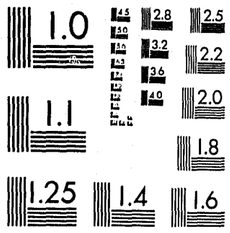

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Decriminalization of Public Drunkenness:

Tracing the Implementation of a Public Policy

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National Institute of Justice

Decriminalization of Public Drunkenness:

Tracing the Implementation of a Public Policy

by David E. Aaronson
C. Thomas Dienes
Michael C. Musheno

January 1982

National Institute of Justice
James L. Underwood, *Acting Director*

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FOREWORD

Decriminalization of certain behaviors, namely victimless crimes, has become a major trend in Western legal systems in the last two decades. Crimes without victims involve such matters of private morality as consensual sexual behavior of adults, gambling, etc., and conditions previously viewed as personal vices which have been redefined as illness or disease such as drug addiction and abuse and chronic public intoxication, which is conceived of as being symptomatic of alcoholism.

This study, authored by David Aaronson, Thomas Dienes, and Michael Musheno, represents a significant contribution to the body of knowledge concerning the policies and practices of decriminalizing public drunkenness in the United States.

Historically in North America and Europe, public drunkenness has been treated as a criminal offense in almost every legal jurisdiction. Laws existed on national, state, and/or local levels prohibiting public displays of drunkenness. Although disorderliness was a prerequisite under some laws, the homeless, skid row inebriates faced repeated arrest for disorderly and nondisorderly drunkenness.

Thus, many individuals arrested for public drunkenness are alcoholics, but treatment for alcoholism is clearly not part of the correctional regimen. The process of arresting inebriates, detaining them for a few hours or a few days, and then rearresting them has been termed by me in an earlier work a "revolving door." Some individuals have been arrested 100 to 200 times and have served 10 to 20 years in jail on short-term sentences, which in reality was life imprisonment on the installment plan. The recidivism rates for public drunkenness clearly indicate the futility of criminal justice system in dealing with the underlying socio-medical problems involved.

Over two decades ago when the results of my first joint study, Revolving Door, on this problem were presented in Rochester, New York, I stated:

> "A Treatment Center should be created for the reception of the chronic public inebriate. This means that they should be removed from the jails and penal institutions as the mentally ill in this country were removed from the jails during the last century. Given the present state of knowledge concerning alcoholism, the time is ripe now for such a change. The present system is not only inefficient in terms of the excessive cost of jailing an offender 30, 40 or 50 times, but is a direct negation of this society's humanitarian philosophy toward people who are beset by social, mental and physical problems." [Pittman and Gordon,

Revolving Door, Glencoe, Ill.: The Free Press, 1958, pp. 141-2]

Today my position remains the same. Fortunately, since 1955 a social movement to decriminalize the public drunkenness offense has occurred in Czechoslovakia, Poland, Sweden, Great Britain, Canada, the United States, and other countries; however, the task of viewing and managing the chronic inebriate as a socio-medical problem instead of a criminal one is still far from being accomplished in Western society. It is to this latter task that the authors have addressed this research, since the majority of the states in America have decriminalized public drunkenness. Despite the fact that the first efforts to remove the chronic public inebriate from the criminal justice system in the United States began in St. Louis in the mid-1960's with changing police procedures toward the public drunkenness offender and the opening of the first detoxification center in the Western Hemisphere for public inebriates in 1966, the implementation of a public policy of decriminalization has been one marked by difficulties. These authors have succinctly made this point in their research in the statement: "Managed decriminalization is not a panacea for problems of public drunkenness but only an initial stage in the process of confronting the problem."

These researchers correctly point out that the decriminalization of public drunkenness is not an issue of great concern to the general public. Despite the efforts of major private and public organizations to enlighten the public that alcoholism is a disease which may affect all segments of the society, the historic negative attitudes toward public "drunks" remain strongly embedded into the fabric of American society. The major premise underlying the social movement of decriminalizing public drunkenness in the United States has been that the diversion of this population to socio-medical facilities would allow the police, judges, and correctional institutions to concentrate their resources on the problems of major crimes. Thus while decriminalization is a practical idea for handling public inebriates, the actual implementation of this concept is a difficult policy to effect. The authors in this meticulous study offer valuable insights as to the reasons why this goal is not always accomplished.

As Aaronson, Dienes, and Musheno indicate, the removal of criminal sanctions for public drunkenness must be accompanied by: (1) the acceptance by public health authorities that the chronic police case inebriate has the illness of alcoholism; (2) the existence of institutional means for processing public inebriates through noncriminal facilities such as detoxification centers, community mental health centers, and/or general hospitals; (3) the acknowledgement by the police in any community which decriminalizes that the above institutional options are available to their officers on the street; and (4) the actual use of these institutional options by the police in processing large numbers of public inebriates who are found in all American major metropolitan centers.

This study is an analysis of decriminalization in operation at one point in time; namely the mid-1970's. The reader should be aware that the situations presented in the various locales studied at that time may not be the same today. To be more explicit, one city which is analyzed by the authors is St. Louis, Missouri; at the time of the study, although St. Louis was

representative of a decriminalized jurisdiction, the Missouri General Assembly had not repealed the public drunkenness laws--although the Missouri legislature decriminalized public drunkenness in 1977. Conversely attempts have been made, fortunately unsuccessful, to recriminalize public drunkenness in the states of Alaska and Nebraska, because the legislators expected miracles to occur in a period of a few years in the handling of this population--a feat which would be difficult for any state to accomplish when the full range of alternatives to incarceration are not available.

The authors' theoretical analysis is based upon the use of three models which all future researchers must attend to; namely (1) the impact model, which investigates the extent to which the handling of public inebriate cases was affected by decriminalization by examining how the police handled these individuals "on the street"; (2) the discretion model, which indicates how police practices were altered in various jurisdictions as a consequence of decriminalization; and (3) the prescriptive model, which discusses what innovations have been made to improve the intake and processing of public drunkenness cases by the various socio-medical facilities to which these individuals have been transported by the police.

These models are the basis of the authors' comparisons of the decriminalized jurisdictions of Washington, D.C., Minneapolis, and St. Louis with the nondecriminalized localities of Houston, San Francisco, and Richmond, Virginia. To their credit, the authors spent extensive time on site visits to these locales interviewing police personnel, community leaders, and members of the public service bureaucracies. Unfortunately what is missing is interviews with the public inebriates themselves as to their situations in decriminalized and nondecriminalized jurisdictions. However, this is not a major deficiency; it only indicates another area to be researched by future scholars.

For those of us who in the 1960's placed so much faith in the decriminalization of public drunkenness as a social policy to solve not only a number of problems for the police but also to provide better care for these human beings, experience has proved that decriminalization is not a panacea for all of the problems we had hoped it would solve. A major contribution of this study is a detailed account of the problems encountered in the implementation of the decriminalization concept and in offering positive alternatives to correct many of these difficulties. St. Louis, as well as many other jurisdictions which decriminalized, found (after the initial success of their efforts) that many police officers in decriminalized jurisdictions failed to transport inebriates to the socio-medical facilities. Furthermore, we were confronted with the fact that even if the police took the inebriate to the detoxification center, that often the individual was not admitted, or, if admitted, the inebriate was frequently back "on the street" within a few days. These authors correctly identify in their study that in most communities there is a strain or friction between the police officers and the treatment facilities' personnel. In many jurisdictions, since such low priority is placed on handling public inebriates, the police officer has no incentive or reward structure offered to him/her to take the time and energy required to transport these individuals to a detoxification center. Furthermore, rarely are police promotions based upon excellence in transporting the public drunkenness cases to socio-medical

facilities. On the other hand, public health agencies, such as detoxification centers, have frequently refused to accept the hardcore public inebriates who are constantly being transported by the police to them. This is at the core of a major problem in communities and states which have decriminalized; i.e., there is friction between the police and socio-medical personnel as to what detoxification centers can realistically accomplish. It should be remembered that detoxification facilities are only the first step in the sequence of providing care for a population group who has been historically denied access to treatment. No short period of stay at a detoxification and diagnostic evaluation center is going to change the life pattern of the public inebriate. What is needed, if decriminalization is to succeed, is a full range of transitional care facilities to which public inebriates can be referred after their initial detoxification. More specifically, most communities which have decriminalized have not had available the full range of resources such as half way houses, domiciliary care facilities, and after-care resources such as counselling in the areas of employment, housing, and family problems. In short, the use of detoxification centers is only the first step in developing a decriminalized system of handling public inebriates.

These researchers are realistic in their emphasis that there must be other alternatives available besides those that involve police transporting of inebriates to the facilities. As Aaronson, Dienes, and Musheno discuss in detail, nonpolice personnel can be very effective in both transporting inebriates to medical care facilities as well as energizing these same individuals to voluntarily seek admission to alcoholism treatment facilities. Such procedures have been developed to use civilian personnel for these tasks in such diverse localities as San Francisco, Minneapolis, Salem, Oregon, and Erie, Pennsylvania.

This work is an indispensable source book for all social policymakers, whether in the political arena or in the social service bureaucracies who have either implemented or are planning to implement decriminalization of the public drunkenness offense. It presents in a cogent and coherent manner not only the rationale for decriminalization but also techniques which should be employed to make this enlightened social policy more effective. It should be realized that developing an effective model of decriminalization in any community involves the close cooperation of what have been historically two antagonistic groups; namely the police who are charged with enforcing the law and keeping the "streets clean of public drunks" and the socio-medical personnel who are to provide excellent treatment and care of this under-serviced population of public inebriates. Unless these two groups keep their avenues of communication open and discuss their problems with decriminalization as these scholars point out, decriminalization will not be fully effective.

The new method of providing care for treatment of public inebriates outside of the criminal justice system is the only answer to this problem in terms of providing each American the dignity that he or she deserves. We cannot return to the unenlightened period of the drunk tank with all of its concomitant problems ranging from death attributed to lack of medical care to custodial care behind bars. Decriminalization can be effective when full cooperation takes place among all interest groups in a community as is witnessed by several of the authors' community case studies.

Alcoholism is a chronic illness in which individuals relapse; this too is the case with decriminalized communities in which systems that worked effectively at one time may then break down or relapse, but this is no excuse for the abandonment of the procedure of decriminalizing public drunkenness.

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CONTENTS

LIST OF GRAPHS

Graph

LIST OF FIGURES

Figure

LIST OF TABLES

CHAPTER 1

DECRIMINALIZATION AND THE POLICY PROCESS

A notable change in attitude has been taking place over the past few decades toward so-called victimless crimes, where the only tangible harm is done to the offender.[1] Nowhere is the change more apparent than in the move toward decriminalization of public drunkenness.[2] The courts,[3] the legislatures,[4] and law enforcement agencies[5] have increasingly eliminated criminal punishment for public drunkenness, in favor of a therapeutic, or health, approach to the problem. More and more, public drunkenness is defined as a sickness requiring treatment, rather than a crime calling for punishment.[6]

On the face of it, the move toward decriminalization would appear to be an enlightened one which can only be beneficial to inebriates, to overworked police departments, and to society as a whole. But for the therapeutic approach to work, there must be a carefully constructed system to remove inebriates from the streets and deliver them to a facility for treatment. Unfortunately, too little attention has been paid to the process of pickup and delivery of inebriates to the public health system.

Among police departments of major cities, techniques for dealing with public inebriates vary widely. In one midwestern city, police routinely give skid row inebriates a choice between going to a short-term, nonmedical sobering-up facility or the local jail. In an east coast city, street inebriates are left alone so long as they stay within informally designated areas which are out of sight and out of mind for downtown shoppers and store owners. A north central city uses a medically based detoxification facility to treat drinking problems. Civilian crews share inebriate pickup chores with uniformed police officers. In one city in the west, civilian-operated vans patrol the streets in one part of town, transporting inebriates to sobering-up facilities when they ask for help; in another section of the city, police, under pressure from merchants, hustle inebriates off to jail in a paddy wagon.

This study was undertaken to describe and assess the performance of the police as the principal agency responsible for the delivery of public inebriates to public health facilities. Primary emphasis is on the District of Columbia, but the study is designed to provide a comparative look at both the criminal and therapeutic approach in several representative American cities.[7] Three research models have been developed and used. (1) The impact model analyzes the effect of changing legal policy on the treatment of public inebriates; (2) The police discretion model attempts to find out how and why police practices have been altered by decriminalization; and (3) The prescriptive model analyzes changes that might be made to improve the intake and handling of inebriates.

In broad terms, the study found that decriminalization brought about significant reductions in the numbers of persons picked up for public drunkenness. There were qualitative, as well as quantitative changes: under decriminalization, more and more emergency-case homeless men, or what are called skid row inebriates, were processed by the police. Other inebriates were increasingly ignored by the police, or disposed of by informal means.

The study found a variety of reasons for these changes, most of them deriving from the attitudes of police officers themselves. Apparently, the introduction of a therapeutic, versus a criminal, approach to public inebriation provides disincentives to police action in this area. The willingness of police to pick up, process, and deliver inebriates to public health facilities is affected by departmental practices, public pressures, relationships with other police officers, and personal experiences and backgrounds. To highlight these factors, the attitudes of police officers in both criminal and therapeutic jurisdictions are contrasted and compared.

Finally, in the prescriptive phase, the study examines policy goals, conflicts among those goals, and the range of delivery mechanisms and treatment facilities available to meet the goals. The study looks at microchanges, such as shifts in the utilization of limited police resources, as well as macrochanges, including alternative pickup and delivery systems. The aim throughout is to explore what delivery techniques and basic treatment approaches best fit the range of results that decriminalization is supposed to bring about.

A. BACKGROUND TO DECRIMINALIZATION

Decriminalization of public drunkenness began to take hold in the 1960's and early 1970's.[8] The regional and national forces that coalesced around this issue focused on the questionable legitimacy and the ultimate futility of handling this social and public health problem through the criminal justice system.[9] By the end of 1975, 28 states, Puerto Rico, and the District of Columbia had invoked the Uniform Alcoholism and Intoxification Treatment Act or similar legislation. The act, drafted by the National Conference of Commissioners on Uniform State Laws in 1971, served as model legislation for the decriminalization movement. Other states and cities have adopted diversionary strategies where criminal statutes remain in force. The trend toward decriminalization is reflected in the FBI's Uniform Crime reports which indicate that 1,504,671 public drunkenness arrests were made in 1961; 1,517,809 in 1967; 1,261,817 in 1971; and 1,161,140 in 1975.

Jurisdictions can shift from a criminal to a noncriminal approach by other means than passing legislation similar to the Uniform Act. Also, when officials in municipalities move to implement decriminalization, they confront situations unique to their respective jurisdictions. These situational factors and the complexity of the concept, decriminalization, are first discussed as background to the empirical study. Each of the following background factors highlights the difficulty of constructing a framework to deal with the multiplicity of options available to states and cities in approaching the problems of public drunkenness.

1. Jurisdictions are seldom purely criminal or purely decriminalized or therapeutic in their handling of public inebriates. They range on a continuum from purely criminal to purely therapeutic, with a bewildering array of combinations in between.

Decriminalization may be de jure or de facto. The former is the result of formal action by the legislature or the courts in removing criminal sanctions from some or all categories of public drunkenness. De facto decriminalization may achieve the same result through informal screening and diversionary programs initiated and controlled by police departments, prosecutors, or courts or, as so often happens, two or more of these working together.

Both de jure and de facto decriminalization may take varying forms: the removal of criminal sanctions; the utilization of voluntary treatment centers by the police (police street diversion); the downgrading of public drunkenness to summary offense status; and the substitution of civil for criminal sanctions.[10] Most jurisdictions have elected to substitute a therapeutic-medical or social welfare approach for the criminal mode. The police remain the principal enforcers, but other means, including self-admission and civilian pickup may be used.

The mere removal of criminal sanctions does not mean a jurisdiction is fully "therapeutic" in its approach to public drunkenness. Whether a jurisdiction is more decriminalized or therapeutic as opposed to criminal depends on the following: (1) acceptance by public health authorities that public drunkenness is an illness requiring treatment rather than criminal incarceration; (2) the existence of an institutional means of processing the inebriate through a noncriminal facility; (3) acknowledgement by the police of this institutional option; and (4) actual use of this method in the processing of a large number of inebriates by the police.

St. Louis, for example, is treated as a decriminalized jurisdiction in this study as well as in other works on decriminalization. However, public drunkenness remains a criminal offense in the city, and the offender, if he "consents," is usually diverted by the police to a civilian detoxification center. The police summons is then voided if the inebriate stays at the center for the requisite period, generally 7 days.

Other jurisdictions such as Kansas City have worked out a formal administrative arrangement with a private agency--the Salvation Army in Kansas City--to refer some inebriates to a treatment facility while processing others under the criminal statutes. In Kansas City, the police officer usually asks an inebriate which he prefers, but the officer may rule out the treatment option based on his own assessment of intent, degree of belligerency, and previous behavior at the treatment facility. Except for the use of a private center, Kansas City uses much the same procedures as those used in St. Louis.

Philadelphia, on the other hand, appears--at least superficially--to follow the standard criminal model. The public inebriate is arrested and jailed. However, no offenders ever appear before a magistrate. They are simply released by the police within 12 hours, the sobering-up period. Thus, while the public inebriate in Philadelphia is released without formal criminal court processing, we would view this procedure as more "criminal" than "therapeutic" because no system for noncriminal handling exists or is accepted by the police.

Jurisdictions often go through a transitional period before achieving a more complete decriminalized or therapeutic status. In some jurisdictions, such as Oregon in the early 1970's, public drunkenness laws are eliminated or revised to create a therapeutic option, but no provision is made for therapeutic processing of the public inebriate and/or no funds are appropriated for implementation. Confronted with public inebriates in need of assistance but with no procedures or alternative facilities for dispensing help, the police may resort to criminal law options which remain on the books or use other minor criminal charges, including the nebulous "protective custody" option (incarceration of an individual for a designated time, such as 24 hours, without the need to press charges). Many cities, such as the District of Columbia and Minneapolis, undergo transitional periods in which the law changes but the development of treatment facilities lags behind. During such periods, we do not label these jurisdictions as completely "therapeutic" or "decriminalized."

2. Public inebriates are not synonymous with alcoholics or skid row (homeless) inebriates. Failure to make this distinction ignores the reality of policing. The distinction is also necessary in assessing the consequences of legal policy changes.

While alcoholism is doubtless a major social problem, public policy has not characterized it as a police problem. However, in the past, public drunkenness alone was generally sufficient in legal policy to generate a police problem. The general effect of the legal reform beginning in the 1960's was to make such public drunkenness, in the absence of some additional aggravating element, an inadequate basis for the imposition of criminal sanctions. Public drunkenness per se was perceived as a basis for civil justice intervention, although the police have been retained as the enforcement arm of the civil justice system. Sometimes public policy demands consent for the detention of public inebriates. Alternatively, at least short-term compulsory detention may be permitted for the public inebriate dangerous to self or others. In any case, the public inebriate need not be categorized as an alcoholic to justify public intervention.

The legal justifications for both criminal and civil intervention vary widely. But regardless of the formal legal mandate, the police have significant latitude or street level and command level discretion in interpreting the law on the books. It is this reality that requires one to make a distinction between the law on the books and the law in action.

An important aspect of this distinction is the problem posed for the police by the different types of public inebriates. The non-skid-row inebriate generally has some place to go and someone who can be called upon to provide assistance. The skid row or homeless inebriate is dependent on institutional assistance. These differences often produce discriminate modes of policing, regardless of the character of the legal mandate. Further, police attitudes can lead to discriminate practices based on the different classes of public inebriates, even if these inebriates have chronic public drunkenness in common. Such distinctions are, of course, reflective of social realities, not merely the police officers' predispositions.

3. To a great extent, urban renewal has eliminated the traditional concentrated skid row. The skid row inhabitants, however, have not disappeared

but tend to be more dispersed throughout the city. Often new mini-skid-row pockets emerge, which complicates the task of the police officer.

In a number of cities studied during this project, urban renewal has made major changes in the character of the public drunkenness problem. The area of St. Louis bordering the Mississippi River, for example, has been renovated as a tourist and sports area. The large and concentrated skid row district has shrunk to a small pocket near the tourist and business district. Similarly, the Nicollet Island area in Minneapolis has been eliminated as an enclave for inebriates and is undergoing substantial renovation.

