to the Center holds great promise for the further involvement of the church community in our future programming.

During the calendar year 1967, the Center handled 1,120 admissions and 1,122 discharges. Appendices K and L present an analysis of aftercare referrals with regard to employment and housing insofar as they indicate the number of patients discharged during this 12 month period who did or did not need assistance and who accepted or refused referral help. It will be noted that the figures for both employment and housing are, in general, quite similar, reflecting the fact that in most instances those patients who did not need assistance

in obtaining employment did not need it in making housing arrangements either. Similarly, the figures indicate that patients who refused help with employment also tended to refuse it for housing.

C. Patient Analysis

During the calendar year 1967 a total of 1,120 patients were admitted to the Center while 1,122 were discharged. Of the 1,122 patients discharged, only 100 (nine percent) signed out AMA (Against Medical Advice). This figure demonstrates in our judgment the voluntary acceptance by the "public intoxicant" of the treatment offered at the Center.

A profile of the patient population for this 12 month period is cited below on the basis of specific socio-economic indices. Of the 1,122 patients discharged during 1967, the great majority were male (93 percent), white (84 percent), with a median age of 48 years. Fifty-four percent were either separated or divorced and 22 percent had never been married. Only 14 percent were currently married and living with their families and approximately eight percent were widowed.

Forty-eight percent had an eighth grade education or less and only 11 percent continued beyond high school. With regard to occupational background, 51 percent were unskilled laborers, 25 percent were semi-skilled and 12 percent were elderly and/or disabled.

The location of arrest of this total group of patients and their place of residence are illustrated in the City maps contained in Appendix M.

With regard to the matter of "repeat admissions", it is interesting to note that the 1,120 admissions represented 674 individual patients seen during this year. Of that number, 464 were hospitalized only one time while less than one-third (210) were hospitalized two or more times. Measuring the rate of repeat admissions, we note that 446 of the 1,120 were admissions of patients who had been at the Center before. This represents a readmission rate of 40 percent.

D. Summary of Patient Follow-Up Study

The following section reflects in part a summary of the Final Evaluation Report for the Detoxification

Center. A complete copy of that report is included as Appendix N.

Method

The clinical aspects of the evaluation are crucial to a successful demonstration. Not only must this kind of treatment program be shown to be economically feasible but, in addition, the individuals treated must accrue some positive therapeutic effects. If the treatment program was unsuccessful or, more likely, if the Center's success was not demonstrated adequately, then the criticism will surely be levelled that the "revolving door" has simply been displaced from the criminal justice system to a medical facility. However, even in this case, there is the possibility of gains from medical experience not now possible.

Every research design entails numerous decisions on the part of the investigator. This study is not unusual in that the ordinary considerations of time and money were crucial. Of those selected for evaluation, a waiting period of 90 days from their first discharge date had to elapse before an attempt was

made to locate and interview them. In longitudinal studies of this type, it has been demonstrated that one year is an optimum compromise period for evaluation in terms of assessing long-range treatment effects while maintaining some capacity for locating the subjects. In this study, however, the practical limitations took precedence. The purpose of this study was not to demonstrate a theoretical construct or even to assess an ideal alcoholism treatment program. It was rather a test of the feasibility of Katzenbach's statement that:

> better ways to handle drunks than tossing them in jail should be considered. Some foreign countries now use 'sobering-up stations' instead of jails to handle drunks. Related social agencies might be used to keep them separate from the criminal process.[1]

As a demonstration project, the Center has been a pioneering effort, particularly in terms of its sponsorship under the St. Louis Metropolitan Police Department. It is not, however, a demonstration in the sense that it is an untried or untested idea. This

1. Attorney General Nickolas deB. Katzenbach - Testimony to Ad-Hoc Subcommittee, Senate Judicary Committee on Law Enforcement Assistance Act of 1965.

would be tantamount to saying that we need proof that treatment measures are better than current punitive procedures under the criminal justice system. There can be no argument that rehabilitation is better than incarceration. It was rather the job of this evaluation to show how much and in what ways our resources can be better utilized in dealing with the chronic police case inebriate.

After selecting the study group, consideration was given to the instruments, scales or measures, and what could be termed "success criteria".

The simple "before and after" design was deemed most appropriate in that each individual would be his own standard in the assessment of any change. This retrospective-prospective model avoids to a great extent the necessity for establishing success standards. This rationale rests on two assumptions. First, that alcoholism is a progressively debilitating disease. Degeneration in the individual is markedly uniform and affects all areas of the alcoholic's life. (This is particularly true for the chronic police case inebriate.) Second, without some therapeutic intervention

into the disease process the prognosis is unfavorable. Success then, in this study, rests on the ability of the measures to demonstrate either the arrest of the disease progression or improvement where found.

Those individuals selected for the follow-up interviews were assigned ratings for before and after the treatment period. The variables selected for measurement were: the drinking pattern, residential accommodations, employment, income, arrests, readmissions and general health. A survey of the existing literature on alcoholism follow-up studies led to the conclusion that there were no scales which could be adapted for use in this study.

The scales which were developed and a complete discussion of methodology will be found in Appendix N.

Population Studied

The first question which must be answered is simply, "Who are these individuals we are treating?" Since the Center opened in November, 1966, until July 1, 1967, there were a total of 548 admissions. A profile of

this group demonstrates that we are indeed treating the chronic police case inebriate. Some of the indices which clearly point this out are the demographic characteristics of race, sex, age, marital status, educational level, income, etc. By comparison, the similarity between the patient population and the drunkenness offender for the year of 1966, shows high congruence. If we limit ourselves to those individuals who were arrested three or more times during the year 1966, the parallels are obvious.

	Average Age	Percent Male	Percent Female	Percent White	Percent Negro
1966 Arrestees (Chronic) (N = 103)	49.4	91%	9%	71%	26%
Treatment Group as of 7-1-67 (N = 548)	48.1	91%	9%	83%	17%

A breakdown of the marital status of the treatment group lends further support to the contention that we are reaching the target population for whom the Center was designed.

	Single	Divorced	Married	Widowed	Separated
Treatment Group as of 7-1-67	40%	27%	21%	6%	6%

The Evaluation Sample

Within the two following limitations the study group can be considered as a random sample of the males:

1. That the individual stayed for the duration of the treatment program (average of seven days) until medical discharge.

2. That the individuals lived in or near the St. Louis metropolitan area for three months prior to their admission to the Center.

In all discernable characteristics the two hundred males selected for evaluation closely approximated the entire treatment group. During the course of the study 82 percent of the sample were located and interviewed. Four of these individuals were not included in the evaluation because their interviews were not filed until after the date when the results were coded and recorded on IBM cards. Hence, the results of the evaluation project are based on 160 interviews or 80 percent of the study group. This extremely high retrieval rate

is the result of diligent work on the part of two experienced police officers assigned by Colonel Curtis Brostron, St. Louis Chief of Police, to aid in this project.

Based on the above sample, the evaluation results are applicable to between 65 to 70 percent of the entire treatment population. Specifically, approximately nine percent of the total treatment group were female, nine percent left against medical advice, and another ten percent were excluded on the residence requirement. In addition, four percent of these individuals were not diagnosed as "chronic alcoholics". Thus, there is a total of 32 percent of the entire treatment group to which these results may not be generalized.

The study group of 200 selected male subjects approximates both of these profiles.

SAMPLE PROFILE (N = 200)

Average Age	Percent Male	Percent White	Percent Negro	
46.0	100%	78%	22%	
Single	**Divorced**	**Married**	**Widowed**	**Separated**
16%	34%	21%	10%	19%

It should be noted that the distribution in the marital categories is markedly different for the sample and the entire treatment group; however, the category of those living with spouse (i.e., "Married") is an exact match. There was probably some confusion on the subjects' part during the intake interview as to whether the categories of "Single", "Divorced", or "Separated" were appropriate. Since this is a Catholic institution, the subjects may have felt the classification of "Single" as preferrable to "Separated" or "Divorced" when interviewed in the Center as opposed to the follow-up interview conducted away from the Center.

For purposes of comparison, the patient profile as of July 1, 1967, is used since all subjects in the study group had been admitted by that date. Some other significant and highly consistent characteristics are shared by the total patient population and the study group.

CATEGORY	ALL PATIENTS	STUDY GROUP
Eighth grade or less	47%	50%
Some high school	29%	24%
High school or beyond	24%	26%

CATEGORY	ALL PATIENT	STUDY GROUP
College graduates	1%	1%
Not employed	34%	32%
Years diagnosed alcoholic	14.3 years	15.4 years

Before proceeding to the clinical evaluation, it should be pointed out that the Center is not only dealing with the revolving door inebriate, but is also effectively eliminating the revolving door process in St. Louis.

The Center serves three out of a total of nine police districts. It serves those districts which accounted for 82 percent of all public drunkenness charges registered in 1966. Below is a table which shows the arrests City-wide for the time the Center has been in operation and the comparable period of the previous year.

Year	1965	1966											
Month	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	12 Month Total
*Arrest Totals For Previous Year	205	162	145	223	221	173	202	139	106	101	120	92	1,889
	1966	1967											
*Arrest Totals While Center In Operation	82	56	64	76	84	75	86	83	76	70	54	50	856
Decrease Of	60%	66%	56%	66%	62%	57%	58%	40%	28%	31%	55%	46%	55%

*These figures represent the total drunkness offenses for the entire City.

These data leave no doubt that the Center is indeed treating the chronic police case inebriate, for whom it was intended.

Results

The following data summarize the results of this study, categorized according to the various indices utilized in the evaluation. Figures presented in table form are percentages rather than raw scores.

Residential Accommodations

The high mobility of this problem group has frequently been noted by the experts in the field of alcoholism. The homeless man stereotype illustrates the migratory patterns and social isolation of this group. This would seem to be compatible with other personality and social characteristics of the indigent alcoholic, all of which point to his inability to assume responsibility and/or function in a stable capacity as a result of his disease. This scale deals with two correlated variables: first, the frequency with which the subject finds shelter, and secondly, the type of

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shelter or lodging to which the individual typically has access.

Of the patients evaluated, approximately 15 percent evidenced some significant improvement in their living arrangements. Eighty-two percent remained about the same level of housing after treatment, while only three percent showed decline.

The table below presents the percentage of individuals assigned to each category before and after treatment. On this scale a rating of four or lower would place the individual in an undesirable and/or unstable residential setting.

Rating	1	2	3	4	5	6	7	Total %
Before Treatment	6	6	6	19	30	14	19	100%
After Treatment	6	5	3	16	33	16	21	100%

In the before-treatment rating of these individuals, 37 percent had what would be considered inadequate housing arrangements. In the after-treatment rating, this figure was reduced to 30 percent. The average

rating before treatment is 4.8 while that for the after measure is 5.0. This is not an impressive change. A rating of four could be characterized by an individual who is a regular inhabitant of the missions, shelters, and transient lodgings in or surrounding the skid row area. This individual averages six days a week in some type of shelter and finds himself sleeping in streets and alleys of the City less than once a week. Category five is characterized by a structured environment, such as a half-way house, accommodations with friends or relatives, or some form of semi-permanent address with some food arrangements within the housing situation. The after-treatment ratings of categories five through seven indicate that 70 percent of the individuals were living in a more or less structured or homelike environment at follow-up. By far, then, the majority of patients after treatment had adequate residential accommodations.

Employment

Even with the progression of alcoholism, many of these individuals are still capable of maintaining their present job skills, if they have any, and of holding

a steady job for varying lengths of time. However, as the individuals move lower and lower on the scale and ultimately enter the skid row environment, many other factors, such as declining health, emotional instability, as well as subtle factors such as one's personal appearance, all combine to lessen one's possibility of steady employment. Thus, the employment scale takes into consideration both type and frequency of employment.

At the time of intake, 34 percent of the sample were totally unemployed; that is to say, for a period of three months prior to admission these individuals had not been gainfully employed. Of this 34 percent, fully 30 percent were retired and/or disabled with many receiving some form of pension or welfare monies. This latter group is not represented in the following table, their numbers being included in the computations for the summary table at the end of this section. Hence, the reader will note a difference in the percentages in the employment results.

A rating of four or below would have to be considered under-employment. Categories five through seven may, depending on the individual's needs, i.e., dependents,

housing, etc., be adequate for some of these individuals. The average rating for all study cases evaluated at intake was 3.8. Again, this rating in terms of our scales must be considered inadequate by any criteria. The after-treatment ratings average 4.4. Although this is a statistically significant change, it would still have to be considered inadequate employment. Twenty-nine percent of those evaluated had shown some significant improvement in their work patterns. This means that they were either working with more frequency or had achieved some stability in an occupational role. Sixty-one percent evidenced no significant change either positively or negatively. The interpretation of this figure must be tempered by the fact that some of these individuals already had adequate employment. Only 10 percent, according to our scales, showed a decline in their employment.

Ratings	1	2	3	4	5	6	7	Total %
Before Treatment	23	10	19	5	10	20	13	100%
After Treatment	19	9	20	5	8	10	29	100%

This table shows 43 percent of the study group as

having "regular" employment as evidenced by a rating of five or higher at the time of admission. Forty-seven percent had achieved this level by the time of the follow-up interview. This latter figure of 47 percent is not indicative of the complete employment picture. Some of those excluded from the table as "unemployable" due to disability or old age do receive adequate incomes. Since the majority of this group are through no fault of their own unproductive, it would be wrong to think of them as not self-sufficient, i.e., a rating of five or higher.

Income

Since the modal occupation of the treatment population is casual day labor, income was best estimated on a per weekly basis. The gross average weekly income of the entire study group was approximately $46.00 at the time of admission. This figure represents all forms of cash income, including pensions, disability payments, welfare, etc. Sixteen percent reported no income on the intake rating. The same was true of only eight percent on the after-treatment measure. At the time of the follow-up interview, the average weekly

income for the entire study group had risen to approximately $52.00. Twenty-six members of the study group or 16 percent are responsible for this increase. Those who showed improvement had an average rise in weekly income amounting to almost $22.00. Seventy-one percent remained at approximately the same level with 13 percent having a lower income.

Health

At the study's outset, it was felt that the most immediate and marked effects of treatment would be found in the area of health. None of the evaluation team can claim competency in the area of medicine; hence, this measure proved to be unscaleable. In an attempt to achieve some assessment, this evaluation was based on gross factors readily available during the interview process. In order to achieve a rating of "improved", the patient must have displayed a significant change evidenced by such things as weight gains, increased appetite, cessation of or a decrease in polyneuritic pains, or the disappearance of other complicating symptomatology (D.T.'s, blackouts, etc.). Forty-nine percent of the study group showed marked

improvement in their physical well-being based on the above factors. Forty-two percent displayed no significant improvement, and nine percent showed a decline in over-all health.

For half of these individuals, the Center represented the first medical treatment they had received for alcoholism. Almost all subjects indicated during the follow-up interview that the care they received at the Center was the first indication in a long time that "somebody cared about me". The interviewers expressed the opinion that perhaps the therapeutic effects were even greater for the individual's mental health than for his physical self. The mere fact that a seven-day program of nutrition, sanitation, and mental hygiene would leave its effects on such large numbers of these individuals three months after the treatment period is evidence of the accomplishments which can be made with this group of "hopeless people".

Drinking

The drinking dimension is the most crucial test of the treatment program. Rehabilitative gains in any

other area must be seen as temporary unless a concomitant improvement is displayed in the individual's drinking patterns. The question is not simply a matter of sobriety or insobriety but also the extent to which the individual copes with his problem. This scale measures primarily the frequency and duration of drinking bouts in relation to periods of sobriety as representative of one's ability or inability to deal with his dependency on alcohol.

At the time of admission the modal rating was category one. This rating represents a prolonged drinking pattern where the individual would have to be drinking steadily (daily) for more than two months prior to rating and the quantity of alcohol consumed would have to exceed approximately two-fifths of wine or one-fifth of whiskey, gin, vodka, etc., per day. The average rating at intake was 2.9. On the basis of our experience with these scales, it would appear that an individual with a rating of 4.0, or lower, would experience a good deal of difficulty in adequately fulfilling familial or employment roles or in achieving a stable residential setting. Eighty-one percent of the patients admitted were rated at four or below.

The remaining 19 percent were marginal in their capacity to function with any degree or normalcy. Only one person achieved a rating of seven at the time of admission.

The after-treatment ratings showed that 47 percent of the patients made significant improvements in their ability to control their consumption of alcohol. Approximately 50 percent demonstrated no markedly improved control, while only three percent actually deteriorated in their drinking pattern. The average rating achieved at the time of the follow-up interview was 4.0, an average of 1.1 over the intake rating. In the categories of five through seven, which represent some degree of stability in the individual's life style, we now find 42 percent of the individuals after treatment as opposed to only 19 percent prior to treatment.

These results greatly exceeded those anticipated by all concerned. Fully 19 percent of the study group had been for all practical purposes abstinent from discharge until the time of the follow-up interview - an average of 120 days of total sobriety.

Certainly, by any standards, this 19 percent would represent unqualified success in treatment outcome. Below is a table of the ratings for the before and after treatment ratings.

Ratings	1	2	3	4	5	6	7	Total %
Before Treatment	26	16	21	18	12	7	-	100%
After Treatment	17	12	15	14	11	12	19	100%

It was found that those achieving a rating of seven after treatment had on the average, slightly higher ratings on the other scales prior to admission. The significance of this result has been demonstrated in other studies of this type - namely, that the type of in-patient treatment administered is not the sole factor for prognosis; in addition, the social settings from which an individual comes and to which he returns after treatment are crucial. The implications of this finding are even more important in a program designed to handle the "revolving door" clientele. A strong referral network and an intensive aftercare program are essential.

Arrests

Discussion of the arrest dimension has been deferred until this point because of the paucity of available data. The seasonal nature of public intoxication arrests precludes comparing equal time periods before and after treatment. Furthermore, a significant percentage of the patients had been residents of St. Louis City for less than one year prior to admission; hence, any measure based on a comparison of specific months for this period prior to admission and after discharge would be incomplete.

This dilemma could not be resolved to this researcher's satisfaction. Earlier in this report, the arrest figures for the City of St. Louis were cited showing a tremendous decrease. The figures presented below, however, provide a better indication of what this lower rate of police contacts meant to the individual in our study group. The findings revealed an average of 1.0 arrests for intoxication in the three months prior to treatment as compared to an average of only 0.3 after treatment. <u>This latter figure represents arrests plus readmissions</u>. As another index, 46 percent were arrested for drunkenness in the three months prior

to their first admission while only 13 percent had been arrested in the same period after discharge.

These figures should be interpreted cautiously, however, as the parameters of these figures have not been fully explored. Nevertheless, it is safe to say that a significant decrease in police intervention after treatment can be noted.

Summary

The scaled scores for each individual were pooled to achieve a cumulative score for both before and after measures. The breakdown of these scores by category is virtually meaningless for individual cases. However, using pooled scores, results showed 50 percent of the patients studied experienced some over-all improvement whereas only eight percent had a lower cumulative score after treatment. Forty-two percent maintained the same score; yet even here actual improvements may have occurred on one scale - only to be canceled out on another.

The following table is presented in summary. The interpretation of these figures should be unequivocal.

Where improvement was reported, it must have been of a significant magnitude to the extent that the individual has, at least in some areas of his life, reversed the prior deterioration process. Many individuals who have received ratings of "remained the same" may well be in the process of establishing new life patterns. It may prove to be unrealistic for this evaluation to demand significant demonstrable change in such areas as housing and employment in a three or four month period. This ideal would seem to be supported by the findings in the area of drinking which indicated more improvement than on the other scales. Further, improved control over one's drinking pattern is certainly a prerequisite for improvement in other areas of life.