In St. Louis, the areas west of the central business district have increased numbers of skid row inebriates located in dispersed pockets. In Minneapolis, both the First and Sixth police precincts have concentrations of former skid row inhabitants. The elimination of Nicollet Island as an enclave for public inebriates has pushed many of these inebriates closer to the commercial and business section of the city. In Kansas City, the revitalization of the old warehouse district along the river currently threatens the last enclave of public inebriate hangouts and lodgings. Business establishments entering the area prompt increased police attention to the drunkenness problem.

The gradual dispersion of the skid row inebriate makes it difficult to assess the number of individuals involved and to determine whether this sector of the public inebriate population has increased or decreased. Some persons interviewed suggested that the increased availability of welfare benefits may have cut into the numbers of skid row inebriates. But these same persons speculated that these benefits were frequently invested in alcohol rather than in lodging, food, and clothes. The estimate that 3 to 5 percent of the alcoholic population is skid row has not markedly altered. In any case, the diversity of the public drunkenness population and the potential for differential policing seem to persist.

4. Criminal jurisdictions vary substantially in the extent to which public drunkenness laws are enforced. Among the factors accounting for this variance in enforcement are community culture, community concern over police command priorities, beat conditions for patrol officers, and officers' priorities.

Jurisdictions may have a similar legal mandate on the books, but there is no assurance that this will produce similar numbers of police arrests even when the public inebriate population is roughly the same size. Rather, there are wide variations in the extent to which public drunkenness laws are enforced, and in the manner of enforcement.

At the same time that Washington, D.C. was averaging 40,000 arrests annually (early 1960's), for example, St. Louis, a somewhat smaller city, was producing only 2,000 to 3,000 public drunkenness arrests. A number of reasons might be given for the extremely low arrest pattern in St. Louis. The city's history as an ethnic and river-front community has produced a cultural milieu more tolerant of public intoxication. Certainly, the level of complaint concerning public drunkenness by the public and business concerns seems to have been far less than in Washington, D.C. Thus, the culture of the community is an important factor affecting enforcement policy.

Another important factor is the policy of the police department toward the offense of public drunkenness. Even when the law on the books mandates a full enforcement policy, the police department may not implement such a policy. In St. Louis, felony and misdemeanor arrests where harm is involved have been emphasized and police tasks, such as public intoxication, have been downplayed. The low priority toward public drunkenness arrests that characterized the St. Louis Metropolitan Police Department (MPD) was reflected in the conduct of rank-and-file officers. Even today, officers who vigorously enforce drunkenness prohibitions are likely to be chided by their fellow officers. The "drunk squad" in the Eighth police district of St. Louis was an obvious source of amusement among other officers in the district.

Reports from officers who were on street duty in Washington, D.C. in the prechange years indicate the absence of any similar negative reaction. Most officers, especially those in the high drunkenness areas, regularly arrested public inebriates to improve their ratings. Near the end of a tour, they would frequently round up large numbers of drunks. The presence of tourist areas near these high drunkenness enclaves provided a ready justification for a full enforcement street policy.

Washington, D.C. and St. Louis in the 1950's and early 1960's present opposite extremes in the spectrum of enforcement of the public drunkenness laws. Other jurisdictions tend to fall on a continuum between these poles. Of crucial importance to this report is the obvious fact that if a jurisdiction tends to follow a "low-arrest" approach to public drunkenness prior to decriminalization or introduction of therapeutic diversion, there is less potential for a quantitative decline in formal pickup and delivery of public inebriates. Similarly, to the extent that the minimal enforcement policy in the prechange period is focused essentially on emergency skid row inebriates, there would naturally be a less measurable qualitative impact--the funneling effect of focusing on fewer classes of public inebriates that accompanies decriminalization is less observable.

5. In criminal and decriminalized jurisdictions alike, there is substantial variation in enforcement policy from police district to police district within the city.

The variation in enforcing public drunkenness laws, whether criminal or therapeutic, is not solely an interjurisdictional phenomena. We found that police precincts or districts within a single jurisdiction also differed markedly, especially in the absence of strong directives from the central police command. Indeed, it often appeared we were studying a number of minipolice departments having different policy approaches. The potential for district autonomy concerning a police problem like public drunkenness, which is often of low departmental priority, is great.

In part, this intra-city variance appears to reflect the character of the area the district encompasses and the kinds of inebriates encountered. One kind of police policy might be expected in a blue-collar, low-income, ethnic residential area where the inebriate is known to the officer; a different policy might be followed then in a heavily commercial, tourist, or entertainment area. Districts containing a concentrated skid row may have their own unique policy orientation. We found police in low-income black residential areas more tolerant of the public inebriate; it was explained that local businesses and the

residents were also more tolerant of the "deviant" behavior. If the area caters to the middle or upper class citizen seeking entertainment, full enforcement of the formal criminal law tends to be uncommon.

In seeking explanations for the qualitative and quantitative impact of decriminalization in a jurisdiction, it is important to consider intra-city variations. Often a particular attitude will have significance only in some parts of the jurisdiction being studied. Thus, police discretion often operates differently in different parts of the police organization.

6. Decriminalization by judicial action tends to lessen the use of criminal processing but does not end it. The limitations of judicial policy reform can produce confusion over the status of public drunkenness in the jurisdiction. On the positive side, judicial action can provide impetus to legislative and administrative actors. Meaningful decriminalization usually requires legislative or administrative action providing for the establishment of alternative means of deposition and institutions for handling the public inebriate.

Courts are often the initial focus for individuals and groups seeking legal policy change since access is more readily available. However, the judiciary suffers substantial impediments as a force for significant change. The courts are largely dependent on outside interests to initiate action and to define the matter in dispute. Court processing is often costly and time-consuming. Judicial means of acquiring information and formulating policy alternatives are usually limited. The court must deal with the concrete case and, in theory at least, is not free to define the scope of the issues raised by the litigants. By looking at laws and administrative policies, however, the courts can note problems or inconsistencies and communicate them to other actors having a greater capacity for substantial, managed change in legal policy.

This perception of the capabilities and limitations of the courts as instruments of social and legal change certainly fits the decriminalization of public drunkenness. In Washington, D.C., for example, the initial impetus came in the Easter decision [Easter v. District of Columbia, 361 F. 2d 50 (D.C. Cir. 1966)]. It became clear that a certain class of public inebriate, i.e., the chronic alcoholic, could not be criminally convicted. But who was to identify the chronic alcoholic--the police, the prosecutor, or the judge? What criteria were to be used? And what was to be done with the chronic case since there was no detoxification center? Should he be left in the street, arrested and brought into court, or should the prosecutor nol pros the case after the inebriate sobered up?

The result was temporary chaos. Police did not know how to proceed. The courts became more of a "revolving door" for chronic cases than they had been under a total criminal system. It became obvious that judicial reform was not sufficient. But judicial action did serve as a catalyst, not only in the District of Columbia, but in other cities, like St. Louis, that did not have their own court case but where administrative actors clearly were aware of the move toward judicial reform of the drunkenness laws. The District of Columbia Alcoholic Rehabilitation Act of 1968, decriminalizing public drunkenness, is clearly responsive to Easter and its chaotic aftermath.

Minneapolis also produced an interplay of legal actors in achieving decriminalization. Early legislative efforts in 1967, i.e., the Hospitalization

and Commitment Act, laid the groundwork by defining potential options for handling the public inebriate. The court decision in Fearon [State v. Fearon, 238 Minn. 90, 166 N.W. 2d 720 (1969)], recognizing chronic alcoholism as a disease requiring treatment, not a criminal offense requiring punishment, became a major catalyst for change. Like Easter, Fearon did not invalidate local ordinances criminalizing public drunkenness but provided only a shift of emphasis. Over the next 5 years, however, the Minnesota legislature responded to the judicial initiative and reformist elements that emerged from earlier decriminalization efforts in other jurisdictions, including Washington, D.C., and decriminalized public drunkenness, provided funds for detoxification and rehabilitation treatment centers, and laid the basis for initiating the civilian van mode of intake. Administrative police regulations were issued reflecting the legal policy change.

In St. Louis, formal change was not achieved by judicial or legislative action but through administrative and financial support from the federal government. While those favoring change in the city were influenced by judicial reform in other jurisdictions, the reform effort had actually begun about 2 years before the Easter decision. Creation of a detoxification center was underwritten by Federal funding grants and by contributions of the police department and other interested individuals and groups. Police regulations were altered to define alternative procedures for handling the public inebriate. Subsequently, city council action removed criminal sanctions for the chronic alcoholic.

Nevertheless, the absence of judicial and legislative action has left a gap in St. Louis' handling of the public drunkenness problem. Public drunkenness remains a criminal offense. Criminal processing is still an option for the city police and a number of individuals are handled in this way each year. When the detoxification center is filled, the inebriate must be arrested or disposed of by informal, unapproved means. Administrative action alone seems not to have achieved the original goals of the reform interests in St. Louis.

Decriminalizing legislation may also not be effective. A number of jurisdictions have decriminalized public drunkenness but have failed to provide funds for treatment centers or have not defined police procedures for handling public drunkenness. Mere removal of the criminal laws seems a most inadequate means for handling the problem. Some of the jurisdictions using this approach--such as Oregon--subsequently enacted comprehensive reform legislation; others have returned to the criminal model--citing lack of funds for establishing and maintaining a treatment system.

7. Decriminalization of public drunkenness requires the organizational involvement of a cadre of interested individuals and groups--a policy subsystem--whose goals are reflected in the legal policy change.

The view that group action plays a pivotal role in initiating and implementing social and legal change finds strong support in the revision of public drunkenness statutes. In the District of Columbia, for example, the Easter decision and the Alcoholic Rehabilitation Act represented a major victory for a cluster of interests that for nearly 20 years sought a therapeutic-oriented policy rather than a criminal approach to public drunkenness. Coordinated by the Washington Area Council on Alcoholism and Drug Abuse, these forces included members of city and federally chartered criminal justice reform commissions,

the news media, civil libertarian groups, public health institutions, and alcoholism interest groups, but not the metropolitan police department.

While all the coalition members backed legal reform, their interests naturally varied and produced conflicting strains in the emerging legal policy. The reform commissions and civil libertarians sought to free the criminal justice system from a responsibility deemed "noncriminal" while retaining constitutional protection for the public inebriate. Alcohol reform groups and the social-medical establishment emphasized the provision of emergency services for inebriates as well as opportunities for rehabilitation of the inebriate. We found no indication of any discussion among coalition members about possible conflicts among their diverse goals.

Therapeutic and law enforcement groups played a vital role in the initiation and implementation of St. Louis' diversionary programs. In these programs, the social-medical interests were headed by the directors of the Social Science Institutes of St. Louis' Washington University and a doctor, who subsequently became the first director of a Detoxification Center. The interests of other organized alcoholism groups appear to have been voiced primarily through the efforts of these dynamic individuals. The St. Louis Metropolitan Police Department represented the criminal justice interest in the diversionary programs. Members of the Research and Planning Division of the Department and the president of the Board of Police Commissioners became prime movers in the project. Indeed, the St. Louis Police Department became the first police department in the nation to apply for and receive Federal funds for a Detoxification Center.

The grant application for the Center reflected the diverse interests of the policy subsystem generating it. Five often conflicting goals were identified:

(a) to remove chronic inebriates to a sociomedical locus of responsibility which will markedly reduce police processing;

(b) to remove chronic inebriates from the city courts or jail;

(c) to provide sociomedical treatment for them;

(d) to begin their rehabilitation;

(e) to refer them to an agency for further rehabilitation with the goal that they will return to society as productive persons.

There are also references to preventing crime but the two goals of conserving criminal justice resources and providing rehabilitation were dominant. Indeed, the value of a detoxification center as a source of short-term emergency services seems to have been overshadowed by an interest in rehabilitation. While the Detoxification Center was theoretically established to handle all public inebriates, the overwhelming emphasis of the project was clearly on the homeless man. It was this focus that dominated the diversion program in its initial stages.

In Minnesota the policy subsystem included widely diversified elements: the traditional alcohol reform lobby (clergy, Alcoholics Anonymous); state commissions and associations (Minnesota Commission on Alcohol Problems, Governor's

Commission on Crime); civic groups (the League of Women Voters); legal professionals; and mental health professionals. Individuals who pressed for decriminalization were often affiliated with more than one of the active groups. For example, in Minnesota, there is no split between members of Alcoholics Anonymous and professionals in the state and county bureaucracies that service alcoholics. Beginning in 1954, the state has allowed recovered alcoholics to serve as therapists and caregivers.

The reformers directed their efforts at three levels of the governmental process: the courts, the state legislature, and county governing bodies. Even prior to decriminalization, informal approaches to the noncriminal handling of public drunks emerged in local jurisdictions. In Hennepin County (Minneapolis), Minnesota, for example, a citizen's task force was appointed by the county commissioners in anticipation of decriminalization. The task force and its professional staff conducted the search for the first receiving center, hired staff for the center, and made the necessary material acquisitions. All this was done prior to July 1, 1971, the date when decriminalization went into effect.

The individuals affiliated with this policy subsystem also established close contact with activists throughout the country. For example, Doris Bradley, Director of Washington, D.C.'s Detoxification Center, reported to the citizen's task force on the District's development of a receiving center. Peter Hutt (the legal architect of the Easter decision) visited Minneapolis and discussed the Fearon case with Philip Hansen, then Chairman of the Minnesota Council on Alcohol Problems.

Largely because traditional alcohol reform groups, public health professionals, and judicial personnel dominated the movement for decriminalization in Minneapolis, the following three goals emerged from the legislation: (1) to end the authority of local courts over the problem; (2) to improve emergency services for the public inebriate; and (3) to increase the opportunities for rehabilitating public inebriates. Indeed, the public health concern was further emphasized when the Department of Mental Health, Mental Retardation, a broad-based agency dominated by public health professionals, was chosen to implement the mandates of decriminalization.

While early efforts to divest the criminal justice system of the public inebriate problem focused on the most destitute of public drunks, the final legislative package defined a much broader constituency for public attention: ". . . any inebriate person unable to manage himself or his affairs or unable to function mentally or physically because of his dependence on alcohol." Those formulating the legislation failed to recognize the potential conflict when they assumed that all types of inebriates are potentially viable clients for both emergency care and rehabilitation efforts.

8. The many goals in decriminalization are often not clearly and fully designated in the resulting legal mandate. These goals often develop and are acted upon without consideration of their potential conflict with one another.

The divergent objectives of the individuals and groups pressing for decriminalization are embodied in the resulting legal policy statement. However, these objectives are often extremely general and ill-defined, and the expectations of the reformers about achieving them are highly exaggerated. Furthermore, there seldom was any discussion of possible conflicts in these policy

goals. While the topic of goal conflict will be dealt with in greater depth elsewhere, some aspects of the problem should be mentioned at this point.

Perhaps the most obvious goal conflict that emerges from decriminalization is between rehabilitation and most of the other policy objectives. For example, the goal of providing emergency services to those in greatest need usually focuses on those who cannot secure assistance elsewhere--skid row, homeless, chronic alcoholics. But these are the clients least likely to produce meaningful rehabilitative success. In St. Louis, this tension between the desire to rehabilitate and the "skid row" character of the typical police case appears to have produced a greater emphasis on the voluntary admission who is believed more amenable to rehabilitative efforts. If street cleaning, i.e., nuisance abatement, is defined as a high priority objective, the chronic case becomes the most frequent admission to the treatment program. And again, there is far less chance for rehabilitative success.

Indeed, the tension between providing treatment services to all public inebriates (indiscriminate target group) and serving a particular segment of the inebriate population (discriminate target group) was a recurring theme in all jurisdictions. While the legal mandate in each was indiscriminate in defining the population to be served, those charged with implementing the legal policy often concentrated on a particular segment of the inebriate population. At least at the outset, therapeutic reformers generally perceive their target group as the homeless persons in greatest need of assistance. Later, as appears to be the case in St. Louis, this may be altered to a more middle class bias if rehabilitation success is perceived as critical to a treatment facility's stature in the public health community. Conversely, the police generally perceive the detoxification center as a place for the street inebriate, not for other kinds of public inebriates.

There is also a certain tension in the objective of saving municipal resources by removing the drunkenness problem from the courts and jails. The courts and prisons still require resources to handle other criminal matters. And the police still are charged with removing the inebriate from the street. In addition, if a meaningful full-treatment system is established, substantial resources will be required. With decriminalization, cost savings in the criminal justice sector may merely be reallocated to the civil justice sector.

There is also some evidence that the objective of providing short-term emergency care for inebriates may conflict with the objective of providing for the overall physical health of the skid row inebriate. A number of therapeutically oriented persons interviewed suggested that the inebriate may be worse off physically under a detoxification program than under a criminal mode of processing. Recidivism was found to be higher in detoxification centers than under the criminal justice system in all three case-study jurisdictions. Inebriates in the centers are often back on the street after 2 or 3 days--hardly time for adequate detoxification, much less physical restoration. (St. Louis does provide for a 7-day stay.) Under the criminal justice system, the skid row chronic alcoholic was the most likely candidate for sentencing to the workhouse or prison farm--an extended period off the street with adequate food and other medical services at least theoretically available. A prolonged period of abstinence from alcohol was insured.

Of course, this was a form of forced confinement and was unlikely to rehabilitate chronic inebriates. Compulsory civil commitment might produce the same benefits but the question is whether we are willing to accept the costs, particularly the loss of human freedom, of forced confinement for alcoholic addiction.

This is not intended to denigrate decriminalization, but it does suggest that conflicts among policy objectives may produce consequences that will thwart the high expectations of reformers. Managed decriminalization is not a panacea for the problem of public drunkenness but only an initial stage in the process of confronting the problem. Exaggerated claims and conflicting objectives built into policy reform can lay the groundwork for frustration, cynicism, and despair in the policy implementation stage.

9. Reform interests seldom give serious consideration to the potential impact of decriminalization on the police and their order-maintenance functions or the need for ameliorative administrative adjustments to promote the quality pickup and delivery of the potential client. It is critically important to the succe..s of a treatment-oriented system that the police department be involved in the initiation of decriminalization and be continually involved in its subsequent implementation.

It was somewhat amazing to members of the research team how little attention was paid by reformers to the impact of the policy change on police, the enforcement agency. There was a facile assumption that the police department and the street patrol officer, regardless of their possible opposition, would do what was necessary to carry out the legal mandate and would somehow reconcile the often conflicting objectives to make the program a success. But if the reform is to be viable, it is essential that the change be accompanied by police administrative regulations notifying the street officers of the change, indicating its purposes in realistic terms, and specifying procedures for implementation of the new policy. Support for the project must be communicated to the patrol officers, both formally and informally. Training must be provided. Failure of the police command to act positively is generally perceived by the line officers as being a negative command. When coupled with the disincentives produced by decriminalization, discussed later, the basis is laid for a negative response to the new policy. Policy implementation also involves an ongoing commitment. If police are retained as the enforcement agent and the police support wanes, achievement of policy objectives will wane.

In spite of these seemingly common-sense propositions, policy reformers frequently proceed with little or no police department involvement. While revised police regulations followed legal change in the District of Columbia, little effort was made to involve the police department in initiating the reform policy--change occurred without any real information flow from the police and without their active participation. Many reformers simply assumed the department would oppose the new policy.

Similarly, the Minneapolis Police Department was only marginally involved in deliberations on decriminalization. The continuing problems that would confront the officer in the street were not given serious consideration. Guidelines issued by the police following statutory decriminalization placed heavy emphasis on the permissive character of the act, on the discretionary character of the mode of disposition (if any) of the inebriate and on the avoidance of

officer liability for good-faith actions taken under the act. Criteria for defining the action to be taken suggest a bias toward handling the transient and destitute inebriate. While there was a training program during the first 2 years of decriminalization, this was eliminated in 1973. No formal or informal ties were established between the police command and the therapeutic staff operating the Alcoholism Receiving Center (ARC).

Conversely, in St. Louis the police department was intimately involved in establishing the alcoholism diversion program. Even before decriminalization, police officials and therapeutic interests worked closely in confronting public intoxication problems. There was general agreement on the target population to be served and the goals (although vague and inconsistent) to be achieved.