	Markedly Improved	Remained Same	Deterio-rated
Drinking	47	50	3
Employment	18	76	6
Income	16	71	13
Health	49	42	9
Housing	15	82	3

IV. TRAINING PROGRAMS

An obvious prerequisite to the development and implementation of an alcohol detoxification program is the assurance that those persons having any kind of role in the operation have a reasonably sound knowledge about the disease of alcoholism and how to treat the person afflicted with that disease. In our situation this applied not only to the traditional therapeutic team of doctor, nurse, social worker, attendants, etc., but also to the police officer since the treatment process literally begins when he makes his first contact with the potential patient.

A. Staff Training

Of primary importance in the establishment of a strong therapeutic program at the St. Louis Detoxification Center was the gathering together of a competent staff and the moulding of them into an effective alcoholism treatment team. In this aspect of its development the Center was fortunate in two respects: St. Mary's Infirmary brought with it a dedicated and capable Hospital Administrator who, with her staff, had quick access to a nucleus of nursing personnel of

demonstrated abilities; further, Dr. Joseph B. Kendis, Medical Director, and Miss Laura E. Root, Social Work Consultant, together brought with them over 40 years experience in the field of alcoholism. These two conducted intensive training sessions for the entire staff during the first three weeks of November, 1966, before the first patient was admitted. During the remaining six weeks of that year, patients were taken on a limited basis in order that concentrated in-service training could be continued. The material covered medical, pharmacological, psychological, and sociological aspects of alcoholism and its treatment with emphasis on the public intoxicant and was presented through didactic lectures, films, reviews of the literature, discussion, group therapy sessions, individual consultation, demonstrations, etc.

Since that time most of the original staff, as well as personnel employed since the opening, have gone through the Alcoholism Education Program conducted by the Social Science Institute of Washington University under the direction of Miss Root. In addition, both Miss Root and Dr. Kendis have held individual and group sessions with the medical externs and with personnel on the

evening and night shifts on an "as needed" basis. Specialized instruction in the techniques of group therapy has also been given to key staff members.

B. Police Officer Training

Since 1962, police recruits at the Police Academy have received training to help them in their recognition of alcoholism, the differentiation of this illness from others, and handling of the inebriate. Originally this consisted of a one hour lecture and time did not permit a thorough training period. This has gradually been expanded to six hours - four hours being conducted by Dr. Kendis, Medical Director of the Center. Two movies are shown. One, "The Mask", illustrates points of differentiation between alcoholism and other illnesses and the police handling of the alcoholic. The other, "For Those Who Drink", tells of the physiological, psychological and social changes related to drinking. In addition, they receive instruction as to the physiology and metabolism of alcohol and further personal instruction as to police handling of inebriated persons and alcoholics. They are also given an opportunity of hearing from and speaking with an alcoholic

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who is now making a success of his life.

In addition, police officers on active duty are shown a Unitrain presentation of "The Road Back". The Unitrain is an instrument consisting of a film strip with a synchronized tape recording. Officers in the Police Academy made this film-tape presentation to acquaint the members of the Police Department with the procedures and operation of the Detoxification Center from the time of pick-up of the intoxicant by the officer, his admission, through the treatment regime. Each of the nine City police districts has a Unitrain machine and through this means, each officer has the opportunity to receive information at regular intervals about the Center.

The last two hours of instruction on alcoholism and the handling of intoxicated persons are given to recruits at the Academy by the police officers. During these two hours recruits learn the procedure of Code 26, taking an intoxicated person to the hospital and booking the subject for "Drunk On The Street" or "Protective Custody". Also included in this period (although not specifically devoted to intoxicated persons) is

instruction to the officer in the procedure at the City Hospital, booking, report writing, record check, "Information" application and appearance in the City Courts.

During his instruction at the Academy, the officer also is assigned for eight days to a car or beat to work with an experienced officer as an observer. This assignment frequently provides an opportunity for him to observe and learn first-hand how situations involving the public intoxicant are handled.

Special Order number 67-S-8 effective March 6, 1967, from the Office of the Chief of Police, gives officers a detailed step by step procedure in handling a Detoxification Center Admission (see Appendix A).

V. TREATMENT SITUATIONS FOR THE PUBLIC INTOXICANT

In the past the chronic police case inebriate has been neglected and/or punished for displaying his drunkenness in public. Unfortunately, this situation has changed very little. Many of these men spend most of their lives in jail even though every indication is that the "revolving door" process - intoxication, arrest, conviction, sentence,

imprisonment, release, intoxication, etc. - has a deteriorating rather than a rehabilitating effect upon the individual.

In a few cities there may be isolated clinics or hospitals which will accept the public intoxicant. In others, such facilities may admit him under very special circumstances. But these instances are the rare exception and even then will usually involve merely sobering him up for release the next morning. In the vast majority of communities - large or small - the jail cell or the "drunk tank" is the only "treatment facility". If he is fortunate he may be given coffee as his "medication". Rather than aid him in his rehabilitation, this system punishes the alcoholic for being sick, forcing him to suffer extremely (and sometimes die) during the withdrawal period from alcohol. As has been documented earlier in this report, this approach is a self-perpetuating one that is costly in law enforcement agency time and in taxpayers' money as well as in human suffering. Nevertheless, outmoded and inhumane and inefficient as it is, one would still have to report that it remains the basic "treatment situation" for the chronic public intoxicant today.

In view of these circumstances, it becomes almost academic

to attempt to determine how many of the persons handled by the Detoxification Center could have been treated as patients in a regular unsegregated hospital facility. If attitudes of all hospital personnel concerning alcoholism and the public intoxicant were positive rather than negative; if all hospital staff were knowledgeable in the treatment of the alcoholic; if sufficient beds were made available; and if ability to pay were not a factor; then, it is quite likely that the vast majority of the Center's patients could have been treated in such a facility. Unfortunately the moral stigma and lack of interest and knowledge is still present and is at least as strong among many medical professionals as it is among lay-people. Substantially more indoctrination and training within the many disciplines at work in the hospital setting will be required before one can realistically rely on them as a major treatment resource for the alcoholic in general and the chronic public intoxicant in particular.

With regard to the question of the relative merits of the separate versus integrated facility, we would certainly concede that detoxification can take place within an integrated facility. However, our experience at the Center and elsewhere leads us to the conclusion that far better results can be achieved in a segregated facility set up solely to

work with the alcoholic. A staff especially trained and experienced in this work can be employed; the initial therapies appropriate for the patients as a group can be provided much more effectively; diagnostic evaluation and recommendations for further treatment can be more thorough because of a more comprehensive picture of the patient; and, the vital "clearing house" role can be implemented by coordinating the necessary referrals to appropriate agencies. However, these conclusions notwithstanding, each community must consider its own individual needs and plan to meet them on the basis of its own resources and knowledgeable judgment.

VI. SUMMARY OF FINDINGS

The broad goals of the St. Louis Detoxification Center experiment as cited in the Introduction were twofold:

1. To determine what rehabilitative effect a short-time treatment approach might have on the life style of the chronic public intoxicant and to what extent his "revolving door" pattern could be altered.

2. To determine to what extent this new process might effect a time saving on the part of the police and

indirectly upon the court and the penal institution.

Findings relative to the impact of the Center on the public intoxicant stemmed from a study of 200 male patients made through interviews conducted an average of four months after discharge. Five areas were evaluated - drinking, employment, income, health and housing. Using pooled rating scores that reflected a composite of all five indices, it was found that 50 percent of the patients studied demonstrated significant overall improvement. Examination of the total sample group according to each of the five categories revealed that almost half of them (47 percent and 49 percent respectively) showed marked improvement in their drinking pattern and general health and 15 percent to 18 percent showed significant improvement in the areas of housing, income, and employment.

As an additional indicator of a change in life style for this sample of the chronic police case inebriate, the "before-and-after" arrest record was also examined. The findings revealed an average of 1.0 arrests for intoxication in the three months prior to treatment as compared to an average of only 0.3 after treatment. This latter figure represents arrests plus readmissions. As another index,

46 percent had been arrested for drunkenness in the three months prior to their first admission while only 13 percent had been arrested in the same period after discharge.

With regard to the potential time-saving effect of the Center on the operations of several law enforcement agencies, findings were arrived at essentially by comparing relevant data from 1966 with those from 1967. The following results were revealed: through the use of the Center the time required to "process" a public drunkenness offender was reduced 50.2 percent and this reflects only the time saved by the arresting officer, not other related Department personnel; there was a 34.5 percent decrease in the number of public drunkenness cases appearing on the docket of the City Court; and, there was a 38.7 percent reduction in the number of prisoners confined in the Workhouse on the charge of being Drunk On The Street.

VII. CONCLUSIONS AND RECOMMENDATIONS

The previous chapter reported the findings revealed in the evaluation study made of the Detoxification Center's impact on the patients it treated and on the operations of several related law enforcement agencies. From these findings

several firm conslusions may be drawn:

1. The public intoxicant can respond to and benefit to a significant degree from treatment. This observation is reinforced by similar clinical results from some European countries as well as by those from the Alcoholism Treatment and Research Center in St. Louis.

2. A detoxification center makes possible a procedure that can drastically reduce the amount of time that the police are involved with the public intoxicant. This procedure also reduces substantially the time involvement of related agencies, particularly the City Courts and penal institution.

3. A detoxification center provides a valuable, much needed and heretofore unavailable service that not only greatly benefits the recipient but also relieves other agencies to devote their time more productively to their own specialized services.

Based on these conclusions as well as on the more generalized, overall experience acquired during the course of the Detoxification Center's operation, the project staff formulated

a number of pertinent recommendations. Only one of these related specifically to the on-going treatment procedure and that was that it would be desirable to have more flexibility in the length of the hospitalization period. Instead of the relatively fixed period of seven days, it was felt that potential variability ranging from a matter of hours up to ten to fourteen days would be preferable.

Other recommendations are of a more general nature and are related to the capacity for the expansion and extension of basic services. It is recommended that consideration be given to the concept of a single detoxification and diagnostic center being developed to handle these functions for the entire City and possibly the metropolitan area, incorporating the role of "clearing house" to avoid duplicating and possibly conflicting treatment of individual patients. Under such an arrangement it is felt that sounder diagnostic evaluation could be made and with them, more appropriate and effective referrals for further treatment if feasible. The success of such an approach is obviously contingent upon a close liaison and smooth working relationship between such a center and the various other alcoholism treatment services and facilities.

It is further recommended that admissions not be limited to those patients brought in by the police but that center staff have the freedom to accept "walk-ins" and referrals from other sources.

Moreover, it is recommended that continuing and expanded efforts be made to strengthen and develop a wide range of aftercare services and facilities - outpatient, day hospital, night hospital, half-way house, domicilary care, sheltered workshop, a broad court-related program, etc.

Finally, it is recommended that the special training of the police in the handling of public intoxicants be continued and, if possible, expanded. Further, that intensified efforts be made to interject the whole area of the treatment of alcoholism into the training programs of such helping professions as medicine, nursing, social work, ministry, etc.

Although most of these recommendations are neither new nor profound, they are brought to the forefront by the tremendous need for services which appear daily in the operation of the St. Louis Detoxification and Diagnostic Evaluation Center.*

* The Center has become a permanent treatment facility and has been moved to the St. Louis State Hospital, 5400 Arsenal Street, St. Louis, Missouri 63139.

APPENDICES

Appendix A-1
METROPOLITAN POLICE DEPARTMENT - CITY OF ST. LOUIS
OFFICE OF THE CHIEF OF POLICE
SPECIAL ORDER

Date Issued March 3, 1967 Order No. 67-S-8

Effective Date March 6, 1967 Expiration Indefinite

Reference

Cancelled Publications

Subject St. Louis Detoxification Center Procedure - (Participating Districts To Be Determined by the Chief of Field Operations)

TO: ALL BUREAUS, DISTRICTS AND DIVISIONS

I. INTRODUCTION

A. This Department has applied for and received a Federal grant from the Office of Law Enforcement Assistance for the operation of a "Detoxification Center". The Center, located on the third floor at St. Mary's Infirmary, 1536 Papin Street, phone CH 1-8720 or police phone station 237, will accommodate a maximum of thirty (30) patients. Treatment is limited to persons brought to police attention on the charge of public drunkenness only. The following procedures will outline the necessary action on the part of police officers in order to assemble the data agreed to in the grant, serving all concerned with the information required for analysis.

B. A new form, the St. Louis Detoxification Center Admitting Form, MPD Form 150-1, Rev. 1, is to be used exclusively when the intoxicated persons are admitted to the Center for treatment.

II. PURPOSE

The desired result of this Center is to provide medical treatment for chronic alcoholics in any case where their only offense is public drunkenness, and to attempt to rehabilitate them. An after-care program will refer them to community agencies for the necessary service. Thus, it is planned to remove the chronic police case inebriate from the streets, court and jail.

III. ADMISSION REQUIREMENTS FOR THE DETOXIFICATION CENTER

A. A police officer, when observing a publicly intoxicated person, will detain the individual, request a Code 27 conveyance, and transport the individual to the Detoxification Center when:

1. There are no other charges against the individual;

2. No signs of injury or illness requiring emergency medical attention at a City Hospital are present or the patient is not unconscious; and,

3. No complainant wishes to pursue the incident as a prosecuting witness; or,

4. The subject does not indicate a wish for trial or legal representation.

B. If the conditions listed above (III., A.) are not met by the publicly intoxicated person, he must be processed as a Code 26 -- that is, taken to a City Hospital for a physical examination and then forwarded to Prisoner Processing Division for booking as "Drunk-on-Street" or "Protective Custody".

C. Intoxicated persons removed from private property must be handled as a Code 26 and booked as "Protective Custody". Being on private property, they cannot be issued a City Court Summons for Public Drunkenness.

D. Only those people who meet the above standards and are conveyed by officers of this Department can be admitted to the St. Louis Detoxification Center.

E. The Center can accept admissions every day of the week, 24 hours each day.

IV. FIELD PROCEDURES

A. Code 27 is the designation to be used when calling the dispatcher to transport a publicly intoxicated person to the Detoxification Center.

B. If an officer is on a radio assignment, such as "Person Down", etc., and he decides that a Code 27 disposition is more appropriate, he will reclassify the incident to a Code 27, inform the dispatcher of the number of subjects to be conveyed to the Detoxification Center, and request a cruising patrol.

C. If the officer has more subjects than the Center can admit, the dispatcher will inform the officer to handle the incident according to present procedure for Drunk-on-Street arrests (as Code 26).

D. When the subject(s) are to be processed as a Code 27, the officer will initiate a wanted check by name on the radio whenever possible.

E. If the patrol car on the Code 27 assignment is a two-man car, one officer, upon arrival of the conveyance, will accompany the subject(s) in the cruising patrol to the Center and the second officer will return to service as a one-man car.

F. The Detoxification Center has no provisions for handling juveniles. If the subject is a juvenile, he will be conveyed to the nearest City Hospital and the Juvenile Detention Center notified.

NOTE: Code 26 and intoxicated juvenile cases require a complaint number; no complaint number is required for a Code 27.

V. ADMITTING PROCEDURE AT DETOXIFICATION CENTER

A. Officers are to use the west entrance door at the Infirmary for admissions. The door is marked ST. LOUIS DETOXIFICATION CENTER - ENTRANCE.

B. Upon arrival at the Infirmary, an officer will press the bell-button designated for the 3RD FLOOR. An attendant will then meet the officers at the entrance with a wheelchair to assist with handling of the patients. The attendant will escort the officers and patient(s) to the third floor Detoxification Center.

NOTE: Patient must be placed in a wheelchair upon arrival to prevent possible injury.

C. At the admitting station on the third floor of the Infirmary, the assisting officer (normally the Cruising Patrol Officer) will accompany the patient until the nurse indicates that his assistance is no longer needed. Each subject is to be thoroughly searched.

D. The reporting officer, first of all, will initiate a wanted check by name via police phone station 237, located at the admitting station on the third floor, if this was not accomplished on the radio.

E. The reporting officer will then prepare in triplicate, an admitting form MPD Form 150-1, Rev. 1, and a City Court Summons with the charge of "Public Drunkenness" for each patient admitted.

F. Distribution of copies of the admitting form and City Court Summons:

1. The Officer's Copy (blue) of the summons is attached to the second carbon copy of the admitting form. This second carbon copy, with summons, and the ORIGINAL copy of the admitting form, are taken by the reporting officer when he returns to service and given to his Precinct Sergeant.

2. The Precinct Sergeant will give the forms to the District Desk Officer. The District Desk Officer will daily forward the original copy of the admitting form to the Planning and Research Division via transmittal envelope; the second carbon copy of the admitting form and the Officer's Copy of the summons will be filed in the District.

3. The Court Copy (white) and Defendant's Copy (pink) of the City Court Summons will remain at the Center with the first carbon copy of the admitting form.

NOTE: Because a police report is not required, (only the admission form) there will be no record of a Code 27 in the Records Section.

G. After the intoxicated person is admitted to the Detoxification Center, his stay is strictly voluntary.

VI. COURT DATE

A. The court date on the City Court Summons will be set at least ten (10) days from the patient's admission to the Center, or on the officer's next court day past the ten (10) days.

B. When the patient is released after treatment, the summons will be forwarded to Planning and Research Division where same will be voided by that Unit.

C. If the patient leaves the Center prior to Medical release, the Court Copy of the summons will be forwarded by the Center personnel to the Fourth District where an officer will apply for an information. In most cases the inebriate will be a "defendant not found" (DNF), and the next time he is arrested, he will be booked and sent to court for trial.

VII. PREPARATION OF ADMITTING FORM (MPD Form 150-1, Rev. 1)

A. When preparing the admitting form, the reporting officer will make every effort to fill in all of the requested information.

B. The only items NOT to be filled in by the reporting officer are: Box 34, Box 35, Box 36, and Box 39.

C. The following items are explained for clarity:

Item 4 The "Admission Number" is the patient identification number and will be issued by the admitting personnel at the Center.

Item 23 "Education refers to the last grade completed by the subject (6th, 8th, 11th, High School Graduate, etc.).

Item 24 "Wanted Check Per". If the wanted check was obtained by radio, write "RADIO". If the wanted check was obtained from the Records Section, give the clerk's name and DSN.

Item 25 "Name of Spouse or Nearest Relative". Include relationship such as wife, cousin, friend, etc. This might be thought of as "Whom to notify in case of emergency". This notification is made by Detoxification Center personnel.

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Item 29 "Time Out of Service".

Item 30 "Arrive Medical" - time arrived at St. Mary's Infirmary.

Item 31 "Leave Medical" - time when leaving the Center.

Item 32 "Time In Service".

Item 33 "Remarks - (Include List of Property)". - This space is for a brief description of the subject's condition when found (i.e., Subject found asleep in alley, stated he had been drinking, subject staggering in middle of street, stated he was lost) and listing of all his personal property, EXCEPT CLOTHING WORN.

NOTE: After listing the patient's property on the admitting form, the police officer will place the items in the property envelope. He will list all items on the envelope, together with the subject's name and admission number. The officer and admitting nurse will both sign the property envelope as evidence to its contents. The property envelope will remain at the Center.

VIII. REVISION OF INTOXICATED PERSON REPORT (MPD Form 42, Rev. 1)

A. A condition of the grant provides that a comparison be made of the time elements involved in the Code 26 and Code 27 operations. To meet this condition, the Intoxicated Person Report was revised to include four (4) additional boxes:

Box 24 "Time Out of Service".

Box 25 "Arrival Medical". Time arrived at a City Hospital.

Box 26 "Leave Medical". Time when leaving a City Hospital.

Box 27 "Time In Service".

B. On the effective date of this Special Order, the revised Intoxicated Person Report is to be used and Form 42, is to be cancelled.

IX. COMMUNICATIONS

A. On-View Incident

1. When an officer calls out-of-service for an on-view incident, and the incident develops into a Code 27 or Code 26, he shall so advise the dispatcher. No complaint number will be issued by radio. If the incident develops into a Code 26, where a report is required, the officer will obtain a no-dispatch complaint number by telephone and proceed in the usual manner.

2. Dispatchers, upon request, can reclassify a self-initiated call out-of-service to either a 4227 (Code 27) or 4226 (Code 26). The dispatcher will not place a complaint number on this ticket.

B. Radio Assignment

1. When a patrol vehicle receives a radio assignment, and the incident develops into a Code 27, the dispatcher upon request will reclassify the incident as a 4227 (Code 27); the disposition will be Code R (Robert).

2. If the incident develops into a Code 26, the dispatcher will reclassify it to a 4226. The assigned officer will give a "Report" disposition and will receive a complaint number via radio.

C. Detoxification Center to Communications Division

Every increase or decrease in the Center's patient population will be noted by the Center's admitting clerk. The clerk will advise the Communications Division of the number of patients it can receive. The dispatcher will insure that officers do not proceed to the Center with more inebriates than can be admitted.

By Order of:

Curtis Brostron

CURTIS BROSTRON
Colonel
Chief of Police

CB/ml:ps
250:16:42

Appendix A-2

METROPOLITAN POLICE DEPARTMENT - CITY OF ST. LOUIS
ST. LOUIS DETOXIFICATION CENTER --- ADMITTING FORM
LEAA GRANT NO. 093

HOW COMPLAINT RECEIVED: (1) ☐ Radio ☐ Station ☐ Citizen ☐ On View		DATE (2)	DIST. OF OCC. (3)	ADMISSION NUMBER (4)
TYPE OF PREMISES (5)	DATE & TIME OCCURRED (6)	LOCATION OF OCCURRENCE (7)		PATROL AREA (8)
NAME (9)		HOME ADDRESS (10)		HOME PHONE (11)
		BUSINESS ADDRESS (12)		PHONE

SEX (13)	AGE (14)	RACE (15)	HEIGHT (16)	WEIGHT (17)	MARITAL STATUS (18) S M D W	OCCUPATION (19)	SOCIAL SECURITY NUMBER (20) — —

DATE OF BIRTH - CITY AND STATE (21)	TIME IN CITY (22)	EDUCATION (23)	WANTED CHECK PER (24) DSN
NAME OF SPOUSE OR NEAREST RELATIVE (25)	HOME ADDRESS (26)		HOME PHONE (27)
	BUSINESS ADDRESS (28)		PHONE

TIME OUT OF SERVICE (29)	ARRIVE MEDICAL (30)	LEAVE MEDICAL (31)	TIME IN SERVICE (32)

REMARKS (33)	LIST OF PROPERTY

ADMITTING FINDINGS (34)	DOCTOR'S SIGNATURE (35)	SIGNATURE OF ADMITTING PERSONNEL (36)
CONVEYANCE (37)	SIGNATURE OF REPORTING OFFICER - DSN - DIST./DIV. (38)	

FOR DOCTOR'S USE ONLY - DIAGNOSIS AND CASE DISPOSITION (39)

MPD Form 150-1 (Rev.-1)

Appendix A-3

METROPOLITAN POLICE DEPARTMENT - CITY OF ST. LOUIS
Intoxicated Person Report

MPD Form 42 (Rev.-1)

HOW COMPLAINT RECEIVED: (1) ☐ Radio ☐ Station ☐ Citizen ☐ On View		DATE (2)	DIST. OF OC. (3)	COMPLAINT NUMBER (4)
TYPE OF PREMISES (5)	DATE & TIME OCCURRED (6)	LOCATION OF OCCURRENCE (7)		PATROL AREA (8)
NAME (9)		HOME ADDRESS (10)		HOME PHONE (11)
		BUSINESS ADDRESS OR PHONE (12)		

SEX (13)	AGE (14)	RACE (15)	HEIGHT (16)	WEIGHT (17)	MARITAL STATUS (18) S M D W	OCCUPATION (19)

HAVE YOU BEEN DRINKING? (20) WHAT? QUANTITY?

(21) CIRCLE APPROPRIATE DESCRIPTION

BREATH	Odor of Alcoholic Liquor Apparently None Faint Moderate Strong
COLOR OF FACE	Apparently Normal Flushed Pale Other
CLOTHES	Orderly Mussed Soiled Disorderly
ATTITUDE	Polite Excited Hilarious Talkative Care-free Sleepy Other Cooperative Indifferent Antagonistic Cocky Combative Insulting
UNUSUAL ACTIONS	Profane Hiccoughing Belching Vomiting Other
EYES	Apparently Normal Watery Bloodshot

DESCRIBE ANY INJURIES (22)
AND HOW RECEIVED

REMARKS (23)

OUT OF SERVICE (24)	ARRIVE MEDICAL (25)	LEAVE MEDICAL (26)	TIME IN SERVICE (27)

DIAGNOSIS (28)	CONVEYANCE (29)	DOCTOR AND HOSPITAL NAME (30)

SUPER. INITIAL (31)	SIGNATURE OF REPORTING OFFICER, DSN, DIST./DIV. (32)	NAME OF ARRESTING OFFICER, DSN (33)

Appendix A-4

SUMMONS

COURT'S COPY

IN THE CITY COURT OF ST. LOUIS, MISSOURI,

DIVISION NO._____

St. Louis, Missouri, Plaintiff

vs.

_____, Defendant

_____, Defendant's Address

Description:

Race	Sex	Weight	Height	Birth Date	Age

Employer: _____

STATE OF MISSOURI)
) SS
CITY OF ST. LOUIS)

The City of St. Louis, Missouri, To The Above-Named Defendant:

You are hereby summoned to appear personally before this court at 1320 Market Street, St. Louis, Missouri

on the _____ day of _____, 19___, at _____ o'clock, ___. M., to answer a complaint (information) charging you with

_____

_____

_____

If you fail to appear a warrant will be issued for your arrest.
Served under my hand this _____ day of _____, 19___.

_____

_____ of the Metropolitan Police Department of St. Louis, Missouri.

RETURN ON SERVICE OF SUMMONS

I hereby certify that I served the within summons:

1) By delivering on the _____ day of _____, 19____, a copy of the summons to the within-named defendant.

_____

_____

2) By leaving on the _____ day of _____, 19____, for the within-named defendant,

_____

_____

a copy of the summons at the respective usual place of abode of the said defendant with some person of his or her family over the age of 15 years.

All done in the City of St. Louis, Missouri, (or) all done in the _____ County, Missouri.

_____ Defendant's Signature

_____ Police Officer

MPD Form 200-47a (Rev. 1)

Appendix B-1

BUREAU OF FIELD OPERATIONS

PILOT PROGRAM

Date Issued February 11, 1963 Effective Date 7:00 a.m., February 13, 1963

Subject: "Drunk on Street" - Pilot Program

PURPOSE

1.1 The purpose of this pilot program is to ascertain the best method for removing intoxicated persons from the streets, alleys and public places in the city. The proposed method minimizes the paper work of arresting officers and expedites the processing of these people. The program is restricted to those individuals whose only violation is a state of drunkenness. Intoxicated persons creating disturbances, driving automobiles, or participating in any additional crime will be processed in accordance with standard practice.

1.2 The "Drunk on Street" pilot program presents four major changes in current practice:

a. Officers who arrest subjects for "Drunk on Street" shall not complete the Intoxicated Person Report.

b. Arresting officers need not apply for information in these cases.

c. During the Second Watch, each District will operate a two-man cruising patrol. On the other watches, intoxicated persons will be transported by two-man cruising patrols from the Second, Fourth and Sixth Districts.

d. Subjects arrested "Drunk on Street" shall be booked in the Fourth District "Drunk on Street" or "Protective Custody."

ARRESTING OFFICERS

2.1 Commissioned personnel of this Bureau shall extend every effort to arrest and remove intoxicated persons from the streets, alleys and public view. Officers making such arrests shall frisk the subject for weapons, request a conveyance via radio for Code 26, and keep the prisoner secure and safe until a cruising patrol arrives. When the subject is placed in the conveyance, the arresting officer shall immediately return to service.

2.2 When the arrest is made as a result of radio assignment, the arresting officer shall record the complaint number and give it to the cruising patrol personnel who will place it in the report.

2.3 When the arrest results from an on-sight observation, the arresting officer will not be given a complaint number. Instead, the officer making the report will get the complaint number via telephone from the Radio Clerk.

CRUISING PATROL PERSONNEL

3.1 On the first and third watches, intoxicated persons will be transported by two-man cruising patrols from the Second, Fourth and Sixth Districts. On the Second Watch, each District shall staff one cruising patrol with two men. Watch Commanders shall advise the Communications Division of the radio call number of the two-man cruising patrol.

3.2 Intoxicated persons shall be transported from the scene of arrest to the nearest City Hospital for diagnosis, and then to the Fourth District where they shall be booked and confined. With the exceptions of subjects arrested in the Fourth District, intoxicated persons shall not be booked in the District of arrest.

REPORT WRITING

4.1 The intoxicated person report shall be completed by police officers assigned to the cruising patrols. At the discretion of the writer, the report may be completed at the hospital or Headquarters. Instructions for completing the report will be provided to cruising patrol personnel. In accordance with current practice, the report form is a multilith mat requiring the use of Department issued multilith pencils or pens.

BOOKING

5.1 Intoxicated persons arrested on the street or in alleys shall be booked "Drunk on Street." Intoxicated persons removed from private property shall be booked "Protective Custody." If additional charges are placed, the arresting officer shall complete the regular reports and follow normal procedure.

5.2 A Fourth District Court Officer shall be responsible for applying for informations on all persons charged "Drunk on Street."

5.3 Intoxicated persons charged "Protective Custody" will be released when sober. Informations shall not be applied for on subjects booked "Protective Custody."

By Order of:

Lt. Col. James L. Shea
Chief, Field Operations

HAD/mjz

Appendix B-2

METROPOLITAN POLICE DEPARTMENT - CITY OF ST. LOUIS

Intoxicated Person Report

WPD Form 42 (1/83)

HOW COMPLAINT RECEIVED: (1) ☐ Radio ☐ Station ☐ Citizen ☐ On View	DATE (2)	DIST. OF OC. (3)	COMPLAINT NUMBER (4)

TYPE OF PREMISES (5)	DATE & TIME OCCURRED (6)	LOCATION OF OCCURRENCE (7)	PATROL AREA (8)

NAME (9)	HOME ADDRESS (10)	HOME PHONE (11)
	BUSINESS ADDRESS OR PHONE (12)	

SEX (13)	AGE (14)	RACE (15)	HEIGHT (16)	WEIGHT (17)	MARITAL STATUS (18) S M D W	OCCUPATION (19)

HAVE YOU BEEN DRINKING? (20) WHAT? QUANTITY?

(21) CIRCLE APPROPRIATE DESCRIPTION

BREATH	Odor of Alcoholic Liquor Apparently None Faint Moderate Strong
COLOR OF FACE	Apparently Normal Flushed Pale Other
CLOTHES	Orderly Mussed Soiled Disorderly
ATTITUDE	Polite Excited Hilarious Talkative Care-free Sleepy Other Cooperative Indifferent Antagonistic Cocky Combative Insulting
UNUSUAL ACTIONS	Profane Hiccoughing Belching Vomiting Other
EYES	Apparently Normal Watery Bloodshot

DESCRIBE ANY INJURIES (22)
AND HOW RECEIVED _____

REMARKS (23) _____

DIAGNOSIS (24)	CONVEYANCE (25)	DOCTOR AND HOSPITAL NAME (26)

SUPER. INITIAL (27)	SIGNATURE OF REPORTING OFFICER, DSN, DIST./DIV. (28)	NAME OF ARRESTING OFFICER, DSN (29)

Time Indicated By Officers' Original Report
That Assignment Was Received As Indicated By Scale
For The Period Of January 1, 1967 to December 31, 1967

*Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	Total
Detoxification Center Admissions																									
District 3	8	4	4	1	1	1	1	2	3	3	7	13	15	19	24	18	25	23	17	20	18	13	14	3	257
District 4	16	6	3	4	1	-	-	3	5	16	15	29	33	42	29	38	45	38	32	27	25	27	24	18	476
District 9	1	1	1	1	1	-	-	1	1	6	6	10	12	8	5	10	6	10	11	2	9	9	2	5	118
Total	25	11	8	6	3	1	1	6	9	25	28	52	60	69	58	66	76	71	60	49	52	49	40	26	851
Protective Custody																									
District 3	2	-	1	1	-	-	-	-	1	-	1	-	2	1	1	4	5	5	6	4	2	3	-	3	42
District 4	3	7	4	6	3	3	2	-	3	7	6	9	9	11	7	11	11	10	17	10	12	7	7	1	166
District 9	2	-	2	-	-	-	-	-	-	-	1	3	1	1	3	3	2	2	4	3	3	1	2	2	35
Total	7	7	7	7	3	3	2	-	4	7	8	12	12	13	11	18	18	17	27	17	17	11	9	6	243
Drunk On The Street																									
District 3	-	-	1	-	-	-	-	-	-	-	2	1	-	-	-	-	-	-	-	1	-	-	-	-	5
District 4	2	2	-	2	-	-	1	-	2	11	8	1	4	3	4	3	6	1	2	1	1	2	-	1	57
District 9	-	-	-	-	-	-	-	-	-	2	-	-	-	1	1	1	-	-	-	-	-	-	-	-	5
Total	2	2	1	2	-	-	1	-	2	13	10	2	4	4	5	4	6	1	2	2	1	2	-	1	67
Total Detoxification Center Admissions, Protective Custody, Drunk On The Street																									
District 3	10	4	6	2	1	1	1	2	4	3	10	14	17	20	25	22	30	28	23	25	20	16	14	6	304
District 4	21	15	7	12	4	3	3	3	10	34	29	39	46	56	40	52	62	49	51	38	38	36	31	20	699
District 9	3	1	3	1	1	-	-	1	1	8	7	13	13	10	9	14	8	12	15	5	12	10	4	7	158
Total	34		16		6		4		15		46		76		74		100		89		70		49		1161
		20		15		4		6		45		66		86		88		89		68		62		33	

*12:00 Midnight to 1:00 AM as 1
1:00 AM to 2:00 AM as 2
2:00 AM to 3:00 AM as 3
3:00 AM to 4:00 AM as 4
4:00 AM to 5:00 AM as 5
5:00 AM to 6:00 AM as 6
6:00 AM to 7:00 AM as 7
7:00 AM to 8:00 AM as 8
8:00 AM to 9:00 AM as 9
9:00 AM to 10:00 AM as 10
10:00 AM to 11:00 AM as 11
11:00 AM to 12:00 Noon as 12
12:00 Noon to 1:00 PM as 13
1:00 PM to 2:00 PM as 14
2:00 PM to 3:00 PM as 15
3:00 PM to 4:00 PM as 16
4:00 PM to 5:00 PM as 17
5:00 PM to 6:00 PM as 18
6:00 PM to 7:00 PM as 19
7:00 PM to 8:00 PM as 20
8:00 PM to 9:00 PM as 21
9:00 PM to 10:00 PM as 22
10:00 PM to 11:00 PM as 23
11:00 PM to 12:00 Midnight as 24

City Drunkenness Arrests Of Persons Ch ged And Detoxification Center Admissions
From January 1, 1966 to December 31, 1966 and January 1, 1967 to December 31, 1967

			Arrest By Charge							
	Detoxification Admissions		Drunk On The Street		Protective Custody		Drunk		Drinking In A Public Place	
Month	1966	1967	1966	1967	1966	1967	1966	1967	1966	1967
January		45	39	16	96	35			17	2
February		68	21	8	104	48	3		13	1
March		101	87	19	123	46	1		11	2
April		80	67	19	135	54			9	1
May		96	58	13	105	54			5	3
June		98	52	14	121	46	1		18	22
July		101	53	25	81	46	1	4	4	7
August		101	36	28	65	46			2	3
September		105	37	21	59	47		1	7	1
October		104	46	19	67	33	1		6	2
November	10	108	28	13	60	35		1	5	1
December	50	113	16	20	52	36			7	4
Total	60	1120	540	215	1068	526	7	6	104	49
	Increase or Decrease			-325		-542		-1		-55
	% of Increase or Decrease			-60.2%		-50.7%		-14.3%		-52.9%

1967 - Adults Arrested and Detoxification Admissions - 1916
1966 - Adults Arrested and Detoxification Admissions - 1779
Increase 137
% of Increase 7.7%

1966 - Adults Arrested for Drunkenness Charges - 1719
1967 - Adults Arrested for Drunkenness Charges - 796
Decrease 923
% of Decrease 53.7%

Source: Computer Listing By Charge of Persons Arrested Indicated By Age, Race and Sex

City Drunkenness Arrests And Detoxification Center Admissions By District

1966					1967				
District	Drunkenness Arrests Adult	Drunkenness Arrests Juvenile	Detox Admissions	Total	District	Drunkenness Arrests Adult	Drunkenness Arrests Juvenile	Detox Admissions	Total
1	41			41	1	14		1	15
2	41	1		42	2	32			32
3	259	8	12	279	3	136	6	348	490
4	915	2	48	965	4	408		610	1018
5	49			49	5	18	1	1	20
6	14			14	6	13			13
7	109			109	7	52		1	53
8	43	2		45	8	31	1		32
9	232	1		233	9	88	1	159	248
B.I.*	1			1	B.I.*				
T.D.**	10			10	T.D.**	2			2
Other	5			5	Other	2			2
Total	1719	14	60	1793	Total	796	9	1120	1925

1966-1967 Comparison of Drunkenness Arrests and Detoxification Center Admissions By District Totals

District/Division	1	2	3	4	5	6	7	8	9	B.I.*	T.D.**	Other	Total
1966	41	42	279	965	49	14	109	45	233	1	10	5	1793
1967	15	32	490	1018	20	13	53	32	248	-	2	2	1925
% Increase/Decrease	-63.4	-23.8	+75.6	+5.5	-59.2	-7.1	-51.4	-28.9	+6.4	-100	-80	-60	+7.4

This information was obtained from the Age, Race, and Sex Report of Persons Arrested or taken into custody for Drunkenness and Admission Forms of Persons Admitted to the Detoxification Center.