In 1965, the St. Louis Police Department became the designated grantee agency for Federal funds to establish the Detoxification and Diagnostic Evaluation Center. A gradual phase-in of the project was planned, beginning with the downtown police district having the greatest incidence of public intoxication arrests and then expanding to the other police districts. The Detoxification Center was located in the highest drunkenness area and an effort was made to make the Center accessible to the officers. Detailed procedures for handling inebriates, emphasizing speed and ease of processing, were issued and disseminated throughout the department. An extensive training program, both at the Academy for recruits and in-service for command and street patrol officers, was available. Financial support was provided by the Department for the project. It is generally agreed that the St. Louis diversion program was launched in a spirit of cooperation and, at least for a time, improved emergency services for the homeless person.

Unfortunately, the era of cooperation did not last. As financial difficulties grew, the Center was moved to a location far removed from the problem area. Travel and processing time increased. Police reported the Center frequently had no beds available. Police training programs on public intoxication were virtually eliminated. While some financial support is still grudgingly provided, command involvement with the operations of the program has diminished, almost to being nonexistent. Communications within the SLPD regarding drunkenness problems are rare.

In Kansas City, the police department was closely involved in the development of the street diversion program. Further, this involvement has continued through permanent links between the Sober House treatment facility and the police department's Office of Planning and Evaluation. A similar arrangement exists between law enforcement agencies and the three-county treatment program in Polk-Mason and Yamhill Counties, Oregon.

10. Decriminalization results in the forced interaction of two sets of bureaucratic actors, i.e., law enforcement personnel and public health personnel. Tension between these actors is a constant reality in the operations of the detoxification program.

Police personnel are faced with problems of order maintenance and law enforcement on the street. The problems must be met with promptness and minimal expenditure of limited police resources. Therapeutic organizations often act in ways that may seem inconsistent with law enforcement interests. Once a person is detoxified and some impetus for long-term rehabilitation introduced, the

client is released. This brings the problem back to the street patrol. While it is an over simplification, the law enforcement approach tends to be societally oriented; the public health approach focuses more on the individual client. While the two patterns can perhaps be logically reconciled, the bureaucracies involved seldom make such an effort.

It is possible that differences in educational and social backgrounds may intensify the potential for tension and conflict. We did find a general lack of communication between police and public health personnel at both street and supervisory levels. Further, in all three of the case-study jurisdictions, we noted substantial hostility by the police officers we interviewed toward the detoxification center and its personnel.

In the District of Columbia, there appears to be no formal or informal communication across agencies at the supervisory level. Also, line officers often spoke disparagingly of the Detoxification Center and its operations. References to the speed at which the inebriate is returned to the street and the lack of "success" at the Center were common. Some officers wondered whether detoxification personnel wanted the police to pick up and deliver more street inebriates.

In St. Louis, where relations between the police command and the therapeutic interests were so promising at the outset, the same tensions have emerged. There is no regular communication flow between the bureaucracies. The department even attempted to cut back on its financial support for the Center, and it has been continued only grudgingly. At the line officer level, there are complaints of the Center's frequently being filled, its reluctance to take hard-core police cases, and its failure to "rehabilitate" the chronic offenders.

In Minneapolis, the integration of the detoxification facility with the larger public health bureaucracy of Hennepin County has resulted in a high priority being placed on channeling individuals into rehabilitation facilities. Detoxification personnel are often seeking a clientele different from that brought in by the police. Such a conflict places increased pressure on police officers to find other alternatives for processing public inebriates. This may be part of the explanation for the heavy use of the disorderly conduct offense by the Minneapolis police department following decriminalization.

In Boston, Massachusetts, conflict in work schedules between the police and public health personnel resulted in unavailable bed space for new detoxification admissions when most police pickups were made. Beds in detoxification became available and were filled during the day when public health officials discharged patients. Public health workers prefer the more desirable daytime hours. The detoxification center suffered its most severe staff shortages during the evening and at night. Police officers are on the street 24 hours a day and most public inebriate pickups occurred during the evening and at night.

The tension and conflict between the law enforcement and public health bureaucracies was not a major focus of this project. However, the degree to which tension and conflict recurred suggests the need for further attention to the problem. A sound working hypothesis is that tension and conflict between the designated delivery agent and the treatment bureaucracy impairs realization of policy objectives.

B. MODELS FOR STUDYING DECRIMINALIZATION POLICY

As indicated earlier in this chapter, three research models have been developed to provide a theoretical and methodological focus to this study. An impact model was designed to investigate the extent to which police street action in handling public intoxication cases was influenced by decriminalization. A discretion model was used to assess why police practices were altered as a result of decriminalization. A third model, labeled prescriptive analysis, provided a framework for studying what changes might be made to improve the intake and handling of public inebriates by public service bureaucracies.

1. Impact Model. Through a review of impact analysis literature in public law and of the writings on public drunkenness, we developed both a general and a specific framework for examining the "fit" between the formal law on the books and informal "law in action." This model was then used to analyze the impact of policy revisions on the treatment of public inebriates by police departments in selected cities.

We set out to test two basic hypotheses. First, we postulated that unless special administrative steps are taken at the time of decriminalization, there will be a statistically significant decline in the number of public inebriates formally handled by the public system. This effect could be described as the quantitative impact of decriminalization. Second, we expected that the decline in numbers would be accompanied by a change in the composition of the inebriates processed by the system. Significantly more "skid row" or homeless inebriates would be picked up than other types of public drunkenness. This is the qualitative impact of decriminalization cases after drunkenness.

In testing these hypotheses, we employed a policy-impact approach[11] which merges the common threads of impact analysis[12] and policy evaluation literature.[13] The general policy framework that emerged (see figure 1) requires an examination of relevant judicial and legislative policy statements to determine the specific goals given to the police under decriminalization. Our intent here is to assess the extent to which the police are aware of such policy directives, and in what manner the police response affects the designated clientele, public inebriates.

FIGURE 1.--General research framework: District of Columbia

Policy goals	Organizational reaction	Policy impact
(e.g., judicial decision or legislative action decriminalizing public drunkenness)	(Police Department Response)	(Intake of Public Inebriates)

From the general policy framework, a specific research framework was developed for each target jurisdiction. In the District of Columbia, for example, the specific framework (see figure 2) involved: (1) identifying legally

approved methods available to the police; (2) providing alternative explanations for a decline in the number of public inebriates picked up by the system; and (3) concluding with the policy impact, measured in terms of the number and types of public inebriates processed before and after the policy change.

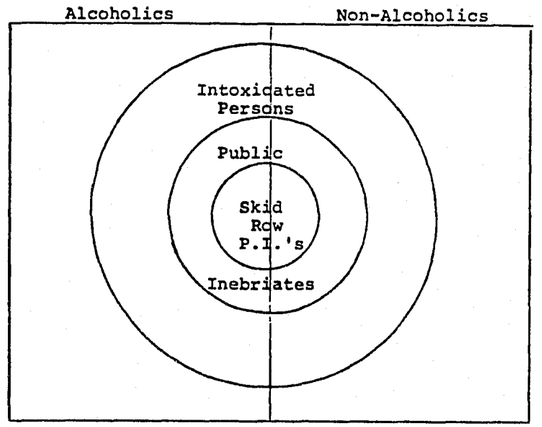
FIGURE 2.--Specific research framework: District of Columbia

Alternative approved dispositions	→ Control factors	→ Policy impact
Delivery to detox	Size of the problem	Numerically less approved dispositions of public inebriates
Self-admission to detox	Drinking population	Nonapproved (informal) dispositions of public inebriates
Use of public and private health facilities	Migration from the jurisdiction	
Home delivery	Recidivism rates--the "Revolving Door"	

In order to measure the quantitative impact of decriminalization, we generally employed interrupted time-series analysis, using drunkenness arrest rates before decriminalization and police delivery rates to detoxification centers afterward.[14] Specifically, we examined the intake practices in two decriminalized jurisdictions (Washington, D.C. and Minneapolis) before and after the policy change. We also traced intake practices in two control jurisdictions which did not decriminalize public drunkenness (Houston and San Francisco) over roughly the same time sequences to determine if there were any national trends in intake practices unrelated to decriminalization.[15] In our case studies of three experimental jurisdictions (Washington, D.C., Minneapolis, and St. Louis), consideration was given to other explanations that might account for observed differences unique to these cities so that variations in pickup rates not attributable to the policy change would be discovered.[16]

To assess the qualitative impact of decriminalization in the three target cities, we first had to define the population under study. The term "alcoholic" is often used to describe public inebriates.[17] A close look at most studies, however, shows that researchers are actually referring to the fact that excessive drinking is a problem common to most public inebriates.[18] Not all intoxicated persons are alcoholics, nor is the term "alcoholic" coextensive with public inebriates as a class.[19] Then, too, not all intoxicated persons are public inebriates: they may do their drinking at home or in other private places.[20] Some public inebriates are "skid row" types, but not all.[21] The classification may be depicted as follows:

FIGURE 3.--Classification of excessive drinking



Skid row public inebriates have at least three distinguishing characteristics:[22]

- One of the most significant is "institutional dependency"--wholesale reliance on the refuge provided by jails, service agencies, and, more recently, public health facilities.[23] A key indicator of this characteristic is lack of a permanent residence or "homelessness."[24]

- A second is low socio-economic status.[25] Indicators of this characteristic include educational impoverishment, lack of primary job skills, underemployment, and poor quality of physical appearance and dress.

- A third is "undersocialization"--lack of or broken family relationships and an aversion for organized groups.[26]

Background data were gathered on public inebriates arrested prior to decriminalization and on those admitted to detoxification centers after the policy change. Using these characteristics of homeless persons or skid row inebriates, we expected that any differences in the qualitative character of the two populations in the three jurisdictions would be revealed.

2. Discretion Model. While several scholars identify factors which partially explain the use of the criminal process by police officers,[27] very few attempt to identify variables that may explain police discretion in specific policy decisions made by patrolmen on a routine basis.[28] There are even fewer

studies which assess police discretion in the intake of noncriminals.[29] Despite limited source material, our review of police discretion literature enabled us to prepare a list of variables which are critical in a patrolman's decision to initiate the intake process. The investigators reviewed library materials on police discretion as well as sources collected by the Law Enforcement Assistance Administration's library on the subject. The literature on public inebriates was also reviewed to develop a list of explanatory factors for police intake practices in cities that use a criminal approach and in cities that use a public health-therapeutic approach. The literature was gathered and analyzed through a search of library sources as well as through sources compiled by the National Clearinghouse for Alcoholic Information (NIAAA).

In this discretion model, police officers are the units of analysis. The objective is to explain the manner in which they exercise their discretion: (1) in deciding whether or not to intervene when encountering a public inebriate, and (2) in deciding the form of the disposition. Essentially the dependent variable is two-fold--acceptable behavior as prescribed by law and unacceptable behavior, which is not prescribed by law (e.g., to arrest on other charges when not appropriate).

Evaluation of the literature suggests the following independent variables:

a. Organization. This variable focuses on the efforts of the police department's chief administrators to influence patrolmen's decisions to arrest or pick up specific types of individuals. These efforts include the department's training programs, the general orders, the chief's letters, statements of top officials, the opinions of line supervisors, the allocation of resources, and the standards established for promotions.[30]

b. Police role. This variable involves identifying the forces that collectively influence the police role and evaluating this "role" as a factor affecting patrolmen's daily behavior. Involved here are factors such as an officer's attitudes toward danger, service, career goals, crime prevention, and law enforcement.[31]

c. Strategic environment. This variable refers to the police officer's attitudes toward significant groups and processes that may predispose him to certain responses toward public inebriates. It includes his attitudes toward the inebriate as well as his attitudes toward the institutions and personnel with which he must deal, e.g., courts, prosecutors, and detoxification centers. It also involves his perception of the seriousness of alcoholism and public intoxication as social problems.[32]

d. Strategic interaction. This variable refers to the officer's perceptions of what others desire in removing public inebriates from the streets and how they are assessing his work. These "others" include the business community, the general public, local community residents, detoxification personnel, political leaders, liquor store owners, and the inebriates themselves.[33]

e. Peer relationship. This variable refers to the effect that fellow officers have on each other's discretionary habits.[34]

f. Personal background. The last variable reflects the impact of age, education, sex, and race as partial determinants in patrolmen's decisions to pick up public inebriates.[35]

Consideration was also given to the myriad of other factors that affect every individual encounter between a police officer and a public inebriate. We have termed this the "situation-specific" variable. It should be stressed that our objective is not to explain individual police behavior in a particular situation. Instead, our purpose is to indicate the factors that influence police officers to intervene or not intervene and to choose one form of disposition over another. Nevertheless, an effort was made to provide some assessment of the influence these situation-specific variables can have on police behavior.[36]

While we emphasized the police discretion model, we also attempted to assess the significance of environmental factors that affect the police officers' behavior independent of his discretion. Certain factors may operate either to limit or even to preclude the exercise of an officer's discretion, e.g., no transport vehicle available to take a person to the treatment center. Our discretion model operates only within the constraints that environmental variables place on the ability to exercise discretion (e.g., if there are few public inebriates in a jurisdiction, there will be a lower rate of pickups). Hence, a criterion in selecting control jurisdictions (i.e., jurisdictions that have never decriminalized) was to keep these environmental factors roughly constant.

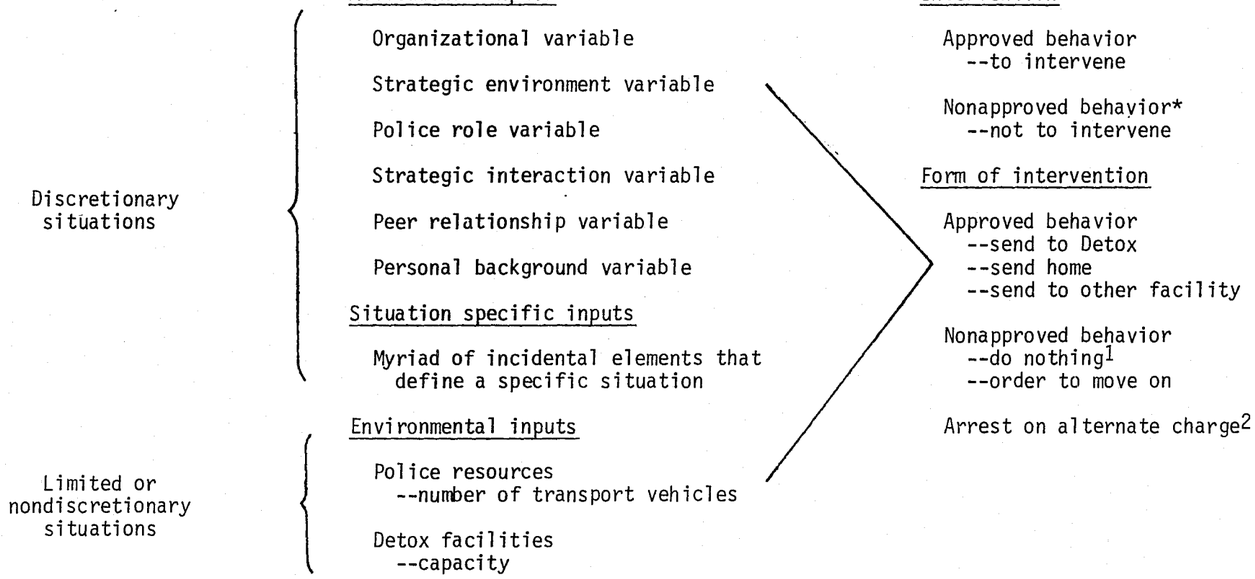
The relation of the independent variables to the various forms of the dependent variable is indicated in figure 4.

Preliminary investigation suggested the need to give special attention to intrajurisdictional pickup patterns. It became clear that within either a criminal or decriminalized jurisdiction, forms of intervention and disposition differ markedly for the skid row inebriate and the non-skid-row inebriate.[37] Differences in the exercise of police discretion in these two types of cases might be explained by considering attitudinal differences from police district to police district within a jurisdiction. Further, it became obvious that significant differences in organization, role, etc. can exist because of the peculiarities of the district (e.g., residential vs downtown business districts) and that these factors can affect the manner of policing.

Our approach is to compare incentives and disincentives operating through this police discretion model in criminal and therapeutic jurisdictions. Controlling for environmental factors, pickup rates will vary in response to changes in the incentive-disincentive structures. The amount of variation will depend on the nature and intensity of the incentives-disincentives introduced in the system operating through one or more of the independent variables in our model.

Examples of changes in the incentive-disincentive structures show the usefulness of this approach. In Richmond, Virginia, in 1972, the number of arrests for public inebriates declined nearly 50 percent from the preceding year. This fall-off was preceded by a change in police department orders, resulting from pressure generated by a lawsuit, which required police officers to appear in court. In Richmond, a court appearance typically involves a substantial amount of police time, and the rate of overtime compensation is deemed inadequate by police officers.

FIGURE 4.--Discretion model on police pickup behavior



1. This may vary for some jurisdictions. Nonintervention or nonaction may be an approved mode of response.

2. The legitimacy of such an arrest will be dependent on the presence of the elements required for the charged offense.

In St. Louis, Missouri, in 1963, the number of arrests of public inebriates more than doubled from the preceding year. This resulted from a department directive which ordered an increased arrest rate in connection with the introduction of required medical service. The directive also reduced demands on arresting officers to complete paperwork and provided for designated police cars to transport the inebriate. After an initial intensive effort, there was a return to a policy that deemphasized pickups. Arrest rates fell off sharply within the next 2 years and then continued to decline following introduction of a therapeutic alternative. Unlike the experience in St. Louis, the change in the incentive-disincentive structure in Richmond continued and was not accompanied by incentives to increase pickups. The consequence was a continuation of pickups at the substantially reduced levels.

The nature and extent of police servicing of public inebriates is determined by the incentive-disincentive structure operating through our model. One illustration was the District of Columbia's initial decision to operate only one detoxification facility and to locate this facility in the area of the highest skid row public inebriate population. This provided both an incentive for police officers to pick up skid row public inebriates in the vicinity and a disincentive for police officers on beats substantial distances away. Police officials do not approve of patrol officers tying up vehicles for long periods of time to transport public inebriates.

Given this approach, studying criminal jurisdictions (1) serves as a control for our therapeutic jurisdictions and (2) illustrates differences in incentive-disincentive structures even within criminal law jurisdictions. Therapeutic jurisdictions are significant, not because they are unique, but because they are an example of a major change in the incentive-disincentive structure, a change which may require positive efforts to offset the disincentives to pick up public inebriates. Our approach does not suggest what the legal goals should be. It does tell us that if a jurisdiction like the District of Columbia wants to service the entire public inebriate population, both skid row and non-skid row, this goal will not be achieved without efforts to counter disincentives produced by the change in the law. If the legal goal in the District of Columbia is only to provide emergency service to skid row public inebriates, then the present system of incentive-disincentives may be adequate, although even then some changes may be appropriate. It can be seen that the incentive-disincentive orientation of our discretion model is also critical to the prescriptive phase of our study.

The above illustrations suggest the wide variety of sources of incentives and disincentives which is reflected in the growing literature on organization theory.[38] Among the widely recognized sources of incentives and disincentives are: economic incentives, information incentives, communication incentives, authority incentives, and power incentives.[39]

a. Economic incentives. In classic management theory, economic rewards are seen as the most important way to motivate individuals.[40] However, the advent of the human relations movement, the discovery of the importance of informal group norms, and advances in behavior science, particularly in information theory, have made us realize that economic gain is often not the most important incentive. Individuals may even accept lower economic rewards as long as their security and independence are protected. Unionization, civil service systems, and heightened professionalization make it more difficult for an organization

to use economic incentives to promote compliance with organizational goals. In interviews with police officers we attempted to identify whether there are any economic advantages or disadvantages in picking up or not picking up public inebriates, such as overtime pay or promotion.

b. Information incentives. Policymakers (e.g., superior police officials) can and often do control the amount and type of information to get subordinates to accept specific decisions.[41] Persons frequently will accept decisions if they are unaware that other alternatives are available, or if the cost of finding such alternatives is too high. It may well be that control or manipulation of information about various alternative courses of action, what they are supposed to achieve, and how achievement is to be measured, is a much more effective way to produce desired role behavior than manipulation of economic rewards or the use of authority. The use of information is also important because police behavior is influenced by the degree to which patrol officers believe that goals are being achieved (regardless of the "objectively true" situation). Perceptions about whether given goals are being achieved are related both to the kind of information made available as well as the attitudes and theories officers have toward the approach used.

In our interviews, we sought to ascertain whether any records are maintained by police officials on the extent of pickups and how these records are used in evaluating officers' performance. We also examined how the department's policy is communicated to patrol officers. We inquired about the contacts or communications between public health personnel (e.g., Detox personnel) and the department, and probed how communications take place.

An interesting example illustrates the importance of information incentives. In St. Louis, we were informed that an influential citizen, Henriette Johnson, a board member of the Alcoholic Task Force, was concerned why the black percentage at Detox was only about 18 percent when the city is 40 percent black and there is a substantial number of black public inebriates. She went to one of the police districts and "raised hell." Officers were told to pick up blacks and within a few months the proportion of black patients at Detox increased from 18 percent to 33 percent. We were informed that the main problem was a lack of information on the availability of Detox and the importance of picking up black public inebriates. This example also shows the effect of feedback on goal achievement, discussed under communication incentives.

c. Communication incentives. An organization must be aware that it is not achieving its goals before it will try new procedures.[42] Policymakers will not know an organization is failing if feedback is not working. When feedback about organizational achievement is weak, groups in the organization become isolated from and unconcerned about programs of other groups in the system. Individuals in one part of an organization may be unaware of what other members of the organization are doing. Important decisions may not become known until well after they are made. When communications in an organization decline to a certain point, the organization may become afflicted with a pathology called "displacement of goals." Rules of behavior become ritualistically important; they become an end themselves rather than a means. They displace goals as the primary factor in motivating organizational behavior. Change under these conditions usually can occur only after a crisis. The study of how crises produce change is an important aspect of policy impact analysis.

d. Authority incentives. When use of information techniques fails to achieve goals, police officials may turn to the use of authority.[43] There are two sides to organizational authority. It can involve the sanctions of force, or it may be "benevolent." Sanctions of force include both negative and positive sanctions such as threats, suspension, dismissal, praise, promotion, and so on. The use of coercion has diminished in modern organizations. Unionization, civil service rules, and professionalism all tend to inhibit the use of coercion. Superiors have turned to other means of persuasion or control. Programming of decisions is one method that is often used. When a decision can be programmed, policymakers simply designate rules that are to be followed under different contingencies. The only choice available to subordinates is the determination of which rule to follow in a given case. Because they have the "illusion" of discretion, they may accept authority without the use of sanctions. If a large number of decisions can be programmed, an organization can appear to be decentralized when in fact it is not. There are limits to how many decisions can be programmed. Predictable and recurring situations are required. Through interviews and examination of departmental orders and procedures we sought to inquire whether there are differences among jurisdictions in the degree of programming of alternative forms and disposition of pickups.

e. Power incentives. It is essential to understand the degree of consensus that exists in an organization about the goals to be achieved (e.g., in a police organization with regard to the pick up of public inebriates) and what indicators should be used to measure achievement of goals. Power in organizations is related to the degree of uncertainty faced by various groups in an organization.[44] Groups that deal with more uncertain environments are likely to have more power. It seems clear that people have power over other people insofar as the latter's behavior is narrowly limited by rules whereas their own behavior is not. A new program or procedure will not be given a fair trial in an agency if it does not fit into the power relationships of groups in the organizations. While certainty is a source of power to some groups, it is also a source of distress to those who are not responsible for decisions involving uncertainty. Many workers prefer to adhere to rules that are predictable because it provides them with protection against arbitrary behavior on the part of superiors. There will be pressure in any organization to reduce uncertainty and make most situations fairly predictable, even if this means that information about goal achievement must be distorted. The introduction of a new procedure in an organization has an impact upon power relations because it introduces new uncertainties into the organization. We attempted to determine the degree of certainty or uncertainty about pickup goals and procedures by officers at various levels and the degree of acceptance of these goals.

We believe that the emphasis on incentive-disincentive structures strengthens the rationale and further refines the discretion model. Its tie-in with developments in organization theory and policy impact analysis provides referents for the organizational, strategic interaction, and peer relationship variables. It is also helpful in tracing the linkages between environmental and police discretion factors. It has provided a perspective for evaluating our research tools and in suggesting additional questions for interview schedules. Finally, it provided a valuable heuristic device for the prescriptive phase of our study.

One of the primary tools for testing the model was a questionnaire administered in all target jurisdictions. (See appendix A.) The instrument was

developed, pretested, and administered. Using police officer students representing both criminal and decriminalized jurisdictions from the American University's Center for the Administration of Justice, a number of seminars were conducted regarding police practices. Various drafts of the questionnaire were administered to the officers and then discussed. A pretest was then conducted in the Sixth Police District of Washington, D.C., and in the city of Alexandria, Virginia, a criminal jurisdiction. The instrument was administered in the target jurisdictions, following instructions and a request for cooperation, to all officers in selected districts or precincts in each jurisdiction, either at roll call or during their tour of duty.

While the questionnaire varied to reflect peculiarities of the jurisdiction, there was a common framework. First, we obtained basic descriptive data on the personal background of the officers; second, we asked officers to identify how they intervene when observing public inebriates in the streets (dependent variables); and third, they were asked to respond to a series of Likert-type questions which measured the importance of discretionary factors found in the model--organization, strategic environment, peer, police role, and strategic interaction, and general questions bearing on the officer's working environment. In addition to serving as independent variables for purposes of analysis, the data on the officers' personal background questions enabled us to test the representativeness of our sample, vis-a-vis the entire department. The specific indicators for each of the other independent variables are indicated in appendix B.

The instrument with variations necessitated by jurisdictional peculiarities was then administered in five target jurisdictions. As indicated in the impact section, the District of Columbia, Minneapolis, and St. Louis provided suitable therapeutic jurisdictions for case studies. The attitudes of officers in each of these jurisdictions toward the task of removing public inebriates from the streets and the relation of those attitudes to reported behavior is analyzed in chapter 3.

We also hypothesize that because decriminalization introduces disincentives to approved actions, significant differences would also be found in attitudes between officers in decriminalized cities and those in criminalized cities regarding the task of picking up and delivering public inebriates to designated facilities and that this will partly explain the quantitative and qualitative impact of decriminalization. It should be noted, as indicated above, that it is obviously an oversimplification to speak of the pickup practices in various jurisdictions as being purely "criminal" or "decriminalized." Rather, police pickup practices in different cities may be plotted along a continuum ranging from a "pure" criminal jurisdiction to a "pure" decriminalized jurisdiction. Nevertheless, the questionnaire results in the three "decriminalized" cities were compared with questionnaire responses of police officers in the "criminal" jurisdictions of Houston, Texas and Richmond, Virginia.

The questionnaire to police officers was supplemented by interviews administered to a selected sample of police officers. (See appendix C.) The objectives of this phase of the study were (1) to provide an opportunity to probe the effect of situation-specific factors influencing police behavior; (2) to provide a basis for interpretation of the statistical results obtained through the questionnaire; (3) to provide qualitative data, admittedly often descriptive or anecdotal in form, that lend richness to the statistical results; and (4) to

provide information regarding the factors influencing the exercise of police discretion in picking up public inebriates as a partial basis for formation of the prescriptive model.

In both decriminalized and criminal jurisdictions, command officers--sergeants and above--were also interviewed using a separate interview form, adjusted for the particular jurisdiction involved. (See appendix D.) This instrument was designed to probe the means through which the police department seeks to translate policy into operative police behavior. It is especially relevant to the organizational dimension of our discretion model although it also probed other dimensions of the model from the police command perspective. The interview probes factors such as evaluation procedures and recordkeeping, economic incentives and disincentives, communication flows, the official's perceptions of the patrolman's proper role, pressures that affect the level of pickup of public inebriates, and official perceptions of the work of the detoxification center and alcoholic rehabilitation centers.

Time and resource pressures prevented interviews of inebriates in each city. However, approximately 30 interviews were conducted at the Detoxification Center with persons picked up for public intoxication in the District of Columbia. (See appendix E.) Informal interviews were also conducted in other cities. The objective of this phase of the project was to gain some insight into the character of the inebriates serviced, their view of police pickup practices, their assessment of the public health facilities serving them, and their perception of the consequence for them of decriminalization. The information derived from such interviews proved to be useful only in a qualitative sense.

We also conducted open-ended interviews with court and prosecutorial personnel in criminal jurisdictions and public health (e.g., detox and rehabilitative) personnel in therapeutic jurisdictions. Our objective in this phase of the project was (1) to secure information useful to interpret statistical data obtained from records, questionnaires, and other interviews, e.g., the changing pattern of public inebriate pickups, the character of the inebriate serviced, the factors affecting the police performance of this task; (2) to get different perspectives on police implementation of policy regarding the pickup of public inebriates; (3) to probe possible policy revisions applicable to the prescriptive phase of our study.

3. Prescriptive Model. In chapter 4, the study focuses on policy alternatives for handling pickup and delivery of public inebriates. Based on findings from the impact and discretion phases of the study, a "prescriptive model" is presented which, we believe, will facilitate examination of such alternatives.

The model is premised on four principal elements:[45] (1) the goals that a jurisdiction may wish to achieve; (2) the conflict and compatibility of these goals; (3) delivery mechanisms that are available to achieve these goals; and (4) techniques of administration whereby the delivery mechanisms are utilized to achieve the goals. The goals, then, are perceived as the dependent variable and the delivery mechanisms as the independent variable. Techniques of administration may be perceived as the intervening variables. The objective has been to analyze the relationships among these elements.

One of the items that emerges most clearly from an examination of the criminal justice and therapeutic approaches for handling the problem of public

drunkenness is the diversity of goals that the policy planners seek to achieve. Among objectives of criminal control jurisdictions are clearing the streets (abating a nuisance), preventing crime either by or against the inebriate, and avoiding accidents or the death of a helpless person. In judicial decisions, decriminalization legislation, policy directives, etc., in reform jurisdictions, one finds differing emphases on conserving criminal justice resources, long-term rehabilitation of the inebriate, provision of emergency services to the inebriate, reform of the criminal justice system by removing criminal sanctions from what is deemed an illness, humanizing the handling of public inebriates, and a myriad of other considerations. Not only are there system-wide policy objectives but individuals and institutions that are charged with achieving these public policy goals have their own interests (self-interest and organizational goals).[46]

The public policy goals may often be in conflict with one another and self-interest goals and goals of police organizations may not be in harmony with desired public policy objectives.[47] On the other hand, some of the goals may be complementary. Appreciation of this potential conflict and compatibility is essential if a workable system is to be developed.

One example of a conflict between goals is clearing the streets and curing the inebriate (i.e., rehabilitation). If the policy objective is defined as clearing the streets (abating a nuisance), the implication is that all inebriates be picked up or at least be removed from public view. But if the objective is to clear the streets in the sense of delivering the inebriates to the legally appointed location, then the system will deliver individuals who are not capable of rehabilitation. The very limited facilities will be flooded and there will be insufficient room for the potentially curable. But that conflict may be avoided. The police officer could clear the streets by channeling the skid row types into alleys and to other out-of-the-way places, and channel other drunks who are perceived as more "curable" into the rehabilitation system. There is no conflict if the pickup agent is willing to violate the letter of the law in channeling the inebriates. It will be shown that systems adjust to achieve both goals. But the way they adjust is, in some instances, a violation of the letter and intent of the law.

The goals of the bureaucracy charged with administering a public policy may also come into conflict with the broader social objectives. For example, one of the primary self-interest goals of any police department is the maintenance of a solid rate of criminal arrests. However, the mandate to remove public inebriates from the streets, to the extent that it draws time and other resources from crime-fighting, can seem inconsistent. Similarly, for the police officer who sees his role as law-enforcer or "crime-fighter," the enforcement of a public health policy, where he is constantly forced into contact with medical rather than law enforcement personnel, can produce a role or goal conflict.

There is also compatibility of goals. Providing emergency services and saving criminal justice resources are probably basically compatible. A minimal commitment of police resources is involved in seeing to the needs of emergency cases. However, this does not mean that there are not more effective ways of handling emergency cases than using the police, or that more effective ways of using the police are not available. This possibility will be explored in chapter 4.

There can also be compatibility between self-interest and public organizational goals and broader public policy goals. For example, to the extent that removal of public inebriates is perceived as a means of nuisance abatement or avoidance of crimes either by or against the inebriate, there is potentially greater agreement between mandates to enforce the criminal law and to pick up and deliver public inebriates. Similarly, a police officer who perceives the task of removal in these terms or who has a greater "helping" role perception may experience greater personal goal compatibility.

The third element of the model deals with the independent variable, the delivery mechanisms. It seems useful to divide this element into two headings, police delivery mechanisms and other delivery mechanisms.

The former category would include the traditional model for police pickup of public inebriates, i.e., squads, scout cars, foot patrol, motorcycles and tricars, and vans. We would also include police variations on the traditional model, such as special squads for both pickup and delivery. In Chicago, for example, police use a "bum squad." In Houston, a wagon is used to patrol the inner city, primarily for picking up and delivering inebriates. Another example is the use of a special transport vehicle. In St. Louis in 1963, one of the factors that produced a large increase in pickup rates was the assignment of designated transport, at the call of patrolmen. It will be desirable, therefore, to distinguish between squads that pick up and deliver and the use of special transport vehicles.

Examples of other delivery mechanisms that will be explored in chapter 4 include medical teams for pickup and delivery, former inebriates to man emergency transports, combined teams such as medical-police or former inebriates and police, private agencies, and emergency squads such as fire and ambulance, and taxi voucher systems.

The fourth element in the prescriptive model emphasizes techniques of administration--how the various independent variables (delivery mechanisms) are utilized to achieve the dependent variable (goals). What kind of factors intervene between the independent variable and the dependent variable and how do they influence the effectiveness of the delivery mechanisms in the achievement of the various goals? The basic techniques of administration have been defined as incentives and disincentives in the discretion model.

The methodology involved both a literature review and site visits requiring record data gathering and interviewing. Our objective in the site visits was to select cities which, when added to those jurisdictions visited for the impact and discretion phases of the study, would provide a viable sampling of alternative delivery mechanisms and techniques of administration. During the visit, we sought to identify the policy objectives--the conflicts and compatibility between them and the success in realizing them.

The selection of cities for site visits during this phase of the study was a difficult one. Most research on treatment of public inebriates has been done on a statewide basis and does not contain the specific information needed about pickup and delivery programs in individual cities. We, therefore, decided on the following initial research approach which yielded our list of cities.

- State plans for all states were read with an eye toward identifying pickup and delivery programs that suited our prescriptive model.

- Letters were sent to the appropriate alcoholism agency of the state Department of Health requesting that a short questionnaire, identifying innovative programs within the state, be completed.

- Personal interviews were conducted in the District of Columbia and other cities with experts in the handling of public inebriates. Often these interviews yielded valuable information, particularly in regard to smaller cities, that we might otherwise not have found.

We also gained access to the results of several national studies conducted on a city-by-city basis. These studies have potentially valuable information on the intake process in those cities.

During the summer of 1976, visits were made to Erie, Pennsylvania; Kansas City, Missouri; Salem, Oregon; San Francisco, California; and San Jose, California. In each jurisdiction we interviewed the various key actors in the system, covering the elements in the model. It was admittedly a fairly crude procedure, and no attempt at quantitative analysis was made. For more sophisticated data, we have used the material gathered in various cities for analysis of the discretion and impact models. There was, in fact, a great deal of empirical data gathered in those cities that was relevant to information and communication flows, economic incentives, power and authority relationships, and environmental conditions influencing the pickup of inebriates. Basic data on the operation of the programs in the cities selected for this phase of the study were gathered.

SUMMARY

This report, then, focuses on the impact of decriminalization on the pickup and delivery of public inebriates to designated places by formal means approved by the "law on the books." The impact is then examined in terms of the exercise of police discretion, and policy alternatives and pickup mechanisms available to reconcile identified public goals and actual street practices. For each of these three phases of study, a model has been formulated and a methodology selected. This study presents the major findings for all three phases of the research.

In analyzing the impact, our objective is to test the hypothesis that if no special ameliorative action is introduced, decriminalization produces a significant quantitative decline in the number of public inebriates formally processed by legally approved means. We anticipated that decriminalization would also have a qualitative impact, with the population of inebriates formally processed by the public system increasingly identifiable as emergency case "homeless men" or skid row inebriates. The study includes both an interjurisdictional component, comparing the experiences of criminal and decriminalized jurisdictions, and an intrajurisdictional component, focusing on the experience of three cities that adopted the therapeutic alternative for handling public inebriates. We have employed a time-series methodology that permits assessment of quantitative changes in pickup and delivery rates over time. The use of the case study permits control for alternative hypotheses to explain quantitative changes in pickup and delivery rates and the disposition of those public inebriates not

formally processed by the system. Analysis of the characteristics of those handled by the formal system over time permits some assessment of the qualitative impact of changing legal policy toward public drunkenness.

The discretion model is designed to offer an explanation for anticipated changes in police behavior. Premised on the link between attitude and behavior, it was hypothesized that the impact of decriminalization can be explained in terms of the attitudinal disposition of the pickup agent, the police officer. The adoption of a therapeutic model for handling public inebriates introduces a mass of disincentives to intervention and formal approved processing by the officer. Incentives and disincentives to action are perceived as operating through a discretion model incorporation organizational, role, strategic environment, strategic interaction, peer relationship, and personal background variables. The attitudes of the officer and the environmental context in which they operate and their relation to police behavior are probed, using questionnaires and interviews.

Again, the analysis proceeds on both an inter- and an intrajurisdictional basis. Attitudes of officers in jurisdictions retaining the criminal model are compared with their counterparts in decriminalized or therapeutic jurisdictions. The attitudes and behavior of officers in each of three target therapeutic jurisdictions (D.C., St. Louis, and Minneapolis) are also examined by comparing them with other therapeutic cities and with the criminal target cities (Houston and Richmond).

Finally, in the prescriptive phase of the report, we examine the policy goals to be achieved in the area of public drunkenness control, the conflict among the goals, the delivery mechanisms designed to realize the policy objectives, and various techniques of administration. Microchanges, involving the manner of utilizing limited police resources, as well as macrochanges, involving alternative pickup and delivery mechanisms, are examined.

NOTES--CHAPTER 1

1. On the increasing interest in decriminalization of victimless crimes, see N. Kittrie, The Right to be Different (1971); N. Morris and G. Hawkins, The Honest Politician's Guide to Crime Control (1969); H. Packer, The Limits of the Criminal Sanction (1968) (see especially pt. 3); E. Schur, Crimes Without Victims (1965); E. Schur and H. Bedau, Victimless Crimes: The Sides of a Controversy (1974); Kadish, The Crisis of Over-Criminalization, 374 Annals 157 (1967). D. Aaronson, B. Hoff, P. Jaszi, and N. Kittrie, The New Justice: Alternatives to Conventional Criminal Adjudication (1977).

2. In the mid-1960's, three prestigious commissions (the United States' and District of Columbia's Crime Commissions and the cooperative Commission on the Study of Alcoholism) rejected the criminal approach to public drunkenness and recommended the substitution of a public health approach. In 1969, the American Bar Association and the American Medical Association collaborated on model legislation for divesting public intoxication of its criminal status. In 1971, the National Conference of Commissioners on Uniform State Laws drafted model legislation for decriminalization--the Uniform Alcoholism and Intoxication Treatment Act. In Washington, D.C., the Washington Area Council on Alcoholism and Drug Abuse worked toward decriminalization throughout the 1960's and in Minneapolis, Minnesota, a similar group worked as members of the Minnesota Council on Alcohol Problems.

   See generally F. Grad, A. Goldberg, B. Shapiro, Alcoholism and the Law (1971) (hereinafter cited as F. Grad, A. Goldberg, and B. Shapiro); R. Nimmer, Two Million Unnecessary Arrests (1971) (hereinafter cited as R. Nimmer); U.S. Dep't of HEW, The Legal Status of Intoxication and Alcoholism, in Alcohol and Health 85 (1971) (hereinafter cited as U.S. Dep't. of HEW); Hollister, Alcoholism and Public Drunkenness: The Emerging Retreat from Punishment, 16 Crime & Delinquency 238 (1970) (hereinafter cited as Hollister); Hutt, Perspectives on the Report of the President's Crime Commission--the Problem of Drunkenness, 43 Notre Dame Lawyer 857 (1968); Murtagh, Arrests for Public Intoxication, 35 Fordham L. Rev. 1 (1966); Tao, Criminal Drunkenness and the Law, 54 Iowa L. Rev. 1059 (1969).