* Bureau of Investigation
** Tactical Deployment Division

Appendix E

Prosecution Statistics

Charge: Drunk On The Street

For The Period Of January 1, 1966 to December 31, 1966 and January 1, 1967 to December 31, 1967

	1966			1967		
	Districts 3, 4, 9 Amount	% of City	City	Districts 3, 4, 9 Amount	% of City	City
Information Applications	479	90	530	207	85	244
Informations Issued	312	90	346	172	83.5	206
Informations Refused	167	91	184	35	92	38
% Issued	65.1	-	65.3	83.1	-	84.4
Number Released On Summons	26	81	32	11	100	11
Pending	22	92	24	10	100	10
No Information Application	1	33	3	1	100	1
Bench Warrant	1	33	3	2	50	4
Withdrawn	3	100	3	1	100	1
Authorized	1	100	1	-	-	-

Information Abstracted From Police Department Computer Center's Daily Arrest Register Listing

Comparison City Court Final Disposition
Charge - Drunk On The Street
Periods January 1, 1966 to December 31, 1966 and January 1, 1967 to December 31, 1967

1966		Acq	Guilty	DNF	NPWE	NPCA	NPCC	DWE	Total	Monthly Total
Jan.	Court 1		11	1			2	9	23	
	Court 2		24				3		27	50
Feb.	Court 1	1	10				1	4	16	
	Court 2	2	6						8	24
Mar.	Court 1		14				1	12	27	
	Court 2	1	32				1		34	61
Apr.	Court 1		6				2	18	26	
	Court 2		7		2				9	35
May	Court 1	1	8	3				7	19	
	Court 2		22		1				23	42
June	Court 1		9	2			1	7	19	
	Court 2	1	25	2			1	4	33	52
July	Court 1		10	2			1	3	16	
	Court 2		9						9	25
Aug.	Court 1		10					4	14	
	Court 2		7	3			2		12	26
Sept.	Court 1		9				2	2	13	
	Court 2		9	1					10	23
Oct.	Court 1	1	16		2				19	
	Court 2	2	9		3				14	33
Nov.	Court 1		6				2	3	11	
	Court 2		5	1	3		3		12	23
Dec.	Court 1		4					1	5	
	Court 2		9		1				10	15
Total		9	277	15	12	-	22	74	409	409

1967		Acq	Guilty	DNF	NPWE	NPCA	NPCC	DWE	Total	Monthly Total
Jan.	Court 1		10	3		1		2	16	
	Court 2		2		1				3	19
Feb.	Court 1		4	2	1		5	2	14	
	Court 2		7	2			1		10	24
Mar.	Court 1		6				1	3	10	
	Court 2		5	1	1		1		8	18
Apr.	Court 1		2				1	2	5	
	Court 2		9	1			1		11	16
May	Court 1		2	1					3	
	Court 2		10		1				11	14
June	Court 1		14	1			2	2	19	
	Court 2		11	2			1		14	33
July	Court 1		10				1	2	13	
	Court 2	1	13		2				16	29
Aug.	Court 1		8	2	1		1	3	15	
	Court 2	1	14	3				1	19	34
Sept.	Court 1		6	2	3		2	2	15	
	Court 2	1	4				2		7	22
Oct.	Court 1		10	2	1			1	14	
	Court 2	1	9	2	1			1	14	28
Nov.	Court 1		5		2		1		8	
	Court 2		8				1		9	17
Dec.	Court 1		5					1	6	
	Court 2		7	1					8	14
Total		4	181	25	14	1	21	22	268	268

Acq - Acquitted
DNF - Defendant Not Found (Warrant)
NPWE - No Prosecution Want of Evidence
NPCA - No Prosecution Cause Abated
NPCC - No Prosecution Cause Consolidated
DWE - Discharged Want of Evidence

Information abstracted from Computer Listing
Monthly Statistics, Court Dispositions by Charge
Prepared By Abstracting Data From Court Docket

Total Drunk On The Street Dispositions
1966 - 409; 67.7% found guilty
1967 - 268; 67.5% found guilty
Decrease of Dispositions - 141, or 34.5%

Appendix H

Yearly Comparison

Commitments For Charge "Drunk On The Street"
To The St. Louis Medium Security Institution
Calendar Years 1966 and 1967

Month	Number Of Persons Committed 1966	1967
January	25	6
February	13	8
March	28	9
April	14	9
May	21	7
June	12	18
July	22	15
August	14	16
September	16	8
October	24	13
November	8	7
December	7	9
Total	204	125
Decrease In Persons Committed		79
Percentage Of Decrease In Commitments		38.7%

The information for the totals listed was obtained from the Medium Security Institution Records and supplied by the Commissioner of Adult Services, Department of Welfare.

Appendix I

Yearly Comparison

Inmate Days For Charge "Drunk On The Street"
At The St. Louis Medium Security Institution
Calendar Years 1966 and 1967

Month	Number Of Inmate Days 1966	1967
January	412	95
February	297	88
March	495	153
April	253	106
May	331	95
June	224	263
July	367	260
August	232	271
September	179	126
October	291	229
November	136	144
December	108	111
Total	3325	1941
Decrease In Inmate Days		1384
Percentage Of Decrease Inmate Days		41.6%

The information for the totals listed was obtained from the Medium Security Institution Records and supplied by the Commissioner of Adult Services, Department of Welfare.

Appendix J

Treatment Regime

The treatment regimen which has been described in earlier reports consists of a number of things done for, to, and with the public intoxicants brought to us. It is an effort to help them move out of their old way of life into becoming WHOLE human beings by showing them that someone cares what happens to them. The process starts with a physical evaluation to determine whether the patients needs only treatment for alcoholism or if additional physical attention may be necessary.

On admission, the patient is immediately showered, examined, dressed in pajamas and put to bed in the intensive care unit. All alcohol intake is stopped at once and replaced temporarily with tranquilizing drugs, such as Librium (chlordiazepoxide), which is slowly withdrawn over several days. The patient is given what other medications he may need, which includes large doses of vitamins both orally and hypodermically. He is fed good nourishing food and orange juice to which has been added extra carbohydrates for additional nutrition. Under this regimen, the patient is detoxified quickly and with a minimum of discomfort.

During this time, each patient receives a complete medical history and physical examination; an injection of tetanus-diphtheria toxoid to help prevent these two diseases; he receives a V.D.R.L.

test for syphilis (and treatment if necessary); a P.P.D. skin test for tuberculosis; and, a small chest X-ray. The X-ray is read by experts at one of our Municipal Health Centers and, if deemed necessary, the patient is then taken there (by a police officer) for a large X-ray of the chest and a special type of sputum test. The patient may be sent for additional care to our City Hospital or one of its special clinics if it is deemed necessary. When patients are found to have severe physical or psychiatric diseases, they are referred to our City Hospital or a State Mental Center.

The actual detoxification process rarely takes more than twelve hours and more often about ten. The patient is ambulatory as soon as he leaves the intensive care unit. He is dressed in clean clothes (generally his own are so ragged they are discarded) and participates in the other duties of the Center, such as keeping his room and the halls clean, aiding in washing dishes after meals, etc. Such duties are a form of task therapy which aids him in a more rapid recovery, and helps him to assume responsibility so he will be better able to meet his own needs when he begins his life in the community as a participating citizen once again.

In addition, the patients have group therapy twice daily. This may be led by one of our physicians, a social worker or

our Chaplain. The group therapy is essentially unstructured and somewhat didactic (reality therapy) and centers around the patient and what he can do in a positive manner to change his way of life to live without alcohol. The patients are taught more about alcohol and alcoholism with some sessions consisting of didactic lectures or movies about alcoholism followed by discussions. During the seven day stay, the patient learns more about the physiological, psychological and social facets of the disease.

Also during this period, limited individual counseling sessions may be held with the patient, focusing on his own particular problems and circumstances. Similarly, discussions are held with him to develop and implement aftercare plans - housing, employment, continuing alcoholism therapy in another community agency, etc.

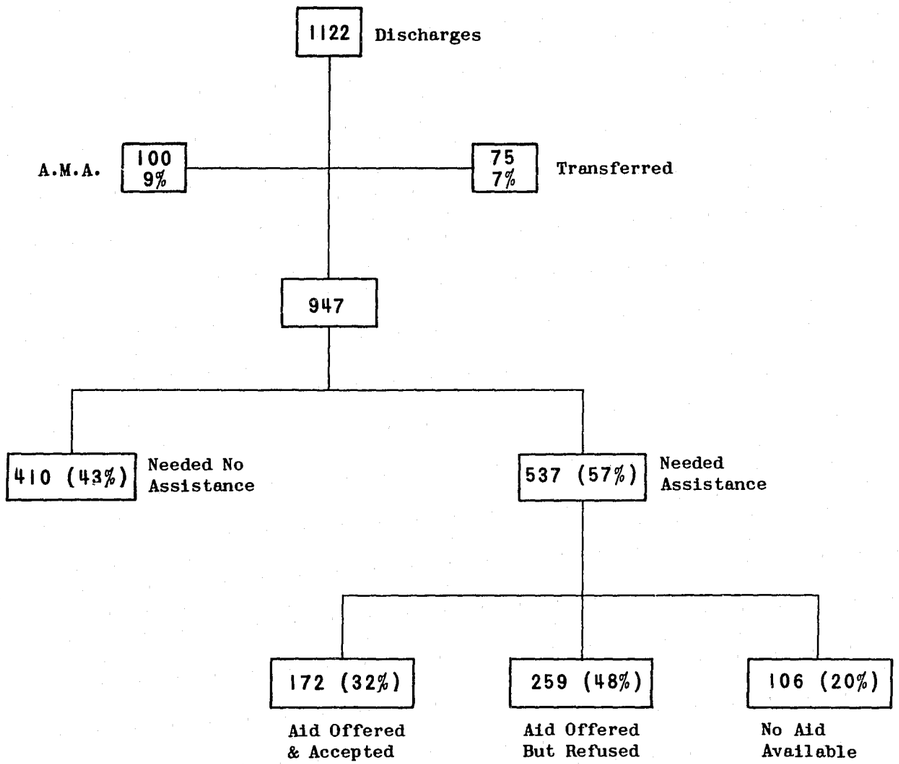
The role of Alcoholics Anonymous in the total treatment approach is extremely important - both during and following the period of hospitalization - as is reflected in the fact that three AA meetings are conducted each week in the Center.

Permeating the entire therapeutic picture is the fact that the staff must perform its duties as a TEAM of firm but KIND and understanding individuals, all of whom have the patient's best interest at heart.

Appendix K

ANALYSIS OF AFTERCARE REFERRALS WITH REGARD TO EMPLOYMENT

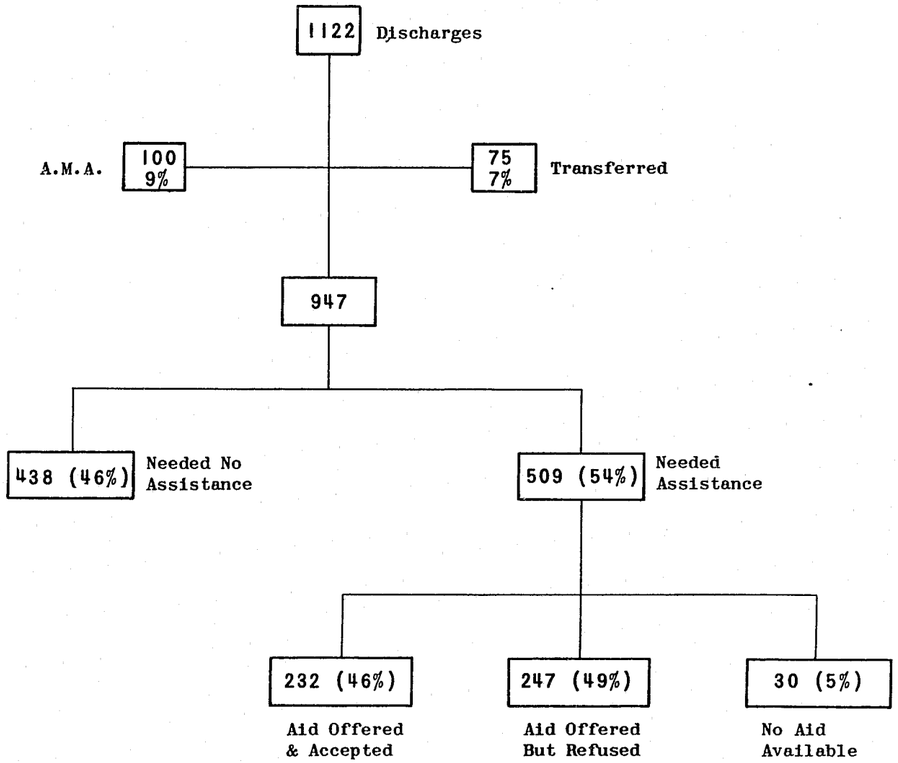
1/1/67 - 12/31/67

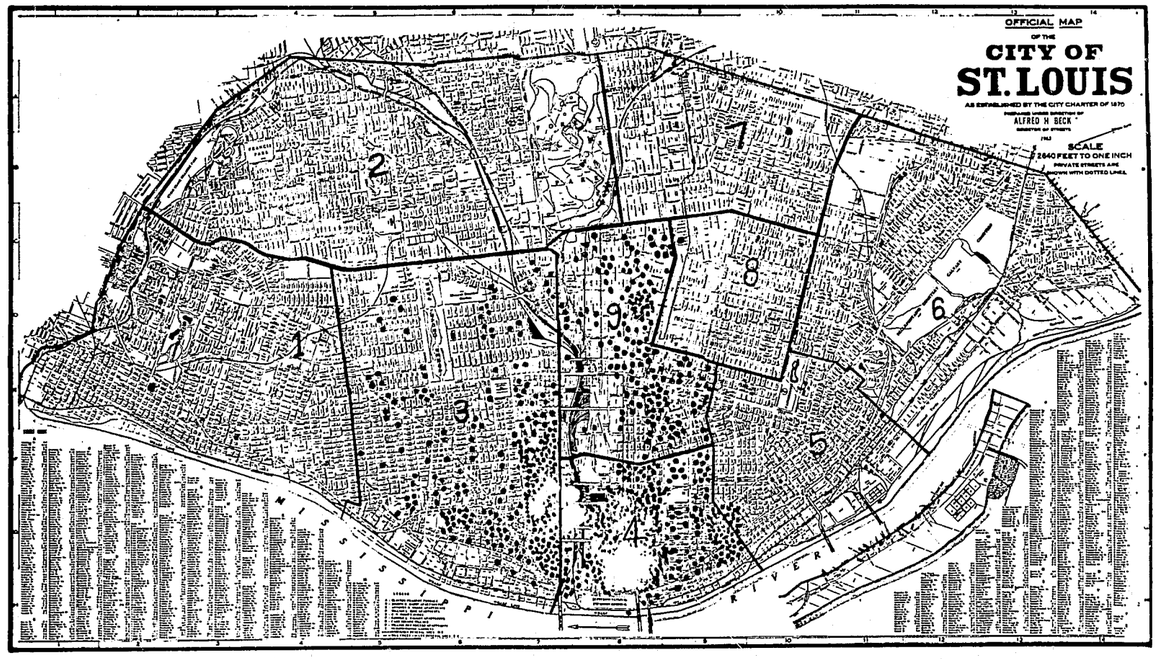


Appendix L

ANALYSIS OF AFTERCARE REFERRALS WITH REGARD TO HOUSING

1/1/67 - 12/31/67





Distribution Of Patients According
To Place Of Arrest
January 1, 1967 to December 31, 1967

765 - St. Louis City
34 - St. Louis County
35 - Out State Missouri
60 - Other States
228 - No Address

Distribution Of Patients According
To Place Of Residence
January 1, 1967 to December 31, 1967

THE SOCIAL SCIENCE INSTITUTE

FINAL EVALUATION REPORT

THE ST. LOUIS DETOXIFICATION AND DIAGNOSTIC EVALUATION CENTER

By

James M. Weber

Under the Direction of:

David J. Pittman, Ph.D.
Director, Social Science Institute
Professor of Sociology
Washington University

ACKNOWLEDGEMENTS

This project and the subsequent evaluation report were the result of the cooperative efforts of an unusual team of people. The Center is co-sponsored by the Sisters of St. Mary, the Social Science Institute and the grantee, the St. Louis Metropolitan Police Department. Nuns, social scientists, social workers, and police provide an uncommon mixture of disciplines.

I wish to express my gratitude to Patrolmen Harold Schlegel, and Delos Schaefer and to Mr. Gary Newmark who worked many long hours in gathering this data. The St. Louis Board of Police Commissioners and Col. Curtis Brostron provided inspired leadership throughout the duration of the project.

Typing and clerical assistance was provided by Ruth Pearlstone, Gerry Adams, and Ruth Bruce.

Miss Laura E. Root and Dr. Joseph Kendis, M.D., gave unstinting cooperation and guidance.

Lastly, to the architect of the Detoxification Center, Dr. David J. Pittman, whose vision and drive gave reality to a dream. There are no words which express my appreciation.

TABLE OF CONTENTS

CHAPTER I

The Origins of the St. Louis Detoxification and Diagnostic Evaluation Center

Any observations of social phenomena, to be meaningful, must be anchored to a theoretical framework. Since the focus of this study is not to propose or defend any theoretical position, it would be somewhat confining to self-impose such a limitation. The approach here is specific and historical. The topic is a small but important aspect of the total social and cultural milieu of alcoholism and criminal justice. The view is historical in that the events presented have occurred and constitute fact at this point in time. The meaning and cohesiveness of these events are clear.

These events outline a transition in the police handling of chronic inebriates. That this transition is a social movement can be readily demonstrated. It involves a conscious, deliberate effort on the part of certain individuals and groups to effect change in the criminal process systems' handling of the chronic police case inebriate. In an effort to understand the human realities of this social change, we will utilize some standard sociological concepts with their operational definitions.

Operationally, social change is the adoption of any new or variant ideology on the institutional level which entails subsequent changes in institutional roles and procedures. In terms of a rationally programmed socio-legal reform, change may be noted as events or happenings which were stages necessary to achieve the goal. Each event or stage viewed individually represents a successful step in the movement toward reform. Each step will be viewed as an interdependent element within the process.

Each step will be analyzed as relevant to certain levels of social life where it either overcame specific barriers to change or facilitated success by reducing the resistance to change on other levels.

Although this analysis proceeds on many levels, the emphasis is on the institutional level. An institution is a fairly permanent, integrated, role complex. Certain institutions, because of their incorporation into our society's governmental structure, possess specific rigidly standardized roles. Legislation and public edict define these roles in the form of bureaucratic policies. Policies and objectives are public expressions. They represent the explicit philosophy of the community as to the why and how of a given function. The criminal justice system contains three basic institutions which are the most manifest societal mechanisms for social control: the police, the courts, and correctional institutions. This study is an instance of social change at the institutional level. It involves the redefinition of a social problem, namely, the chronic inebriate from the traditional criminal imputation to an emphasis on the socio-medical aspects of the problem. The goal of this redefinition is the shifting of responsibility from the criminal justice system to the therapeutic professions for care, rehabilitation, and control.

An Overview: The Macrocosm

The problem of alcoholism has long been recognized and defined. In 1952, the World Health Organization's Expert Committee developed this definition:

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

In 1957, both the Journal of American Medical Association and the American Hospital Association went on record declaring alcoholism a disease. This clearly defines the alcoholic as a sick person in need of medical treatment.

The incidence of alcoholism has been variously estimated. Recently the alcoholic population of the United States was estimated at around six million. These figures, however, outline the larger issue of the problem drinker, as the disease concept only includes those drinkers who are either addicted to or at least psychologically dependent upon the effects of alcohol. Many individuals who would not be categorically "alcoholics" in the disease context are, however, problem drinkers whose behavior is legally sanctioned. The drunken driver, the street brawler, the husband-wife quarrels, etc., are all common examples of alcohol-related offenses which may constitute an enforcement problem.

Historically, this country inherited from English law the legal concept of public drunkenness as a punishable criminal offense. This holds true for almost all legal jurisdictions. Where exceptions do exist, as in New York City, public drunkenness is prosecuted under the general provisions of a disorderly conduct prohibition. Hence the weight of tradition is one barrier to reform. Criminal processing has not only been accepted, but the methods have been made efficient and institutionalized. Many police agencies in urban areas have established "bum squads" or "skid row details" to perform more efficiently what might be termed a "human street cleaning job" by making mass arrests.