3. The two groundbreaking cases were Easter v. District of Columbia, 361 F. 2d 50 (D.C. Cir. 1966) and Driver v. Hinnant, 356 F. 2d 761 (4th Cir. 1966), holding that a chronic alcoholic having lost control over his drinking behavior, could not be criminally punished since his act was not voluntary, a prerequisite for criminal sanctions. Hinnant placed emphasis on the constitutional prohibition against infliction of cruel and unusual punishment. U.S. Const. Amend. VIII. See generally sources cited in note 2 supra, Hutt, The Recent Court Decisions on Alcoholism: A Challenge to the North American Judges Association and Its Members, in President's Comm'n on Law

Enforcement and Adm'n of Justice, Task Force Report: Drunkenness (1967) (hereinafter cited as Drunkenness Report).

But in Powell v. Texas, 392 U.S. 514 (1968), the Supreme Court narrowly rejected the contention that criminal punishment of the chronic alcoholic violated the constitutional ban, placing heavy emphasis on the lack of any general consensus regarding the nature and treatment of alcoholism. The Court quoted from the President's Commission on Law Enforcement and Administration of Justice, stating,

> "(T)he 'strongest barrier' to the abandonment of the current use of the criminal process to deal with public intoxication 'is that there presently are no clear alternatives for taking into custody and treating those who are now arrested as drunks.'" 392 U.S. at 528 n. 22.

The Court added that "it would be tragic to return large numbers of helpless, sometimes dangerous and frequently unsanitary inebriates to the streets of our cities without even the opportunity to sober up adequately which a brief jail term provides." Id. at 528. It followed that "before we condemn the present practice across-the-board, perhaps we ought to be able to point to some clear promise of a better world for these unfortunate people. Unfortunately, no such promise has yet been forthcoming." Id. at 530.

In fact, the Justices divided 4-4, with Justice White concurring in the holding dismissing Powell's appeal, but basing his decision on the lack of evidence that Powell could not avoid being in public. Much of his reasoning, however, supports the principles formulated by the dissent. A 1970 Senate Report stated:

> "(F)ive of the nine justices agreed that alcoholism is a disease, that the alcoholic drinks involuntarily as a result of his illness, and that an alcoholic who was either homeless or who could not confine his drunkenness to a private place for some other reason could not be convicted for his public intoxication. Powell's conviction was upheld by a 5-to-4 vote, however, because the record failed to show that he was homeless or otherwise unable to avoid places when intoxicated."

S. Rep. No. 1069, 91st Cong. 2d Sess. 3 (1970). See U.S. Dep't. of HEW, supra note 2.

4. By the end of April 1975, some 28 states had enacted the Uniform Alcoholism and Intoxication Treatment Act (1971) or essentially similar legislation. Many others have diversionary strategies even though criminal statutes remain in effect. See generally U.S. Dep't of HEW, supra note 2, at 89-96; Goodman & Idell, The Public Inebriate and the Police in California: The Perils of Piece Meal Reform, 5 Golden Gate L. Rev. 259 (1975) (hereinafter cited as Goodman & Idell); Hollister, supra note 2. U.S. Department of Health, Education, and Welfare, Third Special Report to the U.S. Congress on Alcohol and Health 64 (1978).

On the interaction of the legislative and judicial actors in producing legal change responsive to social change, see C. T. Dienes, Law, Politics and Birth Control (1972); Dienes, Judges, Legislators, and Social Change, 13 Am. Behav. Sci. 511 (1970).

5. In St. Louis, for example, persons arrested for public drunkenness who "consent" are generally diverted to a Detoxification Center by the arresting officer. If the person "voluntarily" remains at the Center for seven days, the summons is not processed. See ch. 3, pp. infra. On the Manhattan Bowery Project, see Vera Institute, In Lieu of Arrest: The Manhattan Bowery Project Treatment for Homeless Alcoholics (1971).

   On diversion from the criminal justice system, see D. Aaronson, B. Hoff, P. Jaszi, N. Kittrie, and D. Saari, The New Justice: Alternatives to Conventional Criminal Adjudication (1977); D. Aaronson, N. Kittrie, and D. Saari, Alternatives to Conventional Criminal Adjudication: Guidebook for Planners and Practitioners (1977); R. Nimmer, Dimension: The Search for Alternative Forms of Prosecution (1974).

6. The Uniform Alcoholism and Intoxication Treatment Act (1971), in section 1, provides:

   > "It is the policy of this State that alcoholics and intoxicated persons may not be subjected to criminal prosecution because of their consumption of alcoholic beverages but rather should be afforded a continuum of treatment in order that they may lead normal lives as productive members of society."

   Similarly, John N. Mitchell, former Attorney General, stated in a speech,

   > "(A)lcoholism as such is not a legal problem--it is a health problem. More especially, simple drunkenness per se should not be handled as an offense subject to the process of justice. It should be handled as an illness, subject to medical treatment."

   Address by John N. Mitchell, "Alcoholism--To Heal, and Not to Punish" (Dec. 10, 1971), quoted in U.S. Dep't of HEW, supra note 2, at 119.

7. In this report, the terms "decriminalization" and "therapeutic" will be used interchangeably in referring to the categorization of a jurisdiction. In fact, many jurisdictions have converted to a therapeutic model for handling public drunkenness even while retaining the facade of the criminal model. In St. Louis, for example, public drunkenness remains a criminal offense but the public inebriate is typically handled through a civilian detoxification center. Thus, the jurisdiction is treated as employing a variant of the "decriminalized" or "therapeutic" model. Philadelphia, on the other hand, continues to arrest and jail public inebriates even though those arrested are released without ever appearing before a magistrate. It is classified as a criminal jurisdiction.

8. See Nicholas Kittrie, The Right to Be Different (1971); Norval Morris and Gordon Hawkins, The Honest Politician's Guide to Crime Control (1969); Edwin Schur and Hugo Bedaw, Victimless Crimes: Two Sides of a Controversy (1974).

9. See F. Grad, A. Goldberg, and B. Shapiro, Alcoholism and the Law (1971); U.S. Department of Health, Education, and Welfare, First Special Report to the U.S. Congress on Alcohol and Health (1971); R. Nimmer, Two Million Unnecessary Arrests (1971).

10. See D. Aaronson, B. Hoff, P. Jaszi, N. Kittrie, and D. Saari, The New Justice: Alternatives to Conventional Criminal Adjudication (1977); D. Aaronson, N. Kittrie, and D. Saari, Alternatives to Conventional Criminal Adjudication: Guidebook for Planners and Practitioners (1977); D. Aaronson and J. Sweeney, "Criminal Law Reform in the District of Columbia: An Assessment of Needs and Directions," 24 Am. U.L. Rev. 207, 212-19 (1975).

11. On the role of Impact analysis in public policy research, see C. T. Dienes, Law, Politics and Birth Control (1972); T. Dye, Understanding Public Policy 291-96 (1972); Musheno, Palumbo, & Levine, "Evaluating Alternatives in Criminal Justice: A Policy-Impact Model, 22 Crime & Delinquency 265 (1976).

12. Studies in this category include: Campbell & Ross, "The Connecticut Crackdown on Speeding: Time-Series Analysis Data in Quasi-Experimental Analysis," 3 Law & Soc. Rev. 55 (1968); Glass, Tiao, & Maguire, "The 1960 Revision of German Divorce Laws: Analysis of Data as a Time-Series Quasi-Experiment," 5 Law & Soc. Rev. 539 (1971); Ross, "The Scandinavian Myth: The Effectiveness of Drinking-and-Driving Legislation in Sweden and Norway," 4 J. of Legal Studies 258 (1975); Zimring, "Firearms and Federal Law: The Gun Control Act of 1968," J. of Legal Studies 133 (1975).

13. See D. Dolbeave (ed.), Public Policy Evaluation (1975).

14. On this methodology of impact analysis, see D. Campbell & J. Stanley, Experimental and Quasi-Experimental Design for Research (1966); G. Glass, V. Wilson, & J. Gottman, Design and Analysis of Time-Series Experiments (1975); Lempert, "Strategies of Research Design in the Legal Impact Study: The Control of Rival Hypotheses," 1 Law & Soc. Rev. 121 (1966).

15. Examples of case studies of the legal treatment of public drunkenness in particular jurisdiction other than the target jurisdictions selected for case studies in the present report include:

   California: Goodman & Idell, The Public Inebriate and the Police in California: The Perils of Piecemeal Reform.

   Chicago: R. Nimmer, Two Million Unnecessary Arrests (1971), at 35-57.

   Connecticut: E. Lisansky, The Chronic Drunkenness Offender in Connecticut (1967).

   Florida: Farrell, Florida Courts Regard Public Inebriate as Health Problem, 45 Fla. V.J. 196 (1971);

   Comment, Involuntary Commitment of Alcoholics, 26 U. Fla. L. Rev. 118 (1973);

Note, The Revolving Door Cycle in Florida, 20 U. Fla. L. Rev. 3[illegible] (1968).

Hawaii: Koshiba, Treatment of Public Drunkenness in Hawaii, 7 Am. Crim. L. Q. 228 (1968).

Massachusetts: Landsman, Massachusetts' Comprehensive Alcoholism Law--Its History and Future, 58 Mass. L. Q. 273 (1973);

Note, The Chronic Alcoholic: Treatment and Punishment, 3 Suffolk U. L. Rev. 406 (1969).

New York City: R. Nimmer, supra note 5, at 58-77.

North Dakota: Note, Reform of the Public Intoxication Law: North Dakota Style, 46 N.D.L. Rev. 239 (1970).

Tennessee: Comment, The Proposed Criminal Code: Disorderly Conduct and Related Offenses, 40 Tenn. L. Rev. 725 (1973).

Washington: Recent Developments, 50 Wash. L. Rev. 755 (1975).

Wisconsin: Robb, The Revision of Wisconsin's Law of Alcoholism and Intoxication, 58 Marq. L. Rev. 87 (1974).

16. Lempert, Strategies of Research Design in the Legal Impact Study: The Control of Rival Hypotheses, 1 Law & Soc'y Rev. (1966).

17. See President's Comm'n on Law Enforcement and Adm'n of Justice, Task Force Report: Drunkenness (1967).

18. R. Straus, Escape From Custody 11 (1974).

19. Close to 100 million Americans drink alcohol to some extent. About 15 million Americans are considered heavy drinkers and about 9 million are classified as alcoholics. U.S. Dep't of HEW, The Legal Status of Intoxication and Alcoholism in Alcohol and Health (197_), at VIII; Letter from Dr. Sidney Wolfe, Director, Public Citizen's Health Research Group, Washington Post, June 10, 1976.

The classic definition of alcoholism was provided by the World Health Organization:

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

20. Consider the proposition that when intoxication in public is legalized, an ethical distinction is drawn between proper and improper uses of alcohol. This distinction brings into operation both social and legal rules for

handling behavior. Szasz, Alcoholism: A Socio-Ethical Perspective, 6 Washburn L. J. 225 (1967).

21. Only about 3 to 5 percent of the alcoholic population (i.e., 9 million Americans can be considered "alcohol abusers") can be classified as skid row, "homeless persons." U.S. Dep't of HEW, supra note 9, at viii; Stevenson, The Emergence of Non-Skid-Row Alcoholism as a "Public Problem," 45 Temple L. Q. 529, 531 & n. 14, citing Hearings on an Examination of the Impact of Alcoholism Before the Special Subcomm. on Alcoholism and Narcotics of the Senate Comm. on Labor and Public Welfare, 91st Cong., 1st Sess. 220 (1969) (testimony of Merle Gulick) (1972).

In a study of Sacramento's skid row, a street survey of 118 respondents indicated that "an average of approximately 910 persons live on Skid Row at any given time . . . 550 persons in this total, have serious drinking problems. . . . Alcohol is a predominant aspect of Skid Row, although the residents see basic life needs as more important. When asked to identify their basic problems, only 8 percent felt drinking the most important." The author states: "While the population of this geographical area is by no means composed entirely of the chronic public inebriate, a large part of this population is made up of the same people who 'cycle through' the jail, the Detoxification Center, alcoholic recovery homes and the Missions. . . .

"When asked how many Skid Row residents had a drinking problem, the respondents felt that 55 percent did. Thus, perception does cloud an objective view of the degree of alcoholism among Skid Row residents--the problems of basic survival often seem more immediate." S. Thompson, Drunk on the Street: An Evaluation of Services to the Public Inebriate in Sacramento County 8-11 (1975).

22. Characteristics of the skid row inebriate have been drawn from a number of classic treatments of skid row society such as N. Anderson, The Hobo: The Sociology of the Homeless Man (1923); H. Bahr, Homelessness and Disaffiliation (1968); D. Bogue, Skid Row in American Cities (1963); S. Harris, Skid Row USA (1956); D. Pittman & W. Gordon, Revolving Door: A Study of the Chronic Police Case Inebriate; S. Wallace, Skid Row as a Way of Life (1965). See generally, R. Nimmer, supra note 5, at 15-34; D. Pittman, ed., Alcoholism, pt. 3, at 55-128 (1967); D. Pittman, Public Intoxication and the Alcoholic Offender in American Society, in Drunkenness Report, supra note 9, at 7-13.

23. The Drunkenness Report, supra note 9, at 3, for example, notes that "(W)hat the (criminal justice) system usually does accomplish is to remove the drunk from public view, detoxify him, and provide him with food, shelter, emergency medical service, and a brief period of forced sobriety." The Court in Powell v. Texas, 392 U.S. 514, 528 (1968), also noted the beneficial aspects of criminal justice handling of at least, skid row inebriates. But see Adelson, Huntington Recy, A Prisoner is Dead, 13 Police 49 (1968); Drunkenness Report, supra note 9 at 2.

24. See Rubington, Referral, Post Treatment Contacts and Lengths of Stay in a Halfway House--Notes on Consistency of Societal Reactions to Chronic Drunkenness Offenders, 31 Quarterly J. Study of Alcoholism--(1970).

25. See Griffen, The Revolving Door: A Functional Interpretation, in Social Problems in a Changing Society (W. Gerson ed. 1969).

26. The Pittman-Gordon study of the Revolving Door phenomenon, for example, characterized this as one of the skid row inebriates' "most important attributes." Forty-one percent of the sample had never been married, 32% were separated, 19% were divorced, 6% were widowed, and only 2% had been living with their spouses before incarceration. Pittman & Gordon, The Chronic Drunkenness Offender, in Alcoholism 99, 101 (D. Pittman ed. 1967), (reporting the findings of the Pittman-Gordon study).

27. See, e.g., K. Davis, Police Discretion (1975) (hereinafter cited as K. Davis); W. LaFave, Arrest: The Decision to Take a Suspect Into Custody (1965) (hereinafter cited as W. LaFave).

28. But see J. Wilson, Varieties of Police Behavior (1970).

29. But see R. Nimmer, supra note 5; D. Petersen, The Police Discretion and the Decision to Arrest (unpublished Ph.D. dissertation, U. of Ky., 1968) (hereinafter cited as D. Petersen); Bittner, Police Discretion in the Emergency Apprehension of Mentally Ill Persons, in The Ambivalent Force (A. Niedhoffer & A. Blumberg eds. 1970); Bittner, The Police on Skid Row: A Study of Peace-Keeping, 32 Am. Soc. Rev. 699 (1967), Goodman & Idell, supra note 4.

30. Wayne LaFave, for example, stresses the budgetary restraints on a full-enforcement policy of a police organization. LaFave, supra n. 27.

Two commentators note the existence of department-wide biases toward the enforcement or nonenforcement of certain criminal categories. J. Wilson, Varieties of Police Behavior (1970) (hereinafter cited as J. Wilson); Goldstein, Police Discretion not to Invoke the Criminal Process: Low-Visibility Decisions in the Administration of Justice, 69 Yale L. J. 543 (1960). See also, Goldstein, Administrative Problems in Controlling the Exercise of Police Authority, 58 J. Crim. L. C. & P. S. 171 (1967) (hereinafter cited as Goldstein). See generally B. Grossman, Police Command: Decisions and Discretion (1975).

On the ability of the police organization to control the exercise of officer discretion in the field, compare Goldstein, supra (control possible) with J. Skolnick, Justice Without Trial 74 (1967) (patrolman more like craftsman than bureaucrat, and behavior not susceptible to organizational pressures). James Q. Wilson, takes a middle ground position, saying the ability of the organization to manage police discretion varies according to the issue involved. He suggests, for example, that activities categorized as law enforcement rather than order maintenance and community service are more amenable to control. J. Wilson, supra note 30, at 64-65.

The relevancy of police organization to police behavior in the area of public drunkenness has been noted in R. Nimmer, supra note 5, at 116. The need for training and organizational incentives to encourage police pickups has been noted in Pittman, Interaction Between Skid Row People and Law Enforcement and Health Professionals at 19 (May 8, 1973) (paper prepared for the National Institute on Alcohol Abuse and Alcoholism, Seminar on The Role

of Public Health Services in the Skid Row Subculture). Helen Erskine suggests the relevancy of training and the complexity of procedures and forms on police practices. H. Erskine, Alcohol and the Criminal Justice System: Challenge and Response 17 (1972) (hereinafter cited as H. Erskine).

31. James Q. Wilson identified three basic role orientations of a police officer--law enforcement, order maintenance and community service. J. Wilson, supra note 30, at 17-49. Although the latter two functions probably consume the greatest part of an officer's time, research has indicated officers identify with and evaluate jobs in terms of law enforcement. The Police and the Community 16-30 (R. Steadman ed. 1972).

The relevance of this role perception in creating a negative predisposition to the task of removing inebriates from public places has been noted in D. Bradley, Project Report: Alcoholic Detoxification Center; R. Nimmer, supra note 5, Egan Bittner has noted this negative bias is especially strong when delivery is to a medical treatment center. Bittner, Police Discretion in the Emergency Apprehension of Mentally Ill Persons, in The Ambivalent Force (A. Niederhoffer & A. Blumberg eds. 1970).

32. See, e.g., H. Erskine, supra note 30, at 17; R. Nimmer, supra note 5, at 116; Younger, The Inebriate and California's Detoxification Centers, The Police Chief, May 1972, at 30-38.

33. The relevancy of pressures from the public and businessmen on police behavior is noted in W. LaFave, supra note 27, at 129; R. Nimmer, supra note 5, at 116; D. Petersen, supra note 29, at 158-68; D. Castberg, The Exercise of Discretion in the Administration of Justice at 13 (1972) (paper prepared for American Political Science Association Convention) (hereinafter cited as D. Castberg).

34. The importance of peer group socialization to the exercise of police discretion is noted in J. Wilson, supra note 28, at 283; Bittner, The Police on Skid Row; A Study of Peace Keeping, 32 Amer. Soc. Rev. 99, 701 (1967). D. Castberg, supra note 33, at 9.

35. See, e.g., Wilson, supra note 28, at 280; D. Castberg, supra note 33, at 10.

36. Examples of the relevancy of situation-specific factors are provided in LaFave, supra note 27; D. Petersen, supra note 29, at ch. VI. Petersen also discusses the importance of the location of the violation and the degree of incapacity of the inebriate to police officer behavior in public drunkenness cases. Id. at 185-88.

37. This phenomenon of differential enforcement of the public drunkenness laws by class has been frequently noted. See, e.g., A. Gammage, D. Jorgensen, & E. Jorgensen, Alcoholism, Skid Row and Police 6 (1972); W. LaFave, supra note 27, at 439-44; R. Nimmer, supra note 5.

38. See Palumbo, Power and Role Specificity in Organizational Theory, 29 Pub. Adm. Rev. 237 (1969).

39. This classification is based on work by J. Levine, M. Musheno, & D. Palumbo, Evaluating Alternatives in the Criminal Justice System (Unpublished research monograph 1974).

40. See C. Perron, Complex Organizations: A Critical Essay (1972).

41. See R. Guest, Organizational Change: The Effect of Successful Leadership (1962).

42. See C. Argyris, Organization and Innovation (1965).

43. See P. Plau, Decentralization in Bureaucracies, in Power in Organizations (M. Zald ed. 1970).

44. See R. Bucher, Social Process and Power in a Medical School, in Power in Organizations (M. Zald ed. 1972).

45. See Musheno, Palumbo, & Levine, Evaluating Alternatives in Criminal Justice: A Policy-Impact Model, 22 Crime & Delinquency 265 (1976).

46. Levine, Musheno, & Palumbo, The Limits of Rational Choice Theory in Choosing Criminal Justice Policy, in Policy Studies and the Social Sciences 89 (S. Nagel ed. 1975).

47. Palumbo, Levine, & Musheno, Individual, Group, and Social Rationality in Controlling Crime, in Modeling in the Criminal Justice System (S. Nagel ed. 1977).

CHAPTER 2

THE IMPACT OF DECRIMINALIZATION

A. QUANTITATIVE IMPACT ON A NATIONAL SCALE

We hypothesized that if no special ameliorative action is introduced, decriminalization generally produces a significant decline in the number of public inebriates formally processed by legally approved means. This subsection compares police pick-up and delivery of public inebriates in criminal and decriminalized jurisdictions. It seeks to provide a perspective for examining differences in quantitative pick-up rates. Significant differences were expected in the rates at which police officers in criminal and decriminalized jurisdictions formally process public inebriates.

Our hypothesis--that decriminalized jurisdictions will process fewer public inebriates than criminal jurisdictions--is based on several premises:

(1) with the removal of the criminal sanction, the intake of public inebriates falls outside the parameters of what police officers and the command structure of police departments consider proper and important tasks;[1]

(2) the loss of the criminal sanction eliminates credit for making arrests a critical organizational incentive and forces patrol officers to carry out an often messy and time-consuming job without reward;[2] and

(3) police intake of inebriates under a public health mandate requires the cooperation of two different public service bureaucracies that diverge in both organizational structure and value orientation. Such fragmented authority structure is a potential impediment to goal achievement.[3]

This subsection will present an empirical evaluation of the quantitative impact of decriminalization on police department performance in removing inebriates from public places in Washington, D.C. and Minneapolis, Minnesota. To test the impact of decriminalization empirically, we carried out an "interrupted time-series quasi-experiment"[4] based on a "stratified multiple-group single-I design."[5] Specifically, we collected monthly public drunkenness arrest rates before decriminalization and monthly rates of police deliveries to detoxification facilities after decriminalization in two cities: Washington, D.C. (a high-arrest jurisdiction)[6] and Minneapolis, Minnesota (a moderate-arrest jurisdiction).[7] We also collected the available monthly arrest data

for two control cities where decriminalization has not been implemented: Houston, Texas (a high-arrest jurisdiction) and San Francisco, California (a moderate-arrest jurisdiction).

These selections closely meet the criteria for what scholars often point to as critical ingredients for a strong design. The ". . . design is more valid the more heterogeneous each set of states is within itself and the more similar the two sets of states when each set is viewed as a whole."[8] Time-series analysis requires a laborious effort to gather relevant and reliable data.[9] Indeed, certain jurisdictions selected for study elsewhere in this report could not be used because of inadequate data. Since we were collecting data from four different municipalities, we were unable to collect an equivalent number of monthly observations for each jurisdiction. In addition, the time sequence for each jurisdiction is not the same and the date of decriminalization (I_1) is different in the experimental jurisdictions.

The data we collected do, however, provide considerable support for our decriminalization hypothesis. In Washington, D.C., the estimated change in the pick-up rate is a reduction of 76.4 police intakes per month.[10] In Minneapolis, the impact of decriminalization on police intakes is still more dramatic. There, the estimated change is a reduction of 263.2 police intakes per month.[11] Simple analysis of the data from our control jurisdictions (i.e., visual scanning)[12] shows that no similar effect takes place in police departments where criminal sanctions against public drunkenness remain intact.

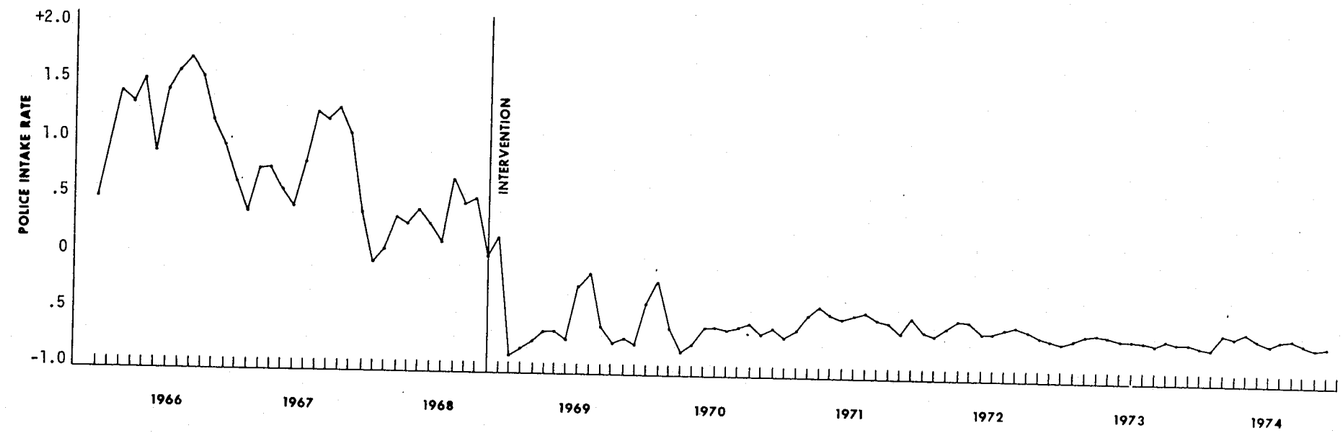
Does this mean, then, that one effect of decriminalization is increased neglect of the public inebriate population? Rather than concluding from our analysis that inebriates are left on the street at a significantly higher rate after decriminalization, we also investigated a series of plausible rival hypotheses and alternative dispositions that could not be controlled for in the stratified multiple-group single-I design. They include self-admissions, home deliveries, and deliveries to other health facilities. These city control factors are discussed below in our case studies.

B. CASE STUDIES--QUANTITATIVE AND QUALITATIVE IMPACTS

For each experimental jurisdiction, we analyzed whether a change in the recidivism rate and/or a change in the size of the drinking population produced the reduction in police pick-ups following decriminalization. The reform legislation in Minneapolis and Washington, D.C. grants formal options for handling public inebriates--e.g., transporting the inebriate to his home or delivery of the individual to a facility equipped to handle alcoholism.[13] An attempt was made to analyze the use of these approved formal means of disposition. In addition to these legislated options, we investigated whether the police are incorrectly processing public inebriates under existing misdemeanor charges (disorderly conduct, vagrancy).

We also hypothesized that decriminalization would have a qualitative impact and that the population of inebriates formally processed by legally approved means would contain increasingly larger numbers of emergency-case homeless men or skid-row inebriates. While it is impossible to arrive at reliable figures for the number of skid-row inebriates throughout the country, the Secretary of the Department of Health, Education, and Welfare gave some idea of

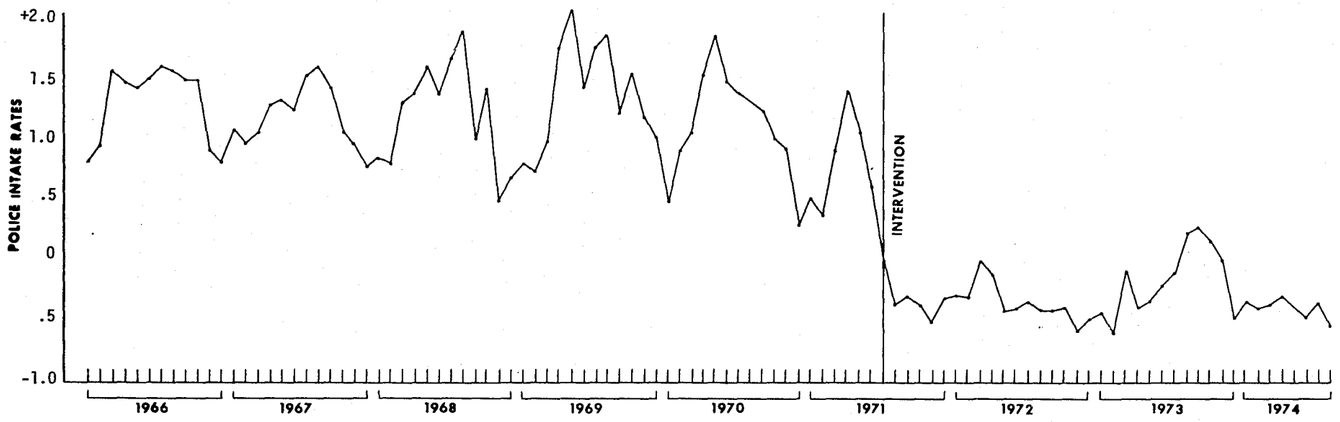
GRAPH 1.--Monthly police intake rates for public intoxication.[a] *Washington, D.C.*[b]



[a]Based on official statistics of Metropolitan Police Department, Washington, D.C. and official records of the D.C. Detoxification Center.

[b]Point of intervention--November 1, 1968. Monthly police intake rates after the point of intervention include arrests and deliveries to detox.

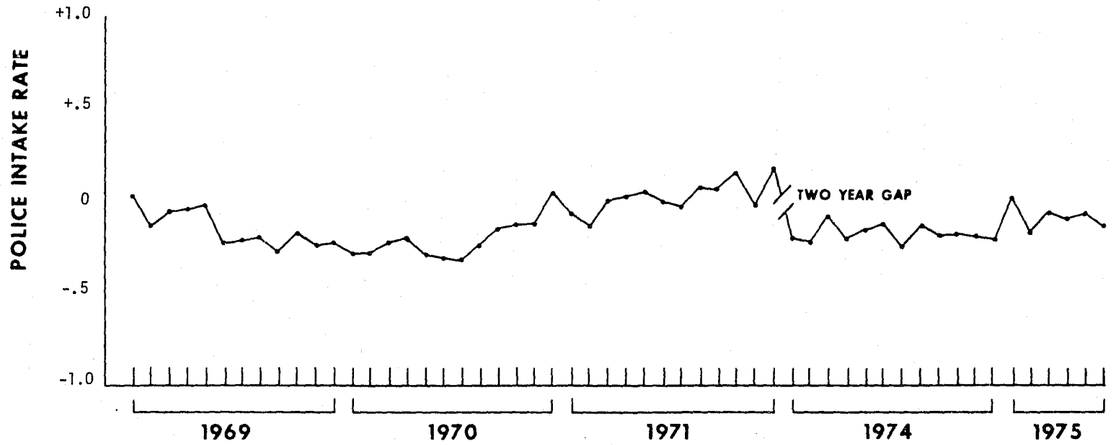
GRAPH 2.--Monthly police intake rates for public intoxication:[a] *Minneapolis, Minnesota*[b]



[a]Based on official statistics of Minneapolis Police Department, Minneapolis, Minnesota, and monthly intake statistics, Alcoholism Receiving Center.

[b]Point of intervention--July 1, 1971. Monthly police intake rates after the point of intervention include arrests and deliveries to detox.

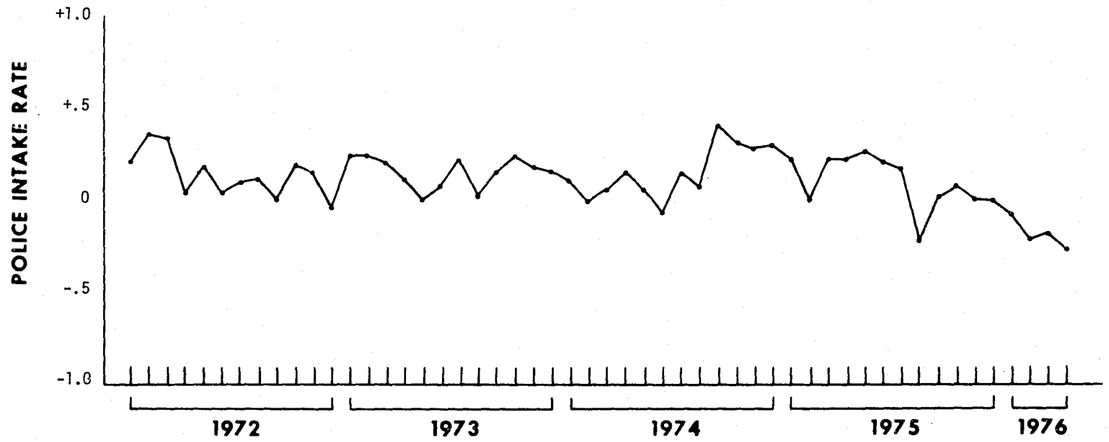
GRAPH 3.--Monthly police arrests for public intoxication:[a]
Houston, Texas[b]



[a]Based on official statistics of Houston Police Department, Houston, Texas.

[b]Point of intervention--July 1, 1970.

GRAPH 4.--Monthly police arrests for public intoxication:[a]
San Francisco, California[b]



[a]Based on official statistics of San Francisco Police Department, San Francisco, California.

[b]Point of intervention--July 1, 1973.

the magnitude of the problem in his "First Special Report to Congress on Alcohol and Health" in December 1971. In that report, he noted that public intoxication alone accounts for one-third of all arrests reported annually; that among the more than 95 million drinkers in the nation, about 9 million men and women are alcohol abusers; and that alcoholic individuals include about 3 to 5 percent who are skid-row inhabitants.[14]

In assessing the qualitative impact of decriminalization, we investigated whether the police have become more selective in their enforcement practices since decriminalization. We also looked into the type(s) of public intoxicants that the police gave formal attention to prior to decriminalization compared to the type(s) of public inebriates receiving formal attention after decriminalization.

Each case study provides an introduction dealing with the historical and present legal context of public drunkenness in the jurisdiction and the environmental context in which policing of the public inebriate takes place both citywide and in selected target districts.

Again, the basic hypotheses are that

(1) if the police remain as the pick-up and delivery agents, and no special administrative changes are introduced to provide special incentives to induce pick-up and delivery, there will be a quantitative decline in the number of individual public inebriates formally processed by the legal-medical system, and

(2) the remaining population of public inebriates formally processed will be, to an increased degree over the prechange period, emergency-case, skid-row (homeless) inebriates.

Other inebriates, not formally processed under the therapeutic regimen, will be ignored by the police or will be informally disposed of by unapproved means. By examining alternative hypotheses for the observed decline in the formal, approved pick-up and delivery of public inebriates (i.e., control factors), it is possible to give greater credibility to the two posited hypotheses.

C. WASHINGTON, D.C.

For many years, Washington, D.C. has been known as a reform city in its handling of the public intoxication problem. Washington's reputation derives, in large part, from judicial and legislative decisionmaking in the 1960's.[15] These court decisions and legislative acts made the District of Columbia a decriminalized jurisdiction well before the Commissioners on Uniform State Laws drafted the Uniform Alcoholism and Intoxication Treatment Act in 1971[16] and before the Act had its impact on jurisdictions throughout the United States.

Despite this early reputation, the District's decriminalized system and especially its means of intake has come under attack from various sources, including groups that worked ardently for the reform.[17] This study is designed to evaluate the performance of the Metropolitan Police Department (MPD) as the major agency responsible for the delivery of public inebriates to designated health facilities in the District of Columbia. It is first necessary to

consider the legal context which emerged from the juridical and legislative reforms in order to determine what goals the police were expected to implement.

1. The Legal Context. Prior to Easter v. District of Columbia, 361 F.2d 50 (D.C. Cir. 1966), the public inebriate was handled under the criminal process. The usual procedure involved a police arrest of the offender based on an alleged violation of the D.C. Code, Section 25-128, which made it a crime to be "drunk or intoxicated in any street, alley, park, or parking in any vehicle in or upon the same or in any place to which the public is invited or at any public gathering, and no person anywhere shall be drunk or intoxicated and disturb the peace of any person." Violations of the statute could mean a fine of not more than $100 or imprisonment for not more than 90 days or both.

The legal challenge to this public intoxication statute in the Easter case relied on the principle of criminal responsibility and the argument that criminal sanctions may be applied only to voluntary action.[18] Specifically, in Easter, the United States Court of Appeals for the District of Columbia held that the defendant could not be convicted of public intoxication because, as a chronic alcoholic, he had lost the power of self-control with respect to the use of alcoholic beverages and thus, under common law principles, could not be convicted for his involuntary intoxication. The Easter decision applied only to the "chronic alcoholic." Public intoxication remained a crime, but there was uncertainty whether an arrest would result in a conviction. Further, the lack of any systematic therapeutic methods for handling the chronic inebriate resulted in higher recidivism rates than under the ordinary criminal processing of inebriates. The result for the police was general confusion.

On August 1, 1968, the District of Columbia Alcoholic Rehabilitation Act went into effect. Its enactment was a direct result of Easter as well as its chaotic aftermath. The law established an alternative to the criminal justice system for handling public inebriates. It directed all public officials in the District of Columbia to "take cognizance of the fact that public intoxication shall be handled as a public health problem rather than as a criminal offense." Nevertheless, the assumption that simple public intoxication is a sufficient cause of public intervention regardless of the wishes of the intoxicated individual is retained in the statute. The police remain the legal instrument for removing intoxicated persons from the streets, but they pick up "patients" under a public health provision which reads:

> "Except as provided in subsection (b) of this section, any person who is intoxicated in public: (1) may be taken or sent to his home or to a public or private health facility; (2) if not taken or sent to his home or such facility under paragraph one shall be taken to a detoxification center."

The Metropolitan Police Department of Washington, D.C. detailed its interpretation of the new law and created a formal policy in MPD General Orders Eight and Eleven, series 1968. There is explicit recognition in General Order Eleven that the Metropolitan Police Department recognizes intoxication in the District of Columbia as a health problem--"Intoxication shall be handled on a public health rather than a criminal basis." In the orders, intoxicated persons are divided into three distinct classes:

(1) those not endangering the safety of themselves or other persons or property,

(2) those who endanger the safety of themselves or other persons or property (D.C. Code §25-218),

(3) those charged with criminal offenses other than those specified in D.C. Code §25-218.

The police department remains the primary intake (or pick-up) vehicle for all three classes under the revised process. The police may take the citizen in the first class home or to the Detoxification Center and no arrest is made. Inebriates in the second class, those who do endanger the safety of themselves or others (a criminal offense), are arrested, and a detainer notice is left with the Detoxification Center medical officer. While those citizens in the third class are also to be taken to the Detoxification Center, the Center does not have adequate security, and therefore a person whose escape is considered likely is presently treated like any other criminal arrest.

The legal formulation of the District's decriminalized approach to public drunkenness is primarily attributable to the intensive efforts of an identifiable set of individuals and groups (a policy subsystem).[19] As with the formulation of a good deal of public policy, it was not an issue of great concern to the general public. Rather, it represented a major victory for the cluster of interests that for nearly 20 years had sought a "therapeutic" rather than a criminal approach to public drunkenness in the District. Coordinated by the Washington Area Council on Alcoholism and Drug Abuse, these forces included members of city and federally chartered criminal justice reform commissions, the news media, civil libertarian groups, public health institutions, and alcoholism interest groups. This policy subsystem was also instrumental in prodding Congress to enact the Alcoholic Rehabilitation Act and has continued to serve as a "watchdog" over the implementation of decriminalization in the District.

While all coalition members backed Easter and the Alcoholic Rehabilitation Act, their reasons for supporting these reforms varied and reflected the differences in professional expertise and interest that existed within the subsystem. The criminal justice reform commissions and the civil libertarians stressed constitutional protections and their desire to free the courts and criminal justice system from a responsibility that was "noncriminal" in nature. The alcoholic reform groups and officials of public health institutions emphasized the provision of emergency services for the inebriate as well as the desire to use decriminalization as a stepping stone for resocializing and rehabilitating inebriates.[20] We found no indication of active discussions among coalition members about possible conflicts among these goals. It is important to note that the Metropolitan Police Department neither volunteered nor was asked to participate in this policy subsystem.

Before presenting an evaluation of how the Metropolitan Police Department actually responded to this change in policy, it will be valuable to consider the environmental context of policing in the District of Columbia. While citywide environmental and demographic characteristics are outlined, emphasis is placed on the unique characteristics of patrol areas (i.e., districts) because

of the variation in the "public drunkenness problems" encountered by the department in the different districts.

2. The Environmental Context for Policing. Washington, D.C. is a city of socioeconomic extremes. Like many central cities, the District is made up of three diverse sectors: (1) entrenched poverty areas; (2) transitional areas; and (3) stable medium- and high-income areas.[21] In a ten-city comparison of cities with equivalent size, the District has the highest percentage of black population (70 percent, followed by 46 percent for Baltimore, 41 percent for St. Louis). Another unique characteristic of the District is its low unemployment rate (1970--4.0 percent). The civilian labor force, however, is disproportionately in low-income jobs. In 1970, 28 percent of the experienced labor force earned less than $4,000. Adding this figure to the unemployment rate, we see that over 110,000 persons in the District are either low-income earners or unemployed.