The impact of the problem drinker on the institution of law enforcement was brought out by former Attorney General Nicholas de B. Katzenbach. In Senate testimony he stated:

> We presently burden our entire law enforcement system with activities which quite possibly should be handled in other ways. For example, of the approximately six million arrests in the United States in 1964, fully one-third were for drunkenness. The resulting crowding in courts and prisons affects the efficiency of the entire criminal process. Better ways to handle drunks than tossing them in jail should be considered. Some foreign countries now use "sobering-up stations" instead of jails to handle drunks. Related social agencies might be used to keep them separate from the criminal process.[2]

On the basis of these figures we can only agree with Pittman's statement, "For the public intoxication offender, the enforcement is indeed intense."[3] In this same report Pittman demonstrates that by including alcohol-related offenses such as driving while intoxicated, disorderly conduct, vagrancy, etc., this alcohol-related percentage of overall arrests nears 50 per cent. In contrast to these official figures stand the findings of a study by the American Bar Foundation.[4] Their report indicates that there can be no reasonable estimate of these offenses inasmuch as the majority are not pursued by arrest and/or detention, let alone prosecution. In some jurisdictions the practice is simply to detain the intoxicated individual until sober. Often this is not considered an arrest, and as such, these occurrences would not even be included in official statistics.

This seeming paradox can be resolved. On the one hand there is minimal enforcement because of limited enforcement resources and the recognized inability of the criminal process to curb recidivism or effect any rehabilitative gain. On the other hand, in large urban centers where a significant skid row population exists, enforcement is intensified to cope with the high incidence of problem drinkers. In response to the efficiency of some urban police departments' mass arrest policies, many over-crowded municipal courts dispense "instant justice." Surveys have indicated that

in dealing with minor offenses like public drunkenness and other alcohol-related offenses, eg., begging, loitering, vagrancy, etc., "trials" often last an average of less than one minute.[5] Thus the criminal justice system's component agencies have successfully adjusted to the problems of the drunkenness offender by establishing efficient institutionalized means to handle them.

The first systematic survey of the criminal process and the chronic inebriate was carried out by David J. Pittman for his doctoral dissertation at the University of Chicago. The results were later incorporated in the new classic work, Revolving Door: A Study of the Chronic Police Case Inebriate, by Pittman and Gordon.[6] Their findings may be summarized as follows:

> Constant jailing occurs when the personal resources of the individual are at a minimum, when other agencies and individuals have despaired of helping in the situation, or when, in summary, the individual has literally hit bottom.[7]
>
> ***
>
> In the process, the resources of the individual suffer further deterioration and the development of the institutionalized offender occurs--one whose pattern of life becomes a constant movement from incarceration to release and reincarceration, with increasing dependency on the institution.[8]

Quite appropriately this process was dubbed by Pittman the "revolving door." Among the recommendations of this study was a plan calling for the creation of a treatment center, "for the reception of the chronic public inebriate."[9] This treatment center was visualized as a total approach consisting of medical and physical, psychological and social rehabilitation to break the dependency cycle. Here then, we have the foreshadowings of social change. The events of the last decade have given this study an almost prophetic quality.

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The reasons behind this lapse of almost ten years from the model solutions' first proposal to reality constitute an example of cultural lag. From the standpoint of social change we will view this in terms of those barriers or negatively charged elements which impeded this change. Obviously, the most immediate prerequisite for this change is the recognition of alcoholism as a disease. Without this ideological shift the chronic public inebriate will forever be a criminal instead of a sick individual involuntarily displaying the symptoms of his disease.

On the broad cultural level we can discern some factors which determine a negative attitudinal set. Becker cites two values as derived from our Protestant Ethic which mark excessive alcohol consumption as evil and sinful.[10] The value of autonomy holds that an individual is and should be completely responsible for his actions and destiny. Any state of loss of control, particularly a self-imposed one, which may lead to dependency can have no moral justification. Secondly, the pursuit of pleasure for its own sake is opposed to the values of pragmatism and utilitarianism.

Socially, the morality dimension of these values has been reinforced in at least two ways. Probably the main authoritative source of information to the public has been Alcoholic Anonymous. In their oft heard and repeated messages they stress the disease concept and the availability of treatment. Unfortunately, they have equally stressed the view of self-help or wanting to be helped as the key to success. This cannot help but reinforce the public's view, and as we shall see shortly, the medical profession's view of alcoholism as a deficiency in character.[11] This is an unintentional by-product of their stated philosophy. It is seen as an affliction of the weak-willed individual who lacks discipline. Further,

the alcoholic or chronic inebriate who comes to the attention of the police and is criminally processed is then stigmatized as a "criminal." With the operation of these elements, the attitudinal set of society which views the problem drinker as a social outcast and a moral degenerate is understandable.

One gauge of these community attitudes may be found in the medical professions. It is not unreasonable to assert that any public enlightenment must come from the professionals within the community. If then, we find in the therapeutic professions a similar attitudinal set, it would follow that the general public will be somewhat less informed or more subjective. These subjective views would most likely reflect the cultural and social factors discussed above rather than the relatively new disease concept based on objective studies. One index of the medical profession's attitudes toward this disease can be determined by viewing their efforts to cope with it.

It has long been noted that there is a lack of medical and social treatment programs and facilities for alcoholics. In the survey by Pittman and Sterne of the St. Louis area, "it was found that 41 per cent of all hospitals do not admit under primary diagnosis (of alcoholism), 16 per cent do sometimes, and 38 per cent do so unqualifiedly."[12] These findings may be generalized beyond the St. Louis Metropolitan area. In relation to the enforcement problem La Fave notes that:

> When adequate noncriminal facilities are lacking, the arrest-release process is perhaps the best available means of caring for the drunk....This is an instance in which the criminal justice process is used, by default, to perform what is essentially a social service.[13]

In the same context, Peter B. Hutt said before the North American Association of Alcoholism Programs (N.A.A.A.P.) in October, 1966, "...the

point that concerns me most, I must admit, is that up to now the health professions have not greeted the Easter and Driver decisions with the sense of challenge and responsibility that I had hoped for."[14] This default on the part of the medical profession was dramatically illustrated in New York City in September, 1966, when all public and private hospitals refused to admit police officers seeking to have drunken offenders examined prior to incarceration.[15]

The Pittman and Sterne[16] study implicated two factors as being of prime importance in the therapeutic professions' disregard of alcoholism: first, the attitudinal set as displayed negatively in moralistic sentiments; and secondly, stemming in part from the moral beliefs, the perceived inappropriateness or inadequacy of medical treatment. The result is that throughout the helping professions there are strong feelings of therapeutic inefficacy. This devolves to two factors: unrealistic therapeutic goals and the inability to accept the chronicity of this disease. Within this last factor we can see the operation of the above moralistic principles. If alcoholism is not accepted as a chronic disease, it must be seen in terms of an imputed deficiency within the individual.[17]

The outcome of this inertia in the therapeutic professions and the resultant lack of medical facilities is a dilemma for the criminal justice system. Although alcoholism per se has no criminal connotation, its symptoms, eg. drunkenness, are a police concern. With virtually no public health facilities to treat the alcoholic, the police have no alternative except to enforce the laws against all drunkenness offenders, alcoholic or not.

Maximally, such enforcement involves the prosecution and sentencing of offenders. Realizing the inability of this process to effect any

substantial change in behavior, many departments have adopted minimal enforcement procedures where the entire criminal process is not invoked. This amounts to an arrest procedure, followed by a drying out period of detention (normally less than 24 hours), and release when sober. Various departments have designated this practice "the golden rule," "safekeeping," "protective custody," etc., terms which serve to point up the noncriminal character of this detention. These procedures also emphasize the underlying police philosophy of arresting the intoxicated person for his own protection. While such a policy may be adopted for laudable reasons, it creates more problems than it solves.

Although the release when sober process may represent a relatively non-punitive approach, it does not provide the arrested individual with the often required medical services.[18] Further, this is one more step in the direction of more deeply rooting special institutionalized methods for handling the alcoholic offender. One more point should be emphasized. The use of such non-punitive measures may seem expeditious and just to those in the therapeutic and public health fields who would rather not assume the burden of responsibilities for dealing with this problem group. Hence, the police are unwittingly supporting the status quo situation.

When maximum enforcement is opted for and prosecution follows arrest, the courts are similarly faced with a dilemma. As noted previously, court proceedings are less than ideal in this area. If the judge routinely releases the chronic inebriate back into the community, he may well face the same defendant on the following day. Added to this is the knowledge that he risks incurring the hostility of the community and the police for

his leniency. Typically, the chronic inebriate is a skid-row inhabitant, a fact which excludes the possibilities of fines or probation. The other alternative of a jail sentence is recognized as not only futile for rehabilitation, but also wasteful of the tax monies supporting the correctional institutions. Faced with these negative choices, many judges adopt the rationalized philosophy of sentencing alcoholics to jails for health reasons when it is felt necessary to "prescribe" an extended drying out period to bolster a failing constitution. This then is the last phase in the "revolving door" cycle before it begins anew.

This overview of the marcrocosm gives the nature and magnitude of the issue. The reform movement utilized a battery of ideas to overcome the barriers outlined above. They stressed the disease concept of alcoholism to neutralize the moralistic orientation implicated in our cultural values. The now popular phrase "revolving door" resonates with all the waste and futility of our present system. It stands as an open indictment to any and all public officials and administrators who have assumed a bureaucratic head-in-the-sand attitude. To this date though, the response of the medical profession and hence public health officials has been appallingly slow. It became apparent to the individuals and groups in this movement that the most immediate impetus to change would be found within the criminal justice system. The rationale behind this was to get the courts to admit the disease concept and put an end to criminally processing the alcoholic. Such a mandate would serve notice to law enforcement activities in this area. It would have the effect of a "cease and desist" order as far as the police are concerned. This would focus the responsibility for the alcoholic solely upon the therapeutic professions.

In 1966, in two separate cases the courts ruled that alcoholism was a defense to a charge of public intoxication.

> In Easter vs. District of Columbia, the United States Court of Appeals for the District of Columbia Circuit held that the well-settled common law principle, that conduct cannot be criminal unless it is voluntary, precludes the conviction of a chronic alcoholic for public intoxication. In Driver vs. Hinnant, the United States Court of Appeals for the Fourth Circuit...held that to convict a chronic alcoholic for public intoxication, and thus to ignore the common law principle followed in the Easter Case, violates the prohibition against cruel and unusual punishment contained in the Eighth Amendment.[19]

However, these decisions affect only a small segment of the country. Peter B. Hutt who prepared the Easter case for the courts now has another brief pending before the United States Supreme Court which, if successful, will require the police and other public agencies to treat the chronic drunkenness offender outside of the Criminal Justice system.

The reactions to these decisions (Easter and Driver) have been both disappointing and reassuring. The arrest rates in Washington, D. C., have only dropped slightly since the Easter decision, and Joe Driver continued to be arrested and convicted for public drunkenness in Durham, North Carolina. Throughout the country enlightened judges and police officials are questioning traditional arrest practices and looking to the medical and helping professions for a practical solution to the public safety problems which the chronic inebriate has and will continue to pose.

Also spurred by these decisions, the Office of Law Enforcement Assistance of the United States Department of Justice awarded two grants in 1966, one to Washington, D. C. for $274,201 and the other to St. Louis for $158,781, to establish detoxification centers on a demonstration basis.

St. Louis -- The Microcosm

In the late 1950's, St. Louis as a community, did not differ appreciably from the macrocosm. In 1955, a fund drive by a few concerned individuals who wanted to establish a local council on alcoholism netted only $400.00. The therapeutic professions were not particularly sensitized to the problem of alcoholism. Few physicians accepted alcoholics as patients, and few hospitals would admit an alcoholic for detoxification. For the public drunkenness offender the traditional societal mechanism, criminal processing, prevailed.

In 1958, David J. Pittman, then professor of sociology at Washington University, received an additional appointment to the Department of Psychiatry in the Medical School of that University.[20] As a logical extension of his previous research and interest areas, he chose the assignment to develop an alcoholism treatment facility. Prior to the

establishment of this facility, an extensive survey of the metropolitan area was conducted to assess the current status of alcoholism programs and accurately gauge the community needs.[21] These findings validated in the St. Louis area what numerous experts have attested to in the literature on alcoholism, the neglect of alcoholism treatment programs on the part of the therapeutic professions. Thus, Pittman and Sterne empirically demonstrated that during the early 1960's, St. Louis, the microcosm, accurately reflected the macrocosm.

Late in 1959, after a series of events which dramatically brought the community to awareness, a combination of contributions and a matching fund grant under the Hill-Burton Hospital Construction Act made over $90,000 available for construction of an Alcoholic In-Patient Treatment and Research Center.[22]

Malcolm Bliss Mental Hospital was the selected site for the facility. After an extensive planning period the United States Public Health Service funded the unit as a three year demonstration project beginning in 1961, (Grant MH-657). In February, 1962, the Malcolm Bliss Mental Hospital's Alcoholism Treatment and Research Center (A.T.R.C.) was operational. The establishment of this unit is the fulcrum on which pivots all succeeding community alcoholism programs.

The impact of the A.T.R.C. unit on the community has been far-reaching and cumulative. The innovative treatment design has revolutionized thinking in professional medical and psychiatric circles. The orientation of the permissively structured therapeutic community served to abate thinking of alcoholism as a purely psychiatric disorder (and hence not a medical entity), while the establishment of an "open door" policy for the

A.T.R.C. has done much to dispel the notion that an alcoholic must be self-motivated prior to treatment.[23] Thus, we see a major barrier of inadequate treatment facilities for the alcoholic has been overcome.

Another outgrowth of this facility came under a grant from the Missouri Division of Mental Diseases to the Social Science Institute of Washington University in 1962. These funds provide for the "Alcoholism Education Program" for all disciplines in the medical public health and welfare fields.[24] This ongoing in-service training program for the helping professions has substantially altered the negative attitudes previously found throughout these disciplines and another barrier was removed.[25]

Since Pittman's initial research in alcoholism dealt with the chronic police case inebriate, he eventually sought the involvement of the St. Louis Metropolitan Police Department. That department he found represented the one significant feature where St. Louis departed from most other urban centers. Reputedly one of the best municipal police agencies in this country, it had developed the most accurate reporting system to be found; yet, for the years 1957-1962, records disclosed only an average of less than 3,500 arrests annually for drunkenness. This was only a fraction of their total arrests and proportionately much lower than the arrests rates found in other major cities. This was unique in that the usual explanations did not test out; namely, that drunkenness arrests were masked by other charges used as residual categories, or that in fact there were fewer public inebriates.

This apparently high tolerance on the part of the police towards the drunkenness offender stems from several sources. First, the

historical background of the city as a riverfront community may be operating on the cultural level in the community at large. Secondly, within the department, stress is placed on quality enforcement rather than quantity. This is demonstrated in the President's Crime Commission Task Force Report on Drunkenness.[26] Although this report notes this "tolerant" attitude and cites the arrest picture for St. Louis and two other cities, it only utilizes percentages of drunkenness arrests. If one considers the absolute figures involved, a quite different interpretation is likely. For the year 1965, St. Louis reports a total number of arrests of 44,701, while Washington, D. C. and Atlanta, Georgia report 86,464 and 92,965 arrests respectively. Now, by deducting all drunkenness, disorderly conduct, and vagrancy arrests (or what in St. Louis is not viewed as quality enforcement), one finds St. Louis has a total of 36,262 "quality arrests" as compared to 20,334 in Washington and 21,751 in Atlanta. Percentage-wise, one city begins with 93 per cent more arrests overall, and yet St. Louis has 78 per cent more "quality arrests." Atlanta starts with 107 per cent more arrests, and St. Louis still makes 67 per cent more "quality" arrests. What is demonstrated here is not a leniency or tolerance for law violations but rather a different set of professional standards as to what constitutes good enforcement.

At this point this researcher will occasionally interject in the first person. This is a convenience which is functional due to my personal involvement in the events which follow. Regarding the above discussion of informal policies on arrests, many a line officer will chide another who is in the habit of making "cheap arrests," such as on drunkenness, loitering, or vagrancy charges. Hence, with no edict from supervisory or command personnel, officers more often than not used informal means to expeditiously

dispose of intoxicated persons and thereby keep "a clean beat." Informal proceedings included such things as placing the inebriate in the local coffee shop to be sobered up; cab drivers were usually willing to take better dressed individuals home even knowing that sometimes they would not be paid; and of course, there are always the missions and cheap hotels available. Unfortunately, for the skid-rowite these are not viable alternatives.

For the wino or the real down-and-out individual jail remains as the only alternative. Even in these cases officers were reluctant to make arrests. These cases were time-consuming and particularly unrewarding. Since 1958, it was common practice to convey intoxicated persons to the nearest City Hospital for a medical examination prior to jailing them, especially if these were injuries or illness apparent. This meant more than one and one half hours processing time to the arresting officer--knowing full well that he would again have to deal with this individual in the next few days. These arrests, then, were viewed as a frustrating waste of time. Eventually the decision to arrest devolved to the officer's judgement as to whether this individual could remain free and not jeopardize his safety or anyone else's and, at the same time, allow the officer to maintain the appearance of "a clean beat." In summary then, the arrest rate for drunkenness offenders was quite low in St. Louis due to:

1. emphasis on quality enforcements
2. procedures were not bureaucratized
3. this enforcement was a general responsibility and not institutionalized
4. non-punitive attitudes of officers
5. this activity was not rewarded by being viewed as "good police work"

Late in 1962, police executives visited the A.T.R.C. unit and, after a series of conferences with Dr. Pittman, established a new procedure called the "Code 26." Pittman, acting as a consultant to the Board of Police Commissioners, convinced the department of the wisdom of a mandatory policy of medical examinations for anyone suspected of being intoxicated. His reasoning was based not only on humanitarian values but was reinforced by the fact that on occasion individuals would die in their cells which, in turn, would result in unfavorable publicity. As a result of this policy change, the entire drunk on the street procedure was reviewed in an attempt to achieve more efficiency. The effects of this revision were immediate and striking.

Under the new "Code 26" procedure, officers in prisoner conveyance vehicles became specialized for this function. Arresting officers no longer completed offense reports or accompanied subjects to the hospital or booking desk. Hence, the arrest procedures became efficient, the method was institutionalized, and one other ingredient was added: Now there was a clear-cut directive to, "extend every effort to arrest and remove intoxicated persons from the streets, alleys and public view."[27] Although this procedure was only in effect from February 13, 1963, into the early part of September, of approximately seven months, the arrest rate doubled. There were 7,847 arrests for public intoxication in 1963. In September of 1963, the program was dropped due to a manpower shortage; however, the policy of a mandatory medical examination is still in effect. As further proof of the effect of this "Code 26" program, the arrest picture for 1964 was again almost in line with years prior to 1963 in that only 3,761 arrests were recorded for that year. If we could assume other

factors were held constant, this would approach the classical A-B-A research design.

Two other changes occurred early in 1963. Dr. Joseph B. Kendis, M.D., the Medical Director of A.T.R.C. unit, began a series of lectures on alcoholism for recruits in the Police Academy. He stressed the disease concept of alcoholism and the need to treat the chronic public drunkenness offender as a sick individual rather than as a criminal.

These lectures coincided with the inception of the "Code 26" procedure. The combined effect of the new policy and the increased education on alcoholism produced a perceptible shift in the attitudes of officers. In the field, I noticed an almost overnight change in the confrontations between officers and public intoxicants. Officers no longer felt constrained to act officiously in effecting the arrest. The typical approach was characterized by the officer's suggesting that the subject accompany him to the hospital where a doctor could examine him. Often the word "arrest" was not mentioned; however, both parties knew the end result of this action. Whether this new approach was the result of more sympathetic attitudes or simply an expedient adopted to minimize aggressive behavior is irrelevant. The crucial point is that even the line police officers emulated the philosophy that this behavior was more properly the focus of the medical profession rather than of the criminal process.

During the years 1962 through 1965, the team of Pittman, Kendis, and Root worked feverishly to mobilize the community to action. The details of their activities are comprehensively documented elsewhere.[28] The outcome of their efforts were:

1. The commitment of the political power structure - both state and local - to deal with the problem of alcoholism.

2. A concerned and favorable press which routinely assisted in publicizing community needs and professional efforts.

3. More positive attitudes towards the treatment of the alcoholic through the Alcoholism Education Program which has been particularly effective in reaching nurses and social workers.

4. The establishment of close working relationships between an alcoholism treatment center (A.T.R.C.) and other related community service agencies. Even to this date, there has been no significant commitment on the part of local physicians to treat the alcoholic.

In 1965, Pittman, Kendis, and Root developed a model comprehensive alcoholism treatment plan. It involved full-scale usage of all community resources and the construction of several new facilities. One phase of their so-called "St. Louis Plan" included a detoxification center. The "St. Louis Plan" was a blueprint specifying total implementation of the recommendations which Pittman devised during his earlier study of the "revolving door" process.[29] From this ideal plan the detoxification center phase was abstracted.

In December, 1965, Dr. Pittman approached Col. Edward L. Dowd, the President of the St. Louis Board of Police Commissioners, with the idea of securing funds under the Law Enforcement Assistance Act for a detoxification center. Captain Frank Mateker, the Director of the Police

Department's Planning and Research Division, proposed the same idea to Col. Dowd the same day after reading Mr. Katzenbach's statements before an Ad Hoc Senate Sub-Committee. (See statement on page 4.) The Board directed the Planning and Research Division to conduct a feasibility study on the need for such a unit and the possible sources of funding. Working in conjunction with the Social Science Institute and the Governmental Research Institute, a grant application was prepared and was funded by the Office of Law Enforcement Assistance on October 1, 1966.

FOOTNOTES

CHAPTER I

1. David J. Pittman, "Interdisciplinary Considerations in Alcoholism Research," in Pittman (ed.) Alcoholism: An Interdisciplinary Approach, Springfield: Charles C. Thomas Co., 1959, p. 51.

2. Testimony before the Ad Hoc Subcommittee of the Senate Judiciary Committee on the Law Enforcement Assistance Act of 1965.

3. David J. Pittman, "The Public Intoxication and Alcoholic Offender in American Society," a report prepared for the President's Commission on Law Enforcement and Administration of Justice, June, 1966, p. 7. Abridged version published in Task Force Report: Drunkenness, President's Commission on Law Enforcement and Administration of Justice, 1967, pp. 7-28.

4. Wayne R. La Fave, Arrest: The Decision to Take a Suspect into Custody, Boston: Little, Brown and Company, 1965.

5. Ibid., p. 449.

6. David J. Pittman and C. Wayne Gordon, Revolving Door: A Study of the Chronic Police Case Inebriate, Glencoe: Free Press, 1958.

7. Ibid., pp. 19-20.

8. Ibid., p. 42.

9. Ibid., p. 141.

10. Howard S. Becker, Outsiders: Studies in the Sociology of Deviance, Glencoe: Free Press, 1963, p. 136.

11. David J. Pittman and Muriel W. Sterne, Alcoholism: Community Agency Attitudes and Their Impact on Treatment Services, Washington, D. C.: U. S. Department of Health, Education, and Welfare, Public Health Service Publication No. 1273, 1965.

12. Ibid., p. 5.

13. La Fave, op. cit., pp. 446-447.

14. Peter B. Hutt, North American Association of Alcoholism Programs in Washington, D. C. on October 11, 1966.

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15. Personal communication from Mrs. Rosemary Masters, Project Coordinator of the Manhattan Bowery Project under the Vera Institute of Justice, New York City.

16. Pittman and Sterne, op. cit., pp. 29-30.

17. For a complete discussion of this point see John R. Seely, "Alcoholism is a Disease: Implications for Social Policy," in David J. Pittman and Charles R. Snyder (eds.), Society, Culture, and Drinking Patterns, New York: John Wiley and Sons, Inc., 1962, pp. 586-593.

18. One notable exception to this is St. Louis. See Sid Ross, "Should We Jail Alcoholics," in Parade Magazine of the St. Louis Post-Dispatch, February 14, 1965, where he reported that at that time St. Louis was the only city out of a nation-wide survey with a policy of medical examinations required for intoxicated offenders.

19. Peter B. Hutt, op. cit., from his address to the N.A.A.A.P.

20. This and many of the events which followed this appointment have been documented by David J. Pittman, "The Open Door: Sociology in an Alcoholism Treatment Facility," in A. B. Shostak (ed.), Sociology in Action: Case Studies in Social Problems and Directed Social Change, Homewood, Illinois: Dorsey Press, 1966, pp. 148-157.

21. Some of the results of this study have been previously cited. See Pittman and Sterne, op. cit.

22. The specifics of these events are beyond the scope of this discussion and hence not cited in detail here. See Pittman, The Open Door, op. cit., pp. 149-151.

23. The implications of this concept are fully detailed in Muriel W. Sterne and David J. Pittman, "The Concept of Motivation: A Source of Institutional and Professional Blockage in the Treatment of Alcoholics," Quart. J. Stud. Alc., 26: 41-57, 1965.

24. As one more indication of the A.T.R.C. unit's impact not only on the local scene but also on the state, Ronald Catanzaro, M.D. became the first director of the Missouri State Alcoholism Program in late 1966. Dr. Catanzaro was one of the first psychiatric residents to work at the Bliss Alcoholism facility.

25. See David J. Pittman, Alcoholism Treatment and Referral Demonstration Project - Final Report, final report under N.I.M.H. grant No. M.H.657, December, 1967, pp. 320-342. This section outlines numerous aspects of the impact of the A.T.R.C.

26. The President's Commission on Law Enforcement and the Administration of Justice, "Task Force Report: Drunkenness," U. S. Government Printing Office, Washington, 1967, p. 2.

27. From a St. Louis Metropolitan Police Department directive establishing the "Code 26" procedure.

28. Pittman, op. cit., "Final Report."

29. Pittman and Gordon, op. cit., pp. 139-146.

CHAPTER II

Method of Study

The major sponsor of this demonstration project is the Office of Law Enforcement Assistance under Grant No. 93. In terms of both the grant stipulations and the continued impact of the socio-legal reform movement in this area, a comprehensive evaluation of the Center was carried out. The evaluation can be dichotomized into the following categories. The macro-social category deals with the impact of the Center's operation on those agencies and institutions traditionally endowed with the responsibility for coping with this social problem. This section of the evaluation consists of a simple cost accounting procedure to weigh the costs of the treatment program against the continuance of the old system. Tangible gains are in the form of admistrative efficiency, reduced clerical operations, man hours saved, and the reduction of supplies and other resources needed to support the criminal processing of these individuals. These savings on the part of the affected agencies and institutions, rather than representing budgetary excesses, are in fact merely "paper economies" which show what proportion of their present resources may be reallocated to other pressing problems in our society.

The clinical aspects of the evaluation are even more crucial to a successful demonstration. Not only must this kind of treatment program be shown to be economically feasible but, in addition, the individuals treated must accrue some positive therapeutic effects. If the treatment program is unsuccessful or, more likely, if the Center's success is not demonstrated adequately, then the criticism will surely be levelled that the "revolving door" has simply been displaced from the criminal justice system to a

medical facility. However, even in this case, there is the possibility of gains from medical experience not now possible.

Every research design entails numerous decisions on the part of the investigator. Research literature, when presented on a "How - to" basis, reflects the optimum approach to a problem. Too often investigators become discouraged, or even worse, in the face of practical limitations, fail to recognize the full impact of these limitations. This may well cause misrepresentations in the data or in the presentation of their findings.

This study is not unusual in that the ordinary considerations of time and money were crucial. Under the terms of the grant the evaluation had to be completed within one year of the award date. In order to assure a minimum of two hundred cases the maximum allowable time for follow-up was limited to three months.

This means that of those selected for evaluation, a waiting period of 90 days from their first discharge date would have to elapse before an attempt could be made to locate and interview them. In longitudinal studies of this type it has been demonstrated that one year is an optimum compromise period for evaluation in terms of assessing long range treatment effects while maintaining some capacity for locating the subjects.[1] In this study, however, the practical limitations take precedence. The purpose of this study is not to demonstrate a theoretical construct or even to assess an ideal alcoholism treatment program. It is rather a test of the feasibility. Katzenbach's statement that:

> better ways to handle drunks than tossing them in jail should be considered. Some foreign countries now use 'sobering-up stations' instead of jails to handle drunks. Related social agencies might be used to keep them separate from the criminal process.[2]

The target group or population under study is mainly composed of individuals who habituate the skid row areas of the city. "Homeless men," "chronic police case inebriates," "transient population" etc., are all terms which characterize the patients. They are individuals who have been technically "arrested" for public intoxication and conveyed to St. Mary's Infirmary at 1536 Papin Street for detoxification. The treatment regime is an intensive seven day program of medical, psychological, and social rehabilitation on a voluntary basis. It was decided that the entire population would be analyzed in the following way: First a demographic profile would be presented on all individuals admitted to the Center. The general characteristics of this patient population would be then compared with the sample selected for follow-up evaluation. This selected group was established by using only two criteria:

1.) The individual must have elected to and have stayed for the full treatment period (normally seven days).

2.) The subject must have resided in or near the greater St. Louis Metropolitan area for approximately three months prior to admission.

These criteria have eliminated less than 30 per cent of the patients thus far admitted. They insure that the subjects have had the opportunity to receive the full benefits of the treatment program, that some personal data are available other than their own report, that these individuals are indeed diagnosed as both acute and chronic alcoholics, and lastly, that they will in some realistic way be locatable. If the comparison between those studies and those excluded yield differences in some discernable characteristics, then it prescribes narrower parameters to any generalizations about the total treatment group.

After selecting the study group, consideration was given to the instruments, scales or measures, and what could be termed "success criteria. The simple "before and after" design was deemed most appropriate in that each individual would set his own standard in assessing any change. This retrospective-prospective model avoids to a great extent the necessity for establishing success standards. This rationale rests on two assumptions. First, that alcoholism is a progressively debilitating disease. Degeneration in the individual is markedly uniform and affects all areas of the alcoholic's life (this is particularly true for the chronic police case inebriate).[3,4,5] Further, without some therapeutic intervention into the disease process the prognosis is unfavorable. Success then, in this study, rests on the ability of the measures to demonstrate either the arrest of the disease progression or improvement where found. Since the scales are presented in full it will be up to the reader in the last analysis to judge.

Most researchers in the field of alcoholism agree that the interview is by far the most powerful investigative tool.[7,8] Questionnaires and other more objective techniques which yield so-called "hard data" have proven not too significant in predicting treatment outcome. On the other hand, "soft data" information, e.g., life style, social milieu, etc., have been valuable prognostic aids. Guze[9] has shown that the use of the personal interview greatly increases the content validity over other secondary sources of information.

It was decided that an unstructured interview was preferable to a more rigid instrument. Although the study group in the main consists of lower or working class individuals, many would be interviewed from the middle class and a few from the upper classes. Even were this not true,

among those in the lower class the range of verbal ability and mental clarity would present insurmountable difficulties to a structured interview. Twelve per cent of this population were diagnosed as displaying the "chronic brain syndrome" in varying degrees. This alone would have confounded the responses so that a large block of data would have been tentative at best. The phenomena of "talking past" each other unfortunately cannot be adjusted for by corrections in the data once it has been collected; it must be prevented whenever possible. As an example of an interview with a respondent with a diagnosis of "chronic brain syndrome" the following interview excerpt is a quoted:

Int: "Hi Herb, how are you feeling today?"

Subject: "Don't I know you?"

Int: "Sure, we're from the Detox. Center."

Subject: "God! . . . oh God!, . . . good God!, . . . well, I been prayin and . . . .

Int: "We thought we would come by here and see you today. How are you getting along Herb?"

Subject: "I remember you! You're from the Detox. Center."

Int: "How long have you been living here Herb?"

Subject: "Oh, . . . good God! . . . is it good to see you again."

This was an extreme case, but with many of these individuals the best setting in which to elicit information is a role reversal situation where they [the inebriates] interview you until they have told you what you want to know. This type of non-directive approach is only possible where a strong rapport exists.

The interview schedule was standardized in terms of classes of information sought. This has the quality of addressing it to the interviewer who must rely on his skills to satisfy the criteria indicated.[10]

Much of the information sought is usually "sensitive" material as it calls for an in-depth look at an individual's life. Clinical experience has shown this to be a negligible problem when dealing with alcoholics. Uninhibited response is further insured by the interviewer's displaying some personal interest. This is best accomplished in the conversational manner of the unstructured interview. For these reasons the standardized unstructured interview becomes the logical tool.

As previously indicated, those individuals selected for follow-up interviews were assigned ratings for before and after the treatment period. Originally the variables selected for measurement were: the drinking pattern, residential accomodations, employment, income, arrests, re-admissions, general health, and social integration. A survey of the existent literature on alcoholism follow-up studies led to the conclusion that there were no scales which could be adapted for use in this study. First, there have been few published studies in this area, and the majority of these do not report the specific scales used to measure change. Some were uni-dimensional, i.e., concerned with changes only in drinking or familial circumstances or some other single aspect. In addition, the studies were conducted by researchers from various disciplines, none of which dealt with either a comparable population or treatment program. Further, many of these studies used gross indices such as, "drinking" or "not drinking," "working" or "unemployed," etc. These measures are laden with value judgmental implications which are unrealistic for use with the population at hand.

In designing the scales which follow, the primary consideration was to set realistic goals for the treatment group in terms of their own socio-economic levels. It was felt that the imposition of any externally derived standards upon this group would constitute a bias. After approximately 175 admissions to the Center, all intake data was compiled, and each case was reviewed for the purpose of locating relatively stable groupings in the variables. This search for variable clusters was an attempt to extrapolate "ideal types" out of the available data. The success of this technique led to a dilemma. It was found that these variables did present relatively stable groupings. For example, the more intense the drinking pattern in frequency and duration, the lower the individual would fall in the other socio-economic categories. There is, however, not complete correlation between the scales; therefore some degree of independence exists among them.

The last point can be illustrated. Too high a correlation between drinking, employment, residential accomodations, etc., might be indicative of a specific etiology in alcoholism. Experience has shown that whereas these variables do in fact co-vary, their sequential and interactional properties are purely individualistic. With one individual, loss of employment or a family break-up may be the direct result of his alcoholic activity, while for another these circumstances would be ascribed a precipitating role in the onset of his alcoholism. One researcher, in taking note of this, has said that there does not appear to be a single alcoholism but rather many alcoholisms.[11]

Since there would seem to be some cohesion between these variables, it made scale construction difficult in that specific data would have to be indigenous to each scale. Without this there is no assurance of independence.

The dilemma was simply that the social integration scale was impossible to define without alluding to housing, employment, etc. It was finally decided to drop this variable in the knowledge that the combination of the other measures would yield an overall index of one's social integration.

The construction of the scales has been the most challenging aspect of this study. The decision was made to focus on the qualitative changes after treatment. The ideal typologies drawn from the initial data were particularly suitable for this purpose. It was feasible to set up categories within some of these scales so that a continuum appeared which imparts the properties of ordinal ranking between classifications. This is a logical outgrowth of two factors cited earlier. First, in the progressive stages of alcoholism there is a pronounced downward movement in the individual's socio-economic ranking. Secondly, the clustering of certain variables (which are actually indices of socio-economic standing) is uniform enough to allow the generalizations implicit in the classifications. Drinking patterns, residential accomodations, and employment are the three variables which are dealt with on this basis. Arrests, re-admissions, and income can quite readily be manipulated in numerical form thereby eliminating the need for categorization and scaling. Before going into the scales actually constructed, a brief discussion of the statistics to be analyzed will follow.

In the income rating, an estimate of the individuals' weekly or monthly income is gathered at the time of his admission. When the follow-up interview is conducted, a second estimate of income since discharge (following the first admission) from the Center is obtained. The time span from the discharge date is computed, and this same time span will then be applied for the period

prior to admission. The resultant figures are to be placed in ratio as illustrated.

Estimate of income for 120 days since discharge $60.00

Estimate of income for 120 days prior to admission $50.00

This ratio equals 1.20 which represents the score achieved by this individual. Scores in excess of 1.00 denote improvement. Unity represents no change and a score of less than 1.00 indicates deterioration. The arrest scale will be scored in the same manner. Here however, the term "arrest" is actually a misnomer. The intake score is simply the raw number of arrests an individual has during the three months prior to his first admission. The first admission is not scored in either direction. The after measure is the combined total of arrests and re-admissions to the Center so that in effect this scale represents the frequency of police contacts rather than simply arrests. Again a score of less than one indicates deterioration or heightened police contacts, while a score over 1.00 shows fewer instances of police intervention since treatment. For example,

Number of arrests for three months prior to admission 6

Total number arrests and re-admissions since discharge 3

One measure which proved to be unscaleable was the variable of general health. None of the evaluation team can claim competency in medicine. Nevertheless, it was thought that in the area of health the patient population would show the most immediate and marked effects of the treatment program. For this reason some assessment should be attempted even if limited to gross factors which yield categorical interpretations. Almost exclusively we have to rely on the subject's report on his conditions at the time of the follow-up

interview. Three categories - improved, same, and declined - are the possible ratings. In order to achieve a rating of improved the individual must display a significant change. Such things as the cessation of complicating symptomatology (D. T.'s, blackouts, etc.), significant weight gains, decrease in polyneuritic pains, increased appetite, etc., are all common items reported by these subjects which would indicate improvement in their overall general health.

The drinking pattern scale is the central issue in terms of the treatment program. An individual's success in any of the other measures is quite dependent upon how well he manages to control his alcoholic consumption. With this in mind then, the reader will see in the following scales that although the variables interact heavily they are nevertheless independent indices.

DRINKING PATTERNS

The drinking history of these subjects is indicative of the level or stages at which they currently find themselves in this debilitating disease. This measure, like the others, is one part of the fabric which constitutes the alcoholic's way of life. The type of beverage consumed is not sociologically, or even in a more narrow clinical sense, significant. The prime determinant of the type of alcoholic beverage consumed would seem to be more economic necessity than any other reason. More often than not these subjects report that their consumption is normally wine or some other cheap beverage of low alcoholic content. As the individual's monetary resources increase, the type of drink becomes more sophisticated, usually beer, whiskey, and even up to the "prestigious" scotch.

There would seem to be one other determinant operating in the context of drinking behavior. A "bottle gang," for example, even if the money were available, would normally prefer a cheap grade of wine for the simple reason that it is something which "lasts longer" as the bottle is passed around and continues the spirit of comradeship within the group. When an alcoholic is confronted with the situation of sharing a pint of whiskey, his expansiveness tends to decline because of the limited quantity available.

This scale will primarily measure the frequency and duration of the drinking bouts regardless of the absolute amounts of alcohol consumed.

Drinking Scale: Types

Category I: Prolonged pattern--The prolonged drinking pattern dominates this category. Individuals rated would have to be drinking steadily (almost daily) for more than two months prior to this rating. The quantity of alcohol consumed should exceed approximately two-fifths of wine or one-fifth of whiskey per day.

Category II: Prolonged pattern--The drinking here is characterized by the same pattern as above; however, daily consumption is considerably less. Intake must exceed approximately one-fifth of wine or one pint of whiskey per day.

Periodic pattern--Periodic drinkers may also be in this category if the last drinking spree lasted for more than one month and less than two months. It was felt that if a spree lasts longer than two months, it probably is degenerating into a prolonged pattern. The differentiation between the periodic and the prolonged pattern is in terms of the sobriety

between drinking sprees. The periodic drinker has approximately equal periods of sobriety and drinking. An example of this would be a periodic drinker who will remain dry for periods of approximately one to two months which are then culminated by a binge of approximately the same length of time. The amount of alcohol consumed would not have to exceed that stated in Category I. The criterion is simply that the individual, once started, drinks until he is intoxicated.