In educational attainment, the District is bimodal, with the highly educated and uneducated each accounting for a large percentage of the population. Well over a third of the younger people (19-24 years) have not completed high school and 24 percent of those 25 and over have less than 1 year of high school education. This places the District well below the figures for such central cities as Baltimore, Cleveland, and St. Louis. Yet, 22 percent of the District's male population has more than 4 years of college, a figure considerably greater than the percentage for comparable cities.

Like many urban centers, the District has experienced serious problems with alcoholism, and the problem drinking population continues to grow.[22] Below are the estimates based on the Jellinek Formula.

TABLE 1.--Problem drinking population, District of Columbia, 1960-1972[a]

Year	No. of problem drinkers	Year	No. of problem drinkers
1960	52,500	1967	95,900
1961	64,100	1968	97,100
1962	68,100	1969	95,400
1963	78,000	1970	98,400
1964	70,000	1971	129,000
1965	86,700	1972	130,000
1966	97,600		

[a]Based on Jellinek Formula as calculated and reported by Dr. Dorothy Mindlin, Director of the Adams Mill Alcoholism Center, Washington, D.C. See D. Aaronson, C. T. Dienes, and M. C. Musheno, First Project Report, pp. 27-34.

The Detox area--First Police District. The Detoxification Center is located in the First Police District, a subdivision of Washington, D.C. roughly comparable to Health Service Areas 6 and 9 combined.[23] Service Area 6 is in an entrenched poverty section of the city with a high concentration of "street" inebriates. However, unlike the Bowery in New York City, the inebriate population is spread out and located in pockets in the many poor and low-income residential neighborhoods. While police officers identify certain corners and lots where the inebriates tend to congregate, they point out that inebriates are mobile and not concentrated in a one- or two-block area.

Policing the inebriate population in the First Police District is further complicated because Service Area 9 is the central tourist area as well as the site of government offices and retail stores. The "street drinking" population often "spills over" into this area, "panhandling" and using the parks for "hang-outs." The proliferation of "honky tonk" bars and striptease joints also attracts problem drinkers to this area. Thus, complaints from many community residents and businessmen can be an everyday problem facing police officers in this patrol area.

The Fifth Police District. The Fifth District encompasses Health Service Areas 2 and 5. In many respects, Area 5 represents a continuation of the entrenched poverty in the First District. Again, "street drinking" represents the major policing problem related to intoxication, but public inebriates in this area are more isolated from tourist attractions and government offices. Thus, complaints are more likely to come from residents.

Service Area 2 is distinctly wealthier than Service Area 5 with large numbers of black middle-class families. Public inebriation is considered a minor problem in this part of the city because drinking is usually confined to homes and bars in the neighborhoods.

The Second Police District. The Second District falls almost completely within Health Service Area 8 and represents the middle- and upper-income white population of Washington, D.C. Officers in this District are also responsible for patrolling the Georgetown shopping and tourist section of the city.

Public inebriation is a lesser problem in District 2 because resident drinking is confined mostly to homes, and most of the street drinkers are located a considerable distance from the commercial section of Georgetown. The police do encounter inebriation problems near the bars along M Street and Wisconsin Avenue which attract young people and servicemen stationed in the metropolitan area.

3. Quantitative Impact. We turn now to an analysis of the major research hypotheses concerning the combined impact of Easter and the Alcoholic Rehabilitation Act on the pick-up of public inebriates. Quantitatively, we showed above that police pick-up of public inebriates decreased significantly since decriminalization in Washington, D.C. despite police officers' continued legal mandate to remove inebriates from the street.

a. Alternative approved dispositions. For each experimental jurisdiction we investigated a series of controls and alternative means of disposition that could perhaps account for the decrease in police intake following

decriminalization (see figure 5). In Washington, this requires consideration of the dispositions sanctioned by the law on the books, possible alternative explanation for quantitative decline, and the policy impacts indicated in figure 1.

FIGURE 5.--Specific research framework: District of Columbia

Alternative approved dispositions	Control factors	Policy impacts
Delivery to Detox	Size of problem--drinking population	Numerically less approved dispositions of P.I.'s by police
Self-admission to Detox*	Size of public inebriate population	
Use of public and private health facilities	Migration from the jurisdiction	Nonapproved dispositions of P.I.'s by police
Home delivery	Recidivism rates: The "Revolving Door"	

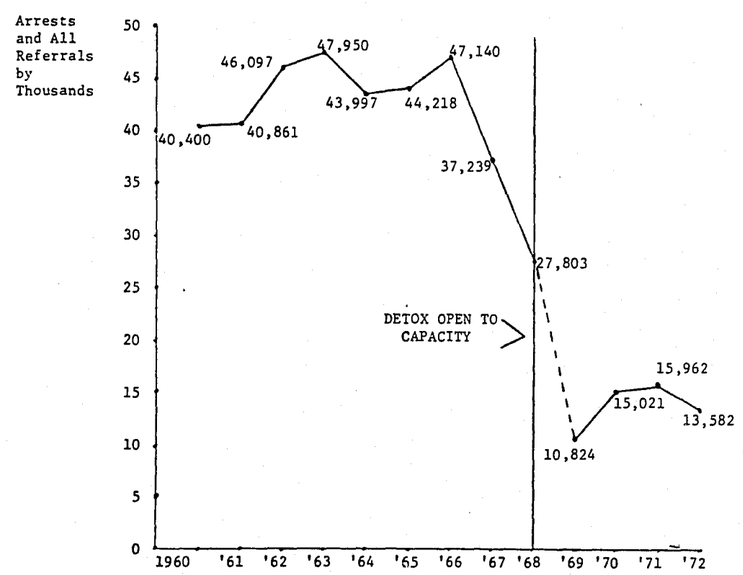
*This is not a police option but it is an approved mode of intake of public inebriates to the public system.

To explore the possibility that self-admission may serve as an explanation for the difference in police intake rates in the two periods, graph 5 shows the police arrest rates and all the categories of admission to the Detoxification Center, including self-admission. Again, the anticipated result of a significant decrease in pick-up rates for public drunks in the post-ARA period is confirmed.[24] Thus, all the data indicate that, in terms of arrest and intake rates, the decrease is significant and dramatic in the post-ARA era.

The Alcoholic Rehabilitation Act stipulates that public inebriates "may be taken or sent to . . . a public or private health facility." However, all police general orders implementing the ARA refer only to private health facilities as the appropriate alternative to the Detoxification Center as a mode of disposition. To determine whether police officers use the option to deliver public inebriates to public and private health facilities, we developed a list of public and private health facilities that service inebriates. This list is based on a publication supplied by the Washington Area Council on Alcoholism and Drug Abuse. Research assistants then contacted the institutions and collected statistics on police deliveries. Where statistics were unavailable, the researchers were asked to conduct interviews to elicit this information.

No record of police deliveries to these facilities was found to exist and, in fact, very few facilities were found to keep accurate records of admissions by type of referral. All of those interviewed stated that police deliveries

GRAPH 5.--Public drunkenness arrests[a] and all admissions to the D.C. Detoxification Center,[b] fiscal years 1960-1972



[a]Figures are official statistics of Metropolitan Police Department, Washington, D.C. Annual Reports, 1960-1972.

[b]Official statistics of D.C. Detoxification Center, Washington, D.C. Monthly Statistics, May 1968-June 1973, All Categories.

to their facilities were extremely rare and, more important, no institution spokesperson reported any significant increase in deliveries in the post-ARA era.

The ARA and police general orders sanction home deliveries of public inebriates. In order to determine if the police were taking or sending a larger number of public inebriates home in the post-ARA period, we contacted police administrative personnel to see if any data on home deliveries were available. Police form PD253 (an Incident Report) is to be filed by any officer transporting a public drunk to his/her home. Despite the Department's specific directions on using the Incident Report in these cases, the MPDC indicated that in the last 4 years no use was made of PD253 for that purpose. We were thus forced to rely on interviews and observations made during ride-alongs with police officers. While we cannot reject the possibility that inebriates have been sent home in significantly greater numbers following the opening of the Detox Center, nothing suggests that this is the case. Certainly there is nothing indicating that an increase in home deliveries would account for the significant quantitative drop in police pick-ups following decriminalization.

b. Control factors. Given the fact that the options available to police officers for handling public intoxicants are being underused, we arrived at our anticipated explanation--that a large number of public inebriates are simply left in the street or are disposed of by informal, unapproved means. However, before reporting this as a conclusive finding, we introduced and analyzed a final set of alternative hypotheses that might otherwise account for the discrepancy. For example, we examined possible changes in the size of the potential target group as defined by the legal policy statements:

-has the class of intoxicated persons decreased significantly enough in the post-ARA period to reduce the potential for police pick-up of publicly inebriated individuals?

-has the public inebriate population decreased significantly enough to lower the potential for intake either through an actual decline in population or through migration?

We also sought to account for the possibility that the number of public inebriates had declined through migration from the target city to adjacent jurisdictions. Finally, we explored the possibility that the post-ARA decline in pick-ups is artificial because of a lower rate of recidivism after decriminalization.

If the population of intoxicated persons has shown a significant decline that is coterminous with decriminalization of public drunkenness, then we would need to weigh this variable in assessing the potential for police intake of public inebriates. Public inebriates are a subset of intoxicated persons. If the entire set decreases, then the subset may shrink. While there is no accurate measure of intoxication in this nation, there is a measure which indicates the trends in the number of intoxicated persons in the District of Columbia--the alcoholism rates determined by the Jellinek formula. The data contained in table 1 above indicate that the population of persons suffering from alcohol abuse in the District of Columbia has steadily increased. This at least suggests that the class of public inebriates has not markedly declined.

There are no precise statistics on the size of the public inebriate population in the District of Columbia. As we indicated above, the Jellinek Formula shows that alcoholism continues to expand as a public health problem throughout the decriminalization period. We conducted a number of interviews with individuals closely associated with the public inebriate problem. None of those interviewed saw any decrease in the size of the public inebriate population. Further, the District of Columbia's Area Council on Alcoholism and Drug Abuse reports that there has been a steady increase in the number of public and private health facilities treating individuals with alcohol-related problems in the last 10 years. The Council does note that recent increases are in large measure related to improved health insurance benefits for treating alcoholism and alcohol-related problems, but the increases do suggest that there has been no significant decline in the size of the public inebriate population.

Has the public inebriate population decreased significantly through migration to surrounding jurisdictions? We selected Prince Georges County, Maryland to analyze this question because it more closely approximates the socioeconomic characteristics of the District than any of the other suburban jurisdictions.

Arrest statistics for public inebriation and disorderly conduct in Prince Georges County were obtained to determine if there had been any increase during the post-ARA period in the District of Columbia. Until 1968, when arrest for public inebriation ended, both public inebriation and disorderly conduct charges were used to process public drunks. Since 1968, the only offense used to process public inebriates in Maryland is disorderly conduct. As indicated in table 2, the figures do not support the hypothesis that a migration of public drunks to Prince Georges County took place at the time of the change in the law in Washington, D.C.

These analyses consider "rate of intake" and not the number of individuals picked up in each period. One could argue that just as many individuals are being picked up in the post-ARA period as in the pre-ARA period with the only difference being a lower rate of recidivism in the latter period.

Table 3 represents an estimate of the number of individuals that the police processed in four pre-ARA years (calendar 1964, 1966, 1967, 1968) to test the "revolving door" argument as an explanation for the higher police pick-up rates before decriminalization. Since the police have no record of the number of individuals they processed for public drunkenness in the pre-ARA period, court records (The D.C. Court of General Sessions Index) listing cases for each calendar year in alphabetical order were used.

Because the District's Court of General Sessions processed only a percentage of the total police arrests (some individuals forfeited their collateral), the court estimate for the number of drunk arrests per individual for each sample year is divided into the police arrest rates for that particular year to obtain an estimated total number of different individuals arrested for drunkenness. It should be noted that this estimate is undoubtedly inflated because more individuals with multiple arrests would be processed in the courts while the more affluent single offenders would forfeit their collateral.

TABLE 2.--Arrest statistics for Prince Georges County, Maryland, public inebriation and disorderly conduct, 1964-1973[a]

Year	and offense	Situations reported[b]	Total persons arrested
1964	P.I.	1,960	961
	D.C.	6,102	940
	Total	8,062	1,901
1966	P.I.	1,735	1,215
	D.C.	2,920	967
	Total	4,655	2,182
1967	P.I.	1,664	1,456
	D.C.	1,809	2,147
	Total	3,473	3,603
1968	P.I.	720	748
	D.C.	1,149	1,276
	Total	1,869	2,024
1969	P.I.	88	92
	D.C.	1,380	1,413
	Total	1,468	1,505
1970	P.I.	1	34
	D.C.	625	1,868
	Total	626	1,902
1971	P.I.	0	1
	D.C.	1,361	1,712
	Total	1,361	1,713
1972	P.I.	1,503[c]	0
	D.C.	1,020	1,156
	Total	2,523	1,156
1973	P.I.	1,454	0
	D.C.	767	885
	Total	2,221	885

[a]From the official records of the Prince Georges County Police Department.

[b]"Situations Reported" refers to citizens' complaints to the police. These situations are recorded according to how the complainant describes them.

[c]This sudden increase has been explained as due to a change in the recording system on the part of the County Police.

TABLE 3.--Estimate of number of individuals arrested by police, 1964, 1966, 1967, 1968

Year	Rate of arrest[a]	Court sample recidivism rate[b]	Estimation of indivs. arrested[c]
1964	44,107	1.58	27,916
1966	42,189	2.59	16,289
1967	31,860	1.48	21,527
1968	14,354	1.23	11,670

[a]Based on official statistics, Metropolitan Police Department, which are compiled on a FY basis. A rough conversion, using 50 percent of each FY has been made to bring these data into congruity with the court data.

[b]Based on sample of arrested individuals, D.C. Court of General Sessions Index, by calendar year.

[c]Rate of arrest divided by court sample recidivism rate.

Due to the thorough record-keeping of Mrs. Doris Bradley, Director of the D.C. Detoxification Center, post-ARA statistics exist on the number of individuals admitted to Detox for each post-ARA year. It is assumed that self-admissions in the post-ARA era would have been primarily police pick-ups in the pre-ARA era. Table 4 shows the total number of individuals admitted to the Center on a calendar year basis.

TABLE 4.--Total number of individuals delivered to Detox, calendar years 1969-1973[a]

Year	Rate of admissions	Recidivism	Individuals admitted
1969	11,695	3.03	3,856
1970	14,293	3.32	4,310
1971	14,845	3.15	4,707
1972	12,465	2.87	4,345
1973	10,436	2.68	3,893

[a]Official statistics of the Men's Detoxification Center.

Graph 6 demonstrates that after controlling for the revolving door phenomenon, the number of individuals picked up by the police in the post-ARA period has shown a significant decrease. It should be noted that if one adds the approximately 500 individuals delivered yearly by the police to the Female Detox Unit since January 1972, the discrepancy in police intake still remains significant.

c. Continued criminal processing. While these analyses of relevant control hypotheses are not definitive, they certainly do not explain the observed differential rates of police pick-ups and deliveries before and after decriminalization. Even given the tentative and limited quality of the data, it tends to support the conclusion that a substantial number of public inebriates in the District of Columbia are not being formally processed, but are either ignored, handled by informal means, or possibly are arrested under other criminal charges.

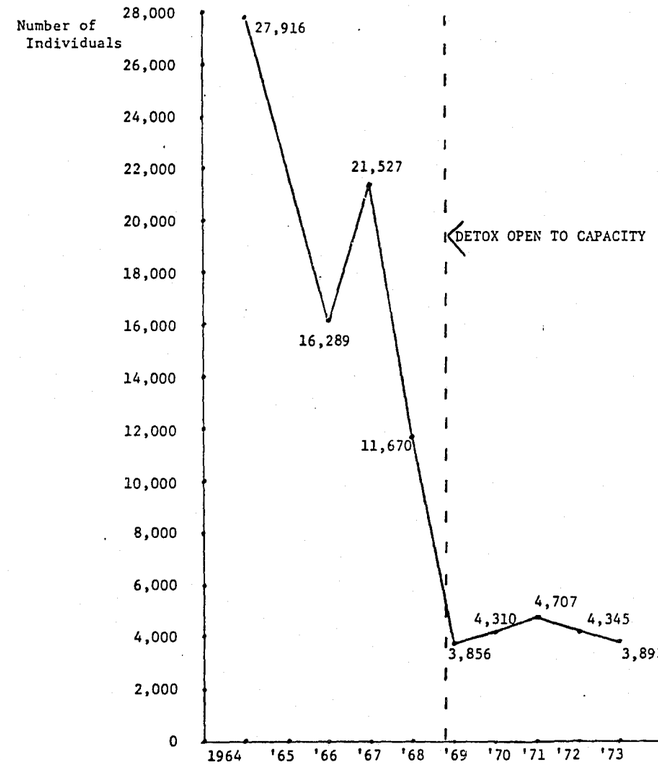
The possibility of processing under other criminal charges might be either a legitimate disposition reflecting an increased incidence of "other crimes" among public inebriates or simply an impermissible method of disposing of a street problem. We sought to explore whether this mode of disposition might be a viable explanation for the numerical discrepancy in pick-up rates.

Interviews were conducted with court personnel to determine whether such a practice was occurring and, if so, to find out what offenses were being used for this purpose. Those interviewed indicated that public inebriates were not being processed by the courts under other charges to any marked degree. Some further suggested that because charges such as disorderly conduct and vagrancy were often attached to public drunkenness charges in the pre-ARA period, the criminal justice system has seen a reduction in these offenses in the post-ARA era.

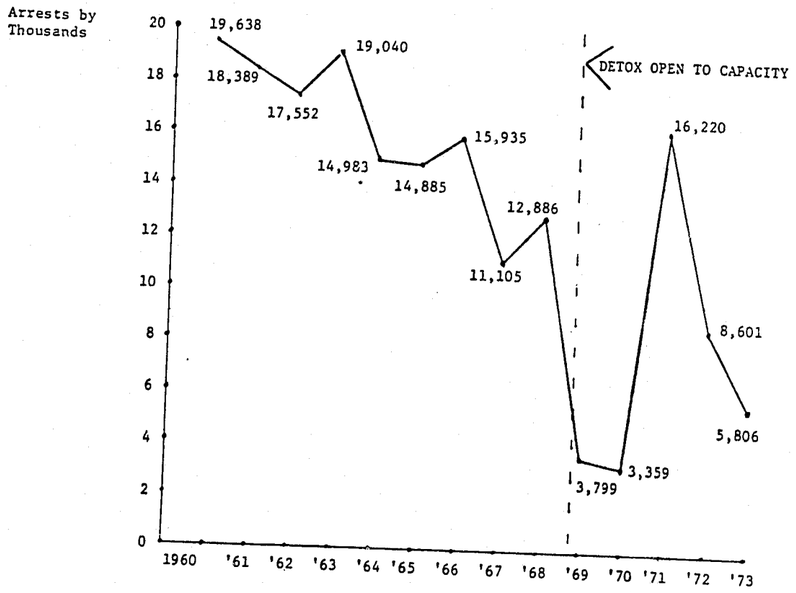
We obtained official police statistics to probe these assertions. As indicated in graphs 7 and 8, official arrest statistics from the Metropolitan Police Department establish that disorderly conduct and vagrancy charges have decreased substantially in the post-ARA period. The sharp increase in disorderly conduct arrests in fiscal year 1971 is most likely attributable to anti-war demonstrations. Over 9,000 of the arrests took place in May 1971, the month of the "May Day Demonstrations" in Washington, D.C. The official statistics and the information derived from the interviews strongly suggest that other crimes are not being used to any significant extent to process public drunks.

The only explanations remaining are that public inebriates in the District of Columbia in the postchange period are either ignored or are disposed of by informal means such as ordering them to move on or otherwise removing them from public view. Direct observation and interviews with police officers and others interested in the public drunkenness problem in the city lent added credibility to this conclusion. Public drunkenness is not as great a police problem at the present time as it was in the past, partially because it is not accepted as a significant police problem. Ignoring the public inebriate or disposing of him informally have become viable alternatives.