Category III: Prolonged pattern--Again we find almost daily drinking occurring; however, the amount of alcohol is substantially less than in Categories I and II. Subjects will usually report drinking to "keep a glow on" or simply to maintain emotional stability. Consumption may consist of a pint of whiskey, several six-packs of beer, or the alcohol equivalent in wine.

Periodic pattern--This rating is characterized by the individual's ability to control his drinking to the extent that the periods of sobriety are of more frequency and duration than his periods of insobriety. For the periodic drinker the quantity of alcohol consumed on a daily basis must be in excess of one-fifth of wine or one pint of whiskey per day.

Weekend pattern--This pattern would have to be of long standing, i.e., for at least the previous six months where the individual goes on a drinking spree at least three weekends a month. The amount of alcohol in this category is unspecified, except for the criterion that the individual must drink until drunk.

Category IV: Periodic pattern--In this category we find those individuals whose periods of sobriety as compared to the periods of insobriety are at a ratio of about two to one. In other words, over the course of a calendar year the individual would have approximately eight months of sobriety interspersed by approximately four months of insobriety.

Weekend pattern--The weekend drinker in this category would have an established drinking pattern of more than two sprees per month, and this pattern must have been displayed for more than four months prior to the rating. For this category and the succeeding ones no amounts of alcohol consumed will be specified.

Category V: Periodic pattern--The pattern displayed here is one of extensive periods of sobriety marked by short relapses. Normally this individual must show a pattern of sober periods of four or more months terminated by a drinking spree of less than one month's duration. That is, the individual can function and remain dry for significant time periods until such time as a crisis is encountered in the individual's employment situation, living arrangements, or familial circumstances. This then would precipitate an ordinarily intense drinking spree of short duration.

Weekend pattern--This individual is categorized by weekend binges no more than twice a month. This would amount to drinking approximately every other weekend. The pattern must be consistent and in evidence for more than three months prior to the rating.

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Category VI: Weekend pattern--The weekend pattern displayed here is one of occasional or infrequent bouts. It is sporadic in that it cannot occur on an average of more than once a month. This pattern must have been consistently displayed for approximately three months prior to the rating. NOTE: Normally in this type of pattern the individual is still able to maintain steady employment and perhaps even function adequately within his family and home setting. Often this individual begins to see himself as marginal in that he may realize that he may at any time "go off the deep end."

Category VII: This category is reserved for individuals who have been diagnosed as alcoholics but whose periods of sobriety may give the impression that their drinking habits are more or less normal. The intake rating would be dependent upon the individual's being dry for a period of over six months prior to the admission. The admission, of course, represents the termination of the spree which ended the six months sobriety. The after-treatment rating would be dependent upon complete abstinance since the first discharge date. In terms of this follow-up evaluation, this would mean that the individual has been dry since leaving treatment, a period in excess of three months.

The above scale approaches a continuum in as much as we have attempted to rank the categories in terms of the pattern displayed. A prolonged drinking

pattern would place the individual in one of the three lower-score categories. A periodic pattern, dependent upon the cycle manifested, would place the individual in a category ranging from II up to, and including V. This weekend drinking pattern, again dependent upon the frequency and duration of the bouts, would place the individual in a category approaching the upper ranges. The amount of alcohol consumed becomes less important as one progresses from the lower scales to the higher end. We assume that these individuals are at that stage in the disease progression that drinking is compulsive. The frequency and duration of their drinking bouts in ratio to their periods of sobriety then represent their ability or inability to cope with their dependency on alcohol.

Most evaluation studies of this type have shown that the area of drinking, irrespective of the criteria used, appears to be a most resistant area of the individual's life as far as positive change due to a treatment program is concerned. This is a function both of the unrealistic criteria which some researchers have devised as well as of the previously mentioned attempt to use the type of beverage as being a significant area. Clearly the question is not sobriety or insobriety as much as how well does the individual cope with his problem. Upon these premises, then, rests the argument for the validity of the above scales.

RESIDENTIAL ACCOMMODATIONS

The high mobility of this problem group has been characterized in a number of ways by the experts in the field of alcoholism. "Geographical escape," and/or the "geographical cure" represent terms which are applicable to behavior of the alcoholic. This would seem to be consistent with the other personality variables and social characteristics of the indigent alcoholic,

all of which point up to his inability to assume responsibility and/or function in a stable capacity. The homeless man stereotype well described in the literature illustrates the migratory patterns and social isolation of this group.

The items on the scale deal with two co-related variables: first, the type of shelter or lodging to which the individual typically has access, and, second, the frequency with which he finds shelter.

Residential Scale: Types

1. At the lowest end of the scale we find the individual who has no home. His usual habitat is that of the streets and public places. Almost exclusively he may be found sleeping in the streets, alleys, doorways, and public places of the city such as bus depots, train stations, etc. A typical week would find this individual having shelter, i.e., a bed to sleep in and a roof over his head, less than twice a week.
2. This individual has no stable residence. Again, he mainly sleeps in the streets, alleys, and public places. Normally, he finds shelter between two and four nights a week. The characteristic shelter is the flop house, cheap transient hotel, or, if the need for other services arises, he may upon occasion go to one of the missions in the skid row area.
3. In this category we find the individual who more often than not has access to some form of housing. Normally this is in the skid row area and it may be a flop house,

transient hotel, or mission. The frequency of sheltered accommodations would be between four and six nights a week. He would not have the same bed every night.

4. At this mid-point in the scales we would find the individual who is a regular inhabitant of the missions, shelters, and transient lodgings in or surrounding the skid row area. Only rarely does this individual find himself sleeping in the streets and alleys of the city (less than once a week). He may have the same bed but usually is in a dormitory setting with no room of his own.
5. Lodgings in this category would consist of a structured environment such as a half-way house, accommodations with friends or relatives, or some form of semi-permanent address. In this category we find the individual who has access to shelter normally <u>when he is sober</u>. In many instances, he has agreed to the fact that when he is drinking, these accommodations are not available to him. The individual must have resided at this address for at least one month prior to the follow-up interview.
6. At this point the beginnings of an established residence are present. The subject must have been at this address for more than two months prior to the follow-up interview. The accommodations here would take the form of a more homelike atmosphere, either with friends or relatives,

where the individual has the same bed every night and, at the least, a semi-private room (may share room with one other occupant). In order to achieve this rating the individual must be able to retain residence regardless of his sobriety or insobriety.

7. In this category we find those individuals whose life has not deteriorated to a great extent due to the onset of alcoholism. They still may have and reside in their residence, meaning a private room with board in a rooming house or a hotel where meals are provided as part of the established arrangements. The individual must have resided at this address for three or more months prior to the follow-up interview.

These categories are fairly accurate representations of existent variations for this group. Two inconspicuous or non-reactive questions were addressed to the subjects in an effort to clarify their standing in regard to these categories. First, it was decided that for the individual to get a score of five or higher, meals or some food arrangements must be present within the residential setting. This then insures that as we move up the scale, we are getting into a more homelike environment. The second non-reactive question is simply a matter of assessing the amount of personal property which the individual has accumulated. The more mobile are normally characterized by their ability to transport their personal possessions in their pockets. Often these possessions consist of such items as a bar of soap, several razor blades, a safety razor, a pocket knife, a can opener, tooth brush, comb, and possibly a few other idiosyncratic items. In order to obtain a score of four

or higher, the individual must have some accumulation of goods which would require several suitcases and/or boxes for him to move.

The most important variable is, of course, the numerical frequency with which the individual either does or does not find shelter on a weekly basis. Most subjects upon entering the Center fall into the lower three scale categories. Their ability to move into the higher scale categories after treatment reflects not just simply an extension of mobility patterns but in a real sense qualitative changes in their life patterns.

EMPLOYMENT

As the disease of alcoholism progresses with these individuals, the stability of their life pattern deteriorates proportionally. With the onset of the disease, many of these individuals are still capable for varying lengths of time to maintain their present skills, if any, and to continue at a steady job. As the individual moves progressively lower on the social scale into the skid row environment, many other factors such as general health, chronic brain syndrome, unreliability, etc., enter to negate the possibility of steady employment. The employment scale then takes into consideration two major factors: both the type of and frequency of employment, with the emphasis on the frequency of days worked.

Employment Scale: Types

Category I: At the lowest end of the employment scale we have those individuals who, due to the onset of old age, diseases, and other physical and mental handicaps, are just simply unemployable. For these people, there is little or no chance for employment in any productive capacity.

Category II: In this category we have the individual who works as a day laborer either contracting out of a labor pool employment service or who may take occasional odd jobs when confronted with the opportunity by friends or relatives. These are for the most part individuals with no skills or trade who have not held a steady job in the last year and who have averaged no more than one day of work per week in the previous three months.

Category III: The unskilled laborer who lacks steady employment within the three month period prior to rating would fall into this category. The individual may have a place of employment where he can report when he wants to work, or he may hire out as a day laborer. This individual may work ~~up to an average of three~~ days a week.

Category IV: The mid-point in this category would be represented by the unskilled employee who has worked at a job within three months prior to the rating. He will average four or more days worked per week.

Category V: In this category we have the low-skilled worker whose work history is one of periodic cycles alternating between steady employment, usually three weeks or more, followed by shorter periods of unemployment which last for about one week before he again finds employment.

Category VI: The usual worker in this category is semi-skilled and possesses some skill in demand within the labor market.

He has steady employment and has been working for more than three months on the same job prior to being rated.

Category VII: This category is represented by the skilled worker who has been employed for six months or more prior to his admission. To achieve this rating in the follow-up evaluation, the individual would have to have been employed steadily at the same job or in the same trade that he had prior to admission. Upon being discharged he must have resumed his job or trade and worked steadily until the follow-up rating.

These scales provide the basis for the ratings which assess change in the individual's life patterns. The assumption, of course, is that any significant change in the direction of improvement is due to the treatment program directly. However, this assumption cannot be justified until after the evaluation results have been analyzed.

The intake or "before treatment" rating was based on information from the Social History Form gathered by the Center's social workers, the admission forms, and police criminal records. The "after treatment" rating is, of course, taken from data obtained during the follow-up interview. In those instances where the interviewer finds gaps or deficiencies in the intake data, this also was obtained at the time of the follow-up. Since these ratings yield numerical indexes of an ordinal nature statistical manipulations are minimal.

These scales were tested for validity and reliability using the Pearson Product Moment Correlation. Fifteen cases were selected at random and assigned to one of the interviewers for rating. He was unfamiliar with the scales, having worked only from the interview schedule. After he rated all fifteen

cases on the three scales, his before and after scores were compared to those this researcher had arrived at previously. Below are the results:

	Before	After
Residence	= .96	= .87
Employment	= .94	= .97
Drinking	= .90	= .85

These correlations demonstrate a high degree of reliability.

Validity was checked in two ways. First, the initial one hundred cases were evaluated in July, 1967, with the remaining sixty cases not being rated until January, 1968. The trends of improvement and the proportions of subjects who showed no change or decline remained stable. Hence, the scales were validated over a time dimension.

Validity was also checked via correlations to show independence. Unless the scales are independent measures, it could be claimed that we measured the same variable three times over (i.e., first on one scale and then on the other two). However, one of our previous assumptions was that the individual's progressive deterioration would affect other areas of his life style in a fairly predictable or uniform manner. By using the same fifteen cases tested for reliability it would seem reasonable to expect significantly lower correlations and at the same time, a strong trend of relatedness. Below are some of these correlations:

Before Ratings

Residential vs. Employment	= .64
Residential vs. Drinking	= .66
*Employment vs. Drinking	= .87

* Intuitively, one would expect this relationship to be the strongest.

After Ratings

Residential vs. Drinking	= .57
*Employment vs. Drinking	= .82

A discussion of the applicability of the results to the entire treatment population is presented in the following chapter. This is based upon the scales which have been presented in detail in this chapter.

* Intuitively, one would expect this relationship to be the strongest.

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CHAPTER III

THE EVALUATION

In keeping with the grant stipulations of the Office of Law Enforcement Assistance and to further exemplify the continuing impact of socio-legal reform movement in this area, an evaluation of the St. Louis Detoxification Center has been carried out. It is the purpose of this chapter to provide the results of this study. The evaluation itself can be dichotomized into the following categories: The macro-social category, which deals with the impact of the Center's operation on those agencies and institutions traditionally endowed with the responsibility for dealing with the social problem. However, this report leaves aside this category in order to focus upon the infra-social level of analysis — the clinical evaluation of the patient population before and after treatment. This particular focus gives the positive side of what can be and has been accomplished by treating the chronic inebriate in a medical, psychological, and social context.

As a demonstration project, the Center has been a pioneering effort, particularly in terms of its sponsorship under the St. Louis Metropolitan Police Department. It is not, however, a demonstration in the sense that it is an untried or untested idea. This would be tantamount to saying that we need proof that treatment measures are better than current punitive procedures under the criminal justice system. There can be no argument that rehabilitation is better than simply incarceration. It is rather the job of this evaluation to show how much and in what ways our resources can be better utilized in dealing with the chronic police case inebriate.

THE CENTER IN OPERATION

The first question which must be answered is simply, "Who are these individuals we are treating?" Since the Center opened in November, 1966, until July 1, 1967, there were a total of 548 admissions. A profile of this group demonstrates that we are indeed treating the chronic police case inebriate. Some of the indices which clearly point this out are the demographic characteristics of race, sex, age, marital status, educational level, income, etc. By comparison, the similarity between the patient population and the drunkenness offender for the year of 1966, shows high congruence. If we limit ourselves to those individuals who were arrested three or more times during the year 1966, the parallels are obvious.

	Average Age	Per Cent Male	Per Cent Female	Per Cent White	Per Cent Negro
1966 Arrestees (chronic) (N = 103)	49.4	91%	9%	71%	26%
Treatment Group as of 7-1-67 (N = 548)	48.1	91%	9%	83%	17%

A breakdown of the marital status of the treatment group lends further support to the contention that we are reaching the target population for whom the Center was designed.

	Single	Divorced	Married	Widowed	Separated
Treatment Group as of 7-1-67	40%	27%	21%	6%	6%

THE EVALUATION SAMPLE

The evaluation sample or study group was selected on the basis of the two criteria reported earlier (Chapter 2). Within these two limitations

then, the study group can be considered as a random sample of the males;

1. That the individual stayed for the duration of the treatment program (average of seven days) until medical discharge.
2. That the individuals lived in or near the St. Louis Metropolitan area for three months prior to their admission to the Center.

In all discernible characteristics the two hundred males selected for evaluation closely approximated the entire treatment group. During the course of the study 82 per cent of the sample were located and interviewed. Four of these individuals were not included in the evaluation because their interviews were not filed until after the date when the results were coded and recorded on IBM cards. Hence, the results of the evaluation project are based on 160 interviews or 80 per cent of the study group. This extremely high retrieval rate is the result of diligent work on the part of two experienced police officers assigned by Colonel Curtis Brostron, St. Louis Chief of Police, to aid in this project.

Based on the above sample, the evaluation results are applicable to between 65 to 70 per cent of the entire treatment population. Specifically, approximately nine per cent of the total treatment group were female, nine per cent left against medical advice, and another ten per cent were excluded on the residence requirement. In addition, four per cent of these individuals were not diagnosed as "chronic alcoholics." Thus, there is a total of 32 per cent of the entire treatment group to which these results may not be generalized.

The study group of 200 selected male subjects approximates both of these profiles.

SAMPLE PROFILE (N = 200)

Average Age	Per Cent Male	Per Cent White	Per Cent Negro
46.0	100%	78%	22%

* * * * * * * * * *

Single	Divorced	Married	Widowed	Separated
16%	54%	21%	10%	19%

It should be noted that the distribution in the marital categories is markedly different for the sample and the entire treatment group; however, the category of those living with spouse (i.e. "Married") is an exact match. There was probably some confusion on the subjects' part during the intake interview as to whether the categories of "Single," "Divorced," or "Separated" were appropriate. Since this is a Catholic institution, the subjects may have felt the classification of "Single" as preferrable to "Separated" or "Divorced" when interviewed in the Center as opposed to the follow-up interview conducted away from the Center.

For purposes of comparison, the patient profile as of July 1, 1967, is used since all subjects in the study group had been admitted by that date. Some other significant and highly consistent characteristics exist between the total patient population and the study group.

CATEGORY	ALL PATIENTS	STUDY GROUP
Eighth grade or less	47%	50%
Some high school	29%	24%
High school or beyond	24%	26%
College graduates	1%	1%
Not employed	34%	32%
Years diagnosed alcoholic	14.3 years	15.4 years

Before proceeding to the clinical evaluation, it should be pointed out that the Center is not only dealing with the revolving door inebriate, but is also effectively eliminating the revolving door process in St. Louis.

The Center serves three out of a total of nine police districts. It serves those districts which accounted for 82 per cent of all public drunkenness charges registered in 1966. Below is a table which shows the arrests for the time the Center has been in operation and the comparable period of the previous year.

Year	1965	1966											
Month	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sep.	Oct.	Nov.	12 Month Total
*Arrest Totals For Previous Year	205	162	145	223	221	173	202	139	106	101	120	92	1,889
	1966	1967											
*Arrest Totals While Center In Operation	82	56	64	76	84	75	86	83	76	70	54	50	856
Decrease Of	60%	65%	56%	66%	62%	57%	58%	40%	28%	31%	55%	46%	55%

These data leave no doubt that the Center is indeed treating the chronic police case inebriate for whom it was intended.

MEASUREMENT OF CHANGE

The scales presented in the preceeding chapter make tedious reading for the average layman. However, some simplification is possible. In dealing with the scale items, the lower the ranking the lower the socio-

*These figures represent the total drunkenness offenses for the entire City.

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economic standing and the more difficult the alcoholic problem of the individual. For one to move into other categories on any of these scales would represent a significant change in his life style since receiving treatment.

The following three case histories illustrate some of the variations found in the study group's reaction to treatment.

CASE HISTORY NO. I -- MR. B.-- SUCCESS

Mr. B., a white male, 60 years of age, married, and presently unemployed, came to the Center the second week in January. Prior to admission, he had been unemployed for six months, and his social history revealed his work experience to consist mainly of manual labor or work as a porter. He was living with his second wife who was in the hospital at the time for an operation.

The patient stated that he had a weekend pattern of drinking for approximately 20 years and that he had deteriorated to the point where six years ago he had lost control of his alcohol consumption. For several months prior to his admission he characterized his drinking as continuous and prolonged. The subject indicated that his wife's illness and the loss of his job had been the precipitating factors in this recent intense drinking bout.

Mr. B.'s diagnosis was acute and chronic alcoholism. He stated that he had never suffered from D.T.s, hallucinations, shakes, or convulsions, but that during this last spree he had experienced his first blackout. He had never received any medical treatment for alcoholism prior to entering the Center.

His arrest record included five previous arrests for misdemeaner violations.

At the time of the follow-up interview conducted during the second week of May, Mr. B. was living with his wife in the same three-room flat that they had occupied for the past four years. He stated that he was not presently employed and that he had just started to look for work. However, Mr. B. was not drawing unemployment or any type of welfare. They were apparently living on his savings. Since his discharge from the Center, he stated that his health has improved significantly, as evidenced by an increased appetite, good mental clarity, and his overall appearance of cleanliness and good grooming.

His drinking pattern has been one of complete sobriety since leaving the Center. Both Mr. B. and his wife verified that he has not had a drink

since receiving treatment. Mrs. B. was quoted as saying that she was deeply grateful to the Center and couldn't get over the complete change in her husband's personality.

This case illustrates rather typically some of the instances in which the treatment program has been a success. Although at the time of the follow-up interview Mr. B. still was not employed, the prognosis for both employment and income was very good. Mr. B. was rated as showing no change either positive or negative on these two scales. Mr. B. was approximately the 20th subject interviewed at the Center and the fifth individual in this group to report total abstinance since treatment. The impression of the interviewer was that Mr. B. had achieved a peaceful or well adjusted "dry" status. The interviewer was particularly impressed by the alertness and cooperation of this subject.

The above case history gives an indication of one type of situation and treatment response. It should be noted, however, that complete abstinence is not and cannot be the universal yardstick for measuring the success or failure of the treatment process. It is unrealistic to attempt to use the same scale for an alcoholic who has a period of three to six months of sobriety that one uses in gauging the progress of an alcoholic whose sobriety is typically measured in periods of a few days or a week. Rather, the response of each patient will have to be gauged in the light of his own individual drinking pattern and general life style to determine in what areas and to what degree his behavior improves, deteriorates, or remains the same.

CASE HISTORY NO. II-- MR. G. -- IMPROVEMENT

This 58 year old, white male was first admitted to the Center the last week of December, 1966, and was discharged the first week of January, 1967. Mr. G. is a high school graduate whose employment history includes work as a truck driver, railroad brakeman, machine operator, and various laboring jobs. His most recent employment was gardening and lawn care during the warm months. There appears to be a downward trend in the types of employment this individual has had.

The subject stated that he started drinking heavily when he was about 28 years old. Both his father and brother committed suicide during severe drinking bouts. He felt that he had lost control of his consumption about 1942, and that since that time he had experienced D.T.'s, hallucinations, convulsions, and blackouts. He had received treatment for alcoholism at least four times prior to his admission to the Center. He considers himself a periodic drinker, and would consume more than two-fifths of wine per day when drinking. His pattern alternates between about four months of sobriety followed by periods of up to two months of insobriety.

The follow-up interview was conducted the second week in March in an apartment which he was renting. He stated that on being discharged from

the Center he stayed for approximately one month at a half-way house before renting his own room. With regard to his employment, he reported being employed as a gardner and handy-man for two individuals for whom he has been working for the past several years. His income is at the same level showing no increase nor decrease. Since his release he has not experienced any blackouts, hallucinations, D.T.'s, etc., which were common prior to treatment. His appetite is good; his overall appearance was one of good grooming, cleanliness, and alertness.

His drinking habits have changed as follows: For approximately two months prior to his admission he was drinking daily and heavily. He estimated that his drinking alone was costing him about $10. a day. Shortly after leaving the Center, he resumed drinking--but less in terms of quantity and costs. As he put it, about a half a pint of whiskey a day is enough to "keep me on an even keel." He has had no intensive drinking bouts since leaving treatment.

In this case we see an individual who has improved in some areas in his life. His residential accommodations are now stabilized and of a better quality than prior to treatment. His employment and income, while not improved, are certainly adequate for his needs. On the basis of his self-report there would seem to be a significant improvement on the health scale. Although he is able to function adequately in other areas of his life, it remains to be seen how permanent these adjustments will be. For the purposes of the evaluation this individual was rated as improving on the drinking scale. The rationale behind this was simply that this individual had not experienced acute intoxication in the more than three months since his discharge, and that his ability to maintain his employment status and even improve his residential accommodations provides an indication of better control over his alcohol consumption than prior to treatment.

CASE HISTORY NO. III --MR. O.-- SHORT-TERM IMPROVEMENT

Mr. O., a white male, 46 years of age, and divorced, was admitted to the Center in January, 1967. Since his first admission he has been readmitted twice for further treatment. Prior to his first admission, Mr. O.'s living arrangements had been highly unstable in that he frequently moved about from transient hotels to rooming houses, etc., on an average of once every three or four weeks. His employment picture was sketchy as he averaged about three days a week as a day laborer. His job skill was that of a furniture refinisher -- a skilled trade in high demand in this area.

The subject characterized himself as a periodic drinker and stated that he had lost control of his alcohol consumption some 10 years ago. He had been dry for approximately three months when he began a drinking spree of three weeks duration at which time he was admitted to the Center for the first time.

The subject has had prior treatment by physicians and psychiatrists and has undergone extended periods of hospitalization for his alcoholism. He has experienced D.T.'s, hallucinations, and shakes frequently and even convulsions and blackouts on several occasions. He was diagnosed as suffering from both acute and chronic alcoholism with possible cirrhosis of the liver.

Mr. O. completed the 12th grade. His police record showed numerous arrests for public intoxication and other misdemeanor offenses.

At the time of the follow-up interview this individual was living in a small efficiency apartment. He stated that he lived alone and did his own cooking. After his first discharge he secured a job with a furniture company in this area and was working overtime every week. His income averaged about $500 a month take home pay. He remained sober for several weeks after his release, at which time he resumed drinking and was readmitted a second time the last week in February. During this stay his employer expressed concern over his health and frequently inquired as to when Mr. O. would be able to return to his job. He was subsequently discharged the first week in March and returned to his job and living accomodations provided at a half-way house for alcoholics. Once again the subject remained dry for several weeks before a prolonged drinking bout, which was terminated by his third admission during the second week of April. As before, his employer contacted the Center and assured Mr. O. of his employment upon release.

It was shortly after this last treatment that the follow-up interview was conducted. Mr. O. stated that he had not worked on his job for the past seven days due to a "nervous" condition he had contracted while in the service. He stated that he was under treatment for this condition and that he had been advised by the physician that he could not work for more than three days a week for the next month.

Mr. O.'s health improved slightly but not significantly. His appetite was improved, and he had a weight gain of approximately 10 pounds since his first treatment at the Center. He was mentally alert, although very nervous, and the interviewer's impression was that he was not well adjusted in his sobriety. Mr. O. remarked that his drinking pattern appeared to be worsening in that periods of sobriety were becoming truncated and periods of heavy drinking increasing. Apparently, the subject was deteriorating from a periodic pattern of prolonged consumption.

On the basis of the above information the evaluation showed that his living arrangements had improved slightly and that he now had a relatively stable residence. Employment had improved significantly over the period prior to the first admission. His income was vastly increased as a result of both his job skill and an apparently enlightened employer. Since the drinking pattern shows deterioration both in frequency and duration, the prognosis on this individual is poor.

RESULTS

The following data summarize the results of this study. Figures presented in table form are percentages rather than raw scores.

RESIDENTIAL ACCOMMODATIONS

The high mobility of this problem group has frequently been noted by the experts in the field of alcoholism. The homeless man stereotype illustrates the migratory patterns and social isolation of this group. This would seem to be compatible with other personality and social characteristics of the indigent alcoholic, all of which point to his inability to assume responsibility and/or function in a stable capacity as a result of his disease. This scale deals with two correlated variables: first, the frequency with which the subject finds shelter, and secondly, the type of shelter or lodging to which the individual typically has access.

Of the patients evaluated, approximately 15 per cent evidenced some significant improvement in their living arrangements. Eighty-two per cent remained about the same level of housing after treatment, while only three per cent showed decline.

The table below presents the percentage of individuals assigned to each category before and after treatment. On this scale a rating of four or lower would place the individual in an undesirable and/or unstable residential setting.

Ratings	1	2	3	4	5	6	7	Total %
Before Treatment	6	6	6	19	30	14	19	100%
After Treatment	6	5	3	16	33	16	21	100%

In the before-treatment rating of these individuals, 37 per cent had what would be considered inadequate housing arrangements. In the after-treatment rating, this figure was reduced to 30 per cent. The average rating before treatment is 4.8 while that for the after measure is 5.0. This is not an impressive change. A rating of four could be characterized by an individual who is a regular inhabitant of the missions, shelters, and transient lodgings in or surrounding the skid row area. This individual averages six days a week in some type of shelter and finds himself sleeping in streets and alleys of the city less than once a week. Category five is characterized by a structured environment, such as a half-way house, accommodations with friends or relatives, or some form of semi-permanent address with some food arrangements within the housing situation. The after-treatment ratings of categories five through seven indicate that 70 per cent of the individuals were living in a more or less structured or home-like environment at follow-up. By far, then, the majority of patients after treatment had adequate residential accommodations.

Even with the progression of alcoholism, many of these individuals are still capable of maintaining their present job skills, if any, and of holding a steady job for varying lengths of time. However, as the individuals move lower and lower on the scale and ultimately enter the skid row environment, many other factors, such as declining health, emotional instability, as well as subtle factors such as one's personal appearance, all combine to lessen one's possibility of steady employment. Thus, the employment scale takes into consideration both type and frequency of employment.

At the time of intake, 34 per cent of the sample were totally unemployed; that is to say, for a period of three months prior to admission these individuals had not been gainfully employed. Of this 34 per cent, fully 30 per cent were retired and/or disabled with many receiving some form of pension or welfare monies. This latter group is not represented in the following table, their numbers being included in the computations for the summary table at the end of this section. Hence, the reader will note a difference in the percentages in the employment results.

A rating of four or below would have to be considered under-employment. Categories five through seven may, depending on the individual's needs, i.e., dependents, housing, etc., be adequate for some of these individuals. The average rating for all study cases evaluated at intake was 3.8. Again, this rating in terms of our scales must be considered inadequate by any criteria. The after-treatment ratings average 4.4. Although this is a statistically significant change, it would still have to be considered inadequate employment. Twenty-nine per cent of those evaluated had shown some significant improvement in their work patterns. This means that they were either working with more frequency or had achieved some stability in an occupational role. Sixty-one per cent evidenced no significant change either positively or negatively. The interpretation of this figure must be tempered by the fact that some of these individuals already had adequate employment. Only 10 per cent according to our scales showed a decline in their employment.

Ratings	1	2	3	4	5	6	7	Total % Rated
Before Treatment	23	10	19	5	10	20	13	100%
After Treatment	19	9	20	5	8	10	29	100%

This table shows 43 per cent of the study group as having "regular" employment as evidenced by a rating of five or higher at the time of admission. Forty-seven per cent had achieved this level by the time of the follow-up interview. This latter figure of 47 per cent is not indicative of the complete employment picture. Some of those excluded from the table as "unemployable" due to disability or old age do receive adequate incomes. Since the majority of this group are through no fault of their own unproductive, it would be wrong to think of them as not self-sufficient, i.e., a rating of five or higher.

INCOME

Since the modal occupation of the treatment population is casual day labor, income was best estimated on a per weekly basis. The gross average weekly income of the entire study group was approximately $46.00, at the time of admission. This figure represents all forms of cash income, including pensions, disability payments, welfare, etc. Sixteen per cent reported no income on the intake rating. The same was true of only eight per cent on the after-treatment measure. At the time of the follow-up interview, the average weekly income for the entire study group had risen to approximately $52.00. Twenty-six members of the study group or 16 per cent are responsible for this increase. Those who showed improvement had an average rise in weekly income amounting to almost $22.00. Seventy-one per cent remained at approximately the same level with 13 per cent having a lower income.

HEALTH

At the study's outset, it was felt that the most immediate and marked effects of treatment would be found in the area of health. None of the

evaluation team can claim competency in the area of medicine; hence, this measure proved to be unscaleable. In an attempt to achieve some assessment, this evaluation was based on gross factors readily available during the interview process. In order to achieve a rating of "improved," the patient must have displayed a significant change evidenced by such things as weight gains, increased appetite, cessation of or a decrease in polyneuritic pains, or the disappearance of other complicating symptomatology (D.T.'s, blackouts, etc.). Forty-nine per cent of the study group showed marked improvement in their physical well-being based on the above factors. Forty-two per cent displayed no significant improvement, and nine per cent showed a decline in overall health.

For half of these individuals, the Center represented the first medical treatment they had received for alcoholism. Almost all subjects indicated during the follow-up interview that the care they received at the Center was the first indication in a long time that "somebody cared about me." The interviewers expressed the opinion that perhaps the therapeutic effects were even greater for the individual's mental health than upon his physical self. The mere fact that a seven-day program of nutrition, sanitation, and mental hygiene would leave its effects on such large numbers of these individuals three months after the treatment period is evidence of the accomplishments which can be made with this group of "hopeless people"

DRINKING

The drinking dimension is the most crucial test of the treatment program. Rehabilitative gains in any other area must be seen as temporary

unless a concomitant improvement is displayed in the individual's drinking patterns. The question is not simply a matter of sobriety or insobriety but also the extent to which the individual copes with his problem. This scale measures primarily the frequency and duration of drinking bouts in relation to periods of sobriety as representative of one's ability or inability to deal with his dependency on alcohol.

At the time of admission the modal rating was category I. This rating represents a prolonged drinking pattern where the individual would have to be drinking steadily (daily) for more than two months prior to rating and the quantity of alcohol consumed would have to exceed approximately two-fifths of wine or one-fifth of whiskey, gin, vodka, etc., per day. The average rating at intake was 2.9. On the basis of our experience with these scales, it would appear that an individual with a rating of 4.0, or lower would experience a good deal of difficulty in adequately fulfilling familial or employment roles or in achieving a stable residential setting. Eighty-one per cent of the patients admitted were rated at four or below. The remaining 19 per cent were marginal in their capacity to function with any degree or normalcy. Only one person achieved a rating of seven at the time of admission.

The after-treatment ratings showed that 47 per cent of the patients made significant improvements in their ability to control their consumption of alcohol. Approximately 50 per cent demonstrated no markedly improved control, while only three per cent actually deteriorated in their drinking pattern. The average rating achieved at the time of the follow-up interview was 4.0, an average increase of 1.1 over the intake rating.

in the categories of five through seven, which represent some degree of stability in the individual's life style, we now find 42 per cent of the individuals after treatment as opposed to only 19 per cent prior to treatment.

These results greatly exceeded those anticipated by all concerned. Fully 19 per cent of the study group had been for all practical purposes abstinent from discharge until the time of the follow-up interview -- an average of 120 days of total sobriety.

Certainly, by any standards, this 19 per cent would represent unqualified success in treatment outcome. Below is a table of the ratings for the before and after treatment ratings.

Ratings	1	2	3	4	5	6	7	Total % Rated
Before Treatment	26	16	21	18	12	7	-	100%
After Treatment	17	12	15	14	11	12	19	100%

It was found that those achieving a rating of seven after treatment had on the average, slightly higher ratings on the other scales prior to admission. The significance of this result has been demonstrated in other studies of this type -- namely, that the type of in-patient treatment administered is not the sole factor for prognosis; in addition, the social settings from which an individual comes to which he returns after treatment are crucial. The implications of this finding are even more important in a program designed to handle the "revolving door" clientele. A strong referral network and an intensive after-care program are essential.

ARRESTS

Discussion of the arrest dimension has been deferred until this point because of the paucity of available data. The seasonal nature of public intoxication arrest precludes comparing equal time periods before and after treatment. Furthermore, a significant percentage of the patients had been residents of St. Louis City for less than one year prior to admission; hence, any measure based on a comparison of specific months for this period prior to admission and after discharge would be incomplete.

This dilemma could not be resolved to this researcher's satisfaction. Earlier in this report, the arrest figures for the City of St. Louis were cited showing a tremendous decrease. The figures presented below, however, provide a better indication of what this lower rate of police contacts meant to the individuals in our study group. The findings revealed an average of 1.0 arrests for intoxication in the three months prior to treatment as compared to an average of only 0.3 after treatment. This latter figure represents arrests plus readmissions. As another index, 46 per cent were arrested for drunkenness in the three months prior to their first admission while only 13 per cent had been arrested in the same period after discharge.

These figures should be interpreted cautiously, however, as the parameters of these figures have not been fully explored. Nevertheless, it is safe to say that a significant decrease in police intervention after treatment can be noted.

SUMMARY

The scaled scores for each individual were pooled to achieve a cumulative score for both before and after measures. The breakdown of these

scores by category is virtually meaningless for individual cases. However, using pooled scores, results showed 50 per cent of the patients studied experienced some overall improvement whereas only eight per cent had a lower cumulative score after treatment. Forty-two per cent maintained the same score; yet even here actual improvements may have occurred on one scale -- only to be canceled out on another.

The following table is presented in summary. The interpretation of these figures should be unequivocal. Where improvement was reported, it must have been of a significant magnitude to the extent that the individual has, at least in some areas of his life, reversed the prior deterioration process. Many individuals who have received ratings of "remained the same" may well be in the process of establishing new life patterns. It may prove to be unrealistic for this evaluation to demand significant demonstrable change in such areas as housing and employment in a three or four month period. This idea would seem to be supported by the findings in the area of drinking which indicated more improvement than on the other scales. Further, improved control over one's drinking pattern is certainly a prerequisite for improvement in other areas of life.

	Markedly Improved	Remained Same	Deteriorated
Drinking	47	50	3
Employment*	18	76	6
Income	16	71	13
Health	49	42	9
Housing	15	82	3

Aside from this clinical picture one might ask the question, "What has the impact of the Center been on the police?" Other than arrest figures, man-hours, and increased efficiency, this question may never be fully answered. For the impact on the patrol officers has been as truly remarkable! Many who were at first openly skeptical of the treatment program have expressed unqualified enthusiasm as a result of some of the Center's success cases whom they have known. Some have even gone so far as to volunteer their services both on and off duty in any way that they might further the treatment program. Many others have donated clothing and other useful articles to the Center. However, the acceptance of the treatment program on the part of the line officers could not help but be recognized when investigators in this research began to hear of informal shuttling procedures being conducted so that an intoxicated individual would be found in one of the districts being served by the Center.

This high degree of professionalism has been noted from many quarters, but the following vignette by Allan Hale better captures the import of this program in terms of human experience.

St. Louis Globe-Democrat, Thursday, May 25, 1967

There was a very pretty bit of professional police work at the corner of Eighth and Washington, Tuesday.

The evening rush hour was just coming to an end. A man in his mid-40's, and staggering drunk, was annoying a bus queue in general and one frail old man in particular.

The man was not violent, but he was loud and large and persistent. Worse, he had a child with him, a little girl.

On the opposite corner a big young policeman was watching the flow of the rush-hour traffic and talking into a two-way radio.

A bystander crossed the road and seemed to indicate that the policeman might interest himself in the situation accross the street. The large young man gave an indifferent half-glance and presently strolled away down Eighth Street to a quieter corner, still talking into his radio.

At that moment a very small, thin-faced young policeman, with a radio at his belt, appeared round the corner of Washington and smilingly greeted the drunk as an old friend.

They stood and they talked, and the drunk gesticulated and the policeman smiled and the drunk smiled and the disapproval of the bus queue grew to an almost visable "Is this what we pay our police for, hey?"

The two talked for perhaps five minutes, or just the period of time in which a man might pass a radio message and be sure that it had been acted on.

Then the little policeman enquired which bus the drunken one wanted and would he like to ride instead? And at the little policeman's suggestion the two walked away from the corner crowded with bus travelers to the quieter corner of Eighth Street, where there was nobody but a large, indifferent young policeman who had by now snapped down his radio antenna and was gazing innocently at the sky.

The little policeman smiled, and the drunk smiled and the child, to whom the procedure seemed to be familiar, skipped happily alongside.

The group reached the quiet corner, crossed the street and stepped up onto the sidewalk.

At that instant, but not until then, a motor scooter patrolman drew up at one angle of the corner and a patrol car halted quietly at the other.

The door was opened, the drunk was ushered in, the child jumped in beside the father, the large, indifferent young policeman dropped into the seat beside the driver and the car drove off.

Nobody got killed, nobody got hurt, nobody even lost his temper. But it was worth watching, all the same.

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