GRAPH 6.--Individuals picked up by police for public drunkenness, pre- and post-ARA calendar years 1964, 1966, 1967, 1968, 1969-73

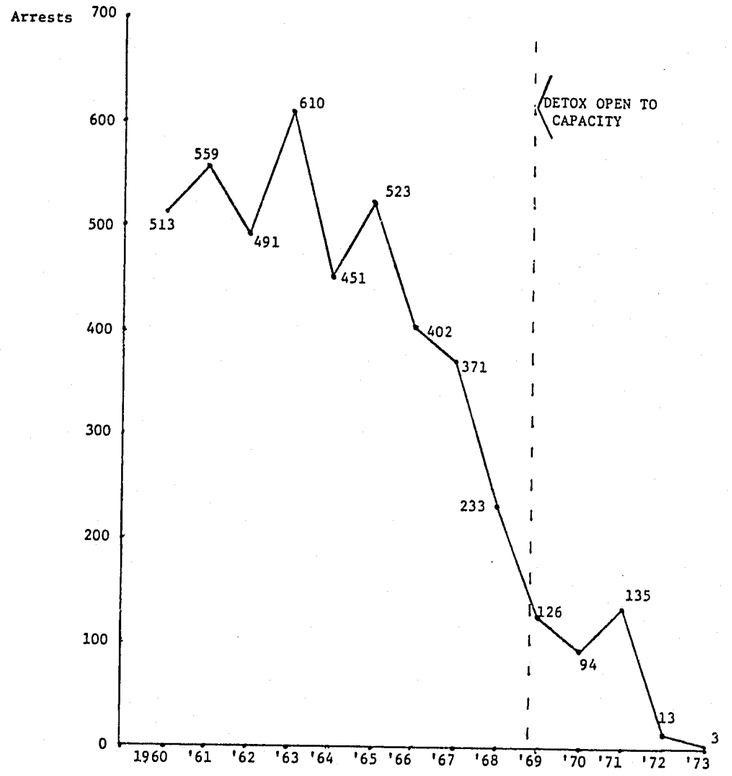


GRAPH 7.--Disorderly conduct arrests,[a] District of Columbia, fiscal years 1960-1973



[a]Figures are official statistics of Metropolitan Police Department, Washington, D.C. Annual Reports, 1960-1973.

GRAPH 8.--Vagrancy arrests,[a] District of Columbia, fiscal years 1960-1973



[a]Figures are official statistics of Metropolitan Police Department, Washington, D.C. Annual Reports, 1960-1973.

4. Qualitative Impact. Examination of the decline in drunkenness pick-ups in the years following decriminalization on a district-by-district basis reveals an interesting item of information. Table 5 indicates that while there were fewer pick-ups in every police district, the rate of decline from one period to the next was not uniform throughout the city. Had the rate of decline in the transition from the pre- to the post-ARA period remained constant across district boundaries, each district would continue to account for the same percentage of total number of pick-ups in the latter period as it has in the former. In reality, however, as table 6 indicates, District 1 exhibited a marked increase in the percentage of public drunkenness cases following the opening of the Detoxification Center. This strongly suggests that the Center is being used by the Metropolitan Police Department to service the large number of skid-row inebriates in District 1, and that officers in other police districts who deal with predominantly nonskid-row inebriates are not using the Center as extensively. This supports the hypothesis that police pick-ups of public inebriates following decriminalization have become far more focused--the concentration is increasingly on the homeless inebriate.

If data were available, we might directly compare the characteristics of the inebriates handled pre-ARA and those cared for by the Detoxification Center. There is, however, very little precise information on the characteristics of the public inebriate population arrested in the pre-ARA era. The Karrick Report concluded in 1957 that the police picked up a wide range of public inebriates including social drinkers, youthful offenders, and problem drinkers. They did not concentrate solely on the chronic skid-row inebriate. On the other hand, studies of individuals entering the Alcoholic Detoxification Center following decriminalization indicate a population largely made up of chronic skid-row inebriates:

> "The composite picture is that of a black man, not married, who tends to be in his mid-forties, having completed ten years of education, of low socioeconomic status . . . . He has an average of 18 prior admissions to the Alcoholic Detoxification Center."[25]

To further assess the qualitative impact of decriminalization, we collected data on the characteristics of the public inebriate population in both periods. Through a random sample from police records of individuals arrested for 2 pre-ARA years (1963, 1967), and a similar sample from the files of the Detoxification Center for 5 post-ARA years (1969, 1970, 1971, 1972, 1973), we have: (1) created a comparative background profile and (2) developed indicators for two of the three characteristics often associated with skid-row inebriates--low socioeconomic status and undersocialization. No indicators of institutional dependence appear in the comparative samples.

The low socioeconomic status occupation indicator fails to show a difference between the pre- and post-ARA populations. Of those reporting on their occupational status from the pre-ARA sample (N=379) 64.1 percent indicate no occupation, unskilled, or semi-skilled; in the post-ARA sample, 64.9 percent (N=412) identify themselves as unskilled or semi-skilled.[26]

To develop one additional measure of socioeconomic status for the post-decriminalization sample, we took note of the addresses of public inebriates admitted to Detox who reported their residences. As we expected, public

TABLE 5.--Police arrests for public drunkenness by district, FY 1960-1968[a,b] and estimate of individuals picked up by police by district, FY 1970-1972[c]

Districts	1960	1961	1962	1963	1964	1965	1966	1967	1968	1970	1971	1972
1	13,890	13,431	14,781	15,110	14,109	14,300	16,208	15,847	10,666	3,013	4,999	6,342
2	2,560	2,199	2,527	2,558	2,175	2,093	3,507	3,195	2,325	838	1,280	848
3	9,537	10,639	11,814	11,901	11,102	11,130	10,735	5,706	4,150	838	461	984
4	5,369	4,711	5,256	5,369	4,865	5,735	5,549	4,148	2,824	334	1,280	286
5	5,972	6,539	8,180	8,773	7,902	7,220	5,780	3,969	2,724	504	1,045	848
6	1,817	1,673	1,773	1,866	1,680	1,589	1,582	1,163	843	-	-	-
7	889	1,224	1,338	1,467	1,719	1,961	2,390	2,151	1,888	-	-	-

[a]Based on official statistics of Metropolitan Police Department, Washington, D.C.

[b]Some estimations have been made because of the redrawing of police district lines (precinct to district system).

[c]Based on sample from Men's Detoxification Center.

TABLE 6.--Percentage of police pick-ups[a] by district, FY 1960-1972

Districts	1960	1961	1962	1963	1964	1965	1966	1967	1968	1970	1971	1972
1	35	33	32	32	32	32	35	44	42	54	55	68
2	6	5	6	5	5	5	8	9	9	15	14	9
3	24	26	26	25	25	25	23	16	16	15	5	11
4	13	12	11	11	11	13	12	11	11	6	14	3
5	15	16	18	19	18	16	13	11	11	9	12	9
6	4	4	4	4	4	4	3	4	3	-	-	-
7	2	3	3	3	4	4	5	6	7	-	-	-

[a]Based on table 2.

inebriates reside in service areas with the highest percentage of socioeconomic, health-related problems. Table 7 reveals that 63.7 percent of the public inebriates admitted to Detox reside in the three most deprived service areas. Note that this figure does not include those admitted to the Center who report no permanent residence.

TABLE 7.--Residency of public inebriates, by service area

	Rank[a]	Service area	Public inebriates'[b] residency (%)
Most SES problems	1	6	29.1
	2	5	12.4
	3	7	22.2
	4	3	5.0
	5	4	6.3
	6	9	8.0
	7	1	7.4
	8	2	4.2
Least SES problems	9	8	5.4

[a]See D.C. Department of Human Resources, "Demographic, Social, and Health Characteristics of the District of Columbia by Service Areas," Office of Planning, April 1973, pp. 5-6.

[b]From random sample, Men's Detoxification Center Permanent File Data (Sample Size = 766; Missing Cases = 306). Combined sample, Calendar 1969, 1970, 1971, 1972, 1973.

a. Undersocialization. Table 8 reveals the degree of undersocialization by showing the low rate of marriage among public inebriates included in our Detox sample. Only 17.9 percent of those revealing their marital status were married; over 60 percent of the public inebriates were either single or separated. This differs greatly from the pre-ARA finding in which 38.8 percent (N=376) reported that they were married and only 9.0 percent (N=376) indicated that they were divorced or separated.

TABLE 8.--Frequency distribution of public inebriates' marital status[a,b]

Marital status	Absolute frequency	Relative frequency (%)	Adjusted frequency (%)	Cumulative adj. freq. (%)
Single	154	20.1	32.0	32.0
Separated	147	19.2	30.6	62.6
Widowed	23	3.0	4.8	67.4
Divorced	71	9.3	14.8	82.2
Married	86	11.2	17.9	100.0
Missing	285	37.2	-	100.0
Total	766	100.0	100.0	100.0

[a]Based on permanent file record of Men's Detoxification Center.

[b]Combined sample, Calendar 1969, 1970, 1971, 1972, 1973.

b. Summary. Besides being intoxicated, the public inebriates admitted to the Detoxification Center in Washington, D.C. have the following traits: mid-forties, black, single or separated, low educational and occupational skills, and residence in areas with high percentages of socioeconomic and health problems. These traits are characteristic of the skid-row public inebriate. The nonskid-row public inebriate rarely finds his way into the Detoxification Center. Direct observation and interviews with police and Detox personnel tended to confirm this finding. These nonskid-row inebriates have minimal contact with public health facilities purportedly designated for the intake and treatment of all public inebriates. Such selective enforcement practices in the post-ARA era raise serious doubts about decriminalization's ability to meet at least two of the principal goals articulated by supporters:

(1) increased potential for rehabilitation/resocialization (i.e., skid-row inebriates are the least likely to respond to rehabilitative attempts), and

(2) improved constitutional protections for public inebriates (i.e., equality of treatment under the law is not being provided).

Conclusions. While we will explore the explanations for these impact results in chapter 3, a few tentative conclusions are in order. At least four factors were relevant in reducing police attention in Washington, D.C. to the problem of public intoxication following decriminalization. First, the "order maintenance" function that various forces expected the police to carry out was neglected in part because the police department played almost no role in the

formulation of the new policy. There was no effort to accommodate the new police tasks with their traditional functions and to make the MPDC a partner in the new enterprise.

Coupled with this lack of foresight was the expectation of police officers that the Detoxification Center would serve as a substitute for jail.[27] This, in turn, resulted in a wide gap in expectations among police officers on the one hand and public health officials on the other, as to what Detox was supposed to accomplish. Therefore, patrol officers almost uniformly expressed anger at seeing inebriates back on the street within 24 hours of having delivered them to the Detoxification Center.[28]

Third, decriminalization's impact on police intake suffered from the problem of "bad timing." In the mid- and late-1960's, the Metropolitan Police Department hoped to give less attention to victimless crimes in order to meet new pressures, particularly the rise in serious crime in the District and the increase in civil rights and antiwar protest activities.

Fourth, the MPDC failed to create any incentives for officers to pick up public inebriates after decriminalization. The tabulation of intakes as one measure of officers' performance was discontinued and only sporadic efforts were made to enforce written directives to patrol officers.

All these factors contributed to the present state of street decision-making. Decisions on whether to pick up inebriates or leave them in the street are shaped largely by officers' perceptions of both the inebriate and outside pressures. The resulting intake practices decrease the potential for rehabilitation/resocialization of the inebriate population, and raise serious questions whether the intended emergency and health services are being extended to these inebriates.

D. ST. LOUIS, MISSOURI

St. Louis is generally regarded as a city which has "decriminalized" the offense of public drunkenness. In fact, the public inebriate in St. Louis continues to be subject to arrest or to booking for protective custody.[29] Further, while statutory provision is made for diversion of arrested inebriates to treatment facilities by the Warden of the Workhouse,[30] or of chronic inebriates to such facilities by the court,[31] there is no legal provision governing police diversion of inebriates from the criminal justice system. Nevertheless, most public inebriates formally processed by the police are taken to a detoxification center rather than to jail. It is necessary, then, to consider how this rather unique system of diversion began and developed and the objectives that its supporters hoped to achieve.

1. The Legal Context. The St. Louis detoxification program, the first in the nation, can be said to have begun when the Alcoholic Treatment Rehabilitation Center (ATRC) at Malcolm Bliss Mental Hospital was opened in February 1962. This facility became a demonstration project, focusing community attention on the possibilities for treating the chronic alcoholic. The ATRC was inspired by David J. Pittman and Laura Root of the Social Science Institute at Washington University and Dr. Joseph B. Kendis who became Medical Director of the Center. They became an active force in arguing the therapeutic case for the decriminalization of public drunkenness.[32]

CONTINUED

1 OF 3

In 1963, members of the St. Louis Metropolitan Police Department visited the ATRC. The same year the police initiated a pilot program, apparently at the urging of the ATRC group, to encourage increased pick-up of those intoxicated in public and to assure an initial medical screening of inebriates at a city hospital.[33] Police officers were ordered to "extend every effort to arrest and remove intoxicated persons from the streets, alleys, and public view." The arresting officer merely had to call for a two-man police cruiser and then he could return to duty. The Intoxicated Person Report was to be completed by the officers in the pick-up cruiser who were also responsible for transporting the inebriate to a hospital for medical diagnosis and then to the Central Police Headquarters for booking.[34] Training programs on handling the public inebriate were given by Dr. Kendis.[35] Drunk on the Street arrests more than doubled in the 7 months the procedure was in operation.[36]

The relationship between the therapeutic and law enforcement interests was to persist. In 1965, both groups began to urge that funds be secured from the Law Enforcement Assistance Administration for the creation of a detoxification center. Captain Frank Mateker, head of the SLPD Research and Planning Division, suggested the need for such a center to department officials. Col. Edward Dowd, the President of the St. Louis Board of Police Commissioners, a prime mover in the project, urged the Division to draft a proposal. The St. Louis Police Department became the first police department in the country to apply for funds to create a Detoxification Center for servicing public inebriates.[37]

While the original grant application was for $318,496 to fund a 60-bed unit, the Law Enforcement Assistance Administration awarded $158,781 in October 1966 to fund a 20-bed unit at the St. Louis Detoxification and Diagnostic Evaluation Center. One month later, the Center began offering medical treatment and supportive social and rehabilitative services at St. Mary's Infirmary, a hospital run by the Sisters of St. Mary. Dr. Kendis became the Center's first medical director, and Laura Root served as consultant. Over 20 community organizations sent representatives to be briefed on the Center's operations, and Center staff made personal visits to various interested community groups.[38] Every effort was made to attract public attention and support for the project.

Originally, the Center limited its admissions to police cases from the Fourth District, which had accounted for over 50 percent of all drunkenness arrests in 1966. Within 1 month, the Third District was added, and in March 1967, the Ninth District was included. These three districts accounted for 82 percent of the city's 1,733 drunkenness arrests in 1966.[39] The remaining six police districts did not formally participate until 1970, although it appears that some of those arrested in these six districts found their way into participating districts and were delivered to the Center.

Police regulations,[40] originally drafted in 1967 in response to the new program, provide that if there are

(1) no other charges against a person arrested for public drunkenness;

(2) no signs of injury or illness requiring emergency hospital treatment;

(3) no complainant wishes to pursue the incident as a prosecuting witness;

(4) the inebriate does not indicate the desire for criminal treatment; and

(5) if room is available,

the arresting officer is to request a Code 27 conveyance from the dispatcher, transport the inebriate to the Detoxification Center, and fill out an admitting form. A wanted check is to be made, a police admitting form is to be completed, and a court summons charging public drunkenness is to be issued. The subsequent stay of the inebriate at the Center is designated by the regulations as "strictly voluntary." However, if he leaves before medical release (usually 7 days), the summons is supposed to be forwarded by Detox personnel to the police, who are to apply for a warrant. The summons was devised as a means of assuring the continued cooperation of the "voluntary" admission although "elopers" are seldom prosecuted. If the inebriate is a "defendant-not-found," the regulations provide that his next arrest should result in booking and court trial, but this provision does not seem to be implemented. If the inebriate remains at the Center for the treatment period, the summons is voided and there is no arrest record since the formal police report is never filed.[41]

If these conditions for Code 27 are not met, the police regulations indicate that the arrested intoxicated person should be processed as a Code 25, the traditional method for processing public inebriates. He is taken to one of the two city hospitals and then to Prisoner Processing at Central Headquarters for booking as a drunk-on-street. The officer prepares an Intoxicated Person Report and applies at the City Counselor's office for an information (warrant). The inebriate is then tried in City Court.

Although a charge of Protective Custody is available in principle only for drunkenness in a private place, this offense has been heavily used for processing public inebriates. In the early and mid-1960's, pick-ups on this charge exceeded drunk-on-street arrests by a 2 to 1 ratio, although this is no longer the case. Under the Protective Custody charge, an individual is retained in custody for up to 20 hours and then released. The police do not seek a warrant. Since there is a police Intoxicated Person Report, the charge is added to the person's police record. There are indications that this device is being phased out after the city attorney expressed reservations about its legality.[42]

The law on the books, then, makes all persons intoxicated in public guilty of a misdemeanor. Police regulations (with the apparent agreement of the City Prosecutor's Office) provide alternative formal dispositions of the arrested inebriate. In addition to these approved formal dispositions, there are a number of unapproved, informal dispositions such as telling the inebriate to move on, taking him home, moving him to a difference place, and doing nothing.

The cooperation of therapeutic interests and the police in the establishment of the Detoxification Center was reflected in the Center's goals. In the original grant proposal, five goals were set forth:

- to remove chronic inebriates to a sociomedical locus of responsibility which will markedly reduce police processing;
- remove chronic inebriates from the city courts or jail;
- provide sociomedical treatment for them;
- begin their rehabilitation; and
- refer them to an agency for further rehabilitation with the goal that they will return to society as productive persons.[43]

While one finds references to other objectives such as preventing crime, the two goals of saving criminal justice resources and promoting rehabilitation tend to dominate in police correspondence and news articles.[44] There seems to have been far less emphasis on the short-term well-being of the inebriate through provision of emergency services than on the possibility of longer term rehabilitation. The 7-day detention in Detox reflects this orientation.[45] After a brief period in intensive care, the inebriate spends his time in therapy, counseling, and developing a program for aftercare.[46] The Grant Application states simply: "The chronic court and police case inebriate have a potential for rehabilitation."[47] While concern for providing emergency services was clearly present--the initial 2 days at Detox are devoted to acute emergency care[48]--the emphasis on rehabilitation is marked.

There seems to have been little question about the target population to be serviced by the new program. In the Detox Center's final evaluation report, it was stated that "the target group 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."[49] The SLPD generally followed a pattern of non-action and informal disposition of public inebriates when action was required and regarded arrest as a last-resort mechanism for the down-and-out and predominantly "skid-row" inebriate. Given the common target population, the goals of rehabilitating homeless persons and conserving criminal justice resources were thus generally compatible in St. Louis.

At first, Detox officials accepted marginal success in rehabilitation while providing emergency services to those in greatest need of assistance. But as new officials took over and the Center became more institutionalized, there was increasing concern about readmissions.[50] Recidivism, however, might decline if the population serviced by the Center was changed. In 1973, Detox stopped reserving beds for police cases, and patients were taken on a first-come-first-serve basis.[51] The Center accepted more volunteer admissions which resulted in fewer skid-row patients.[52] The ratio of voluntary admissions to police admissions was radically altered.[53] Detox officials submit that more inebriates are finding their way to the Center on their own.[54] There are also indications that police drop the inebriates off at the Center and let them admit themselves.[55] In any case, police officers report that they frequently find the Center filled--there is less room for the emergency case, the chronic police case inebriate. As a result, police referrals to Detox decreased substantially in 1974, after 4 years of general increase.[56] Center officials were said by police officers interviewed to have shown increasing reluctance to take chronic cases and to have released inebriates before the end of the

7-day period. Even as the Center continued to proclaim its interest in rehabilitation and the success of its rehabilitation program, police officers continued to encounter the same inebriates on the street day after day.

The close involvement of the SLPD with the initiation of Detox explains the Department's initial enthusiasm for the Center. Extensive training programs for recruits and police officers were conducted. Special orders for processing public inebriates were issued. Later, financial support was provided by the Department.

The location and personnel of the Center also contributed to the initial favorable police reaction. St. Mary's was located near the downtown business district, readily accessible to the skid-row areas of the city. The sisters who ran the infirmary and assisted in the hospital were warm and friendly to police officers.[57] The involvement of the Washington University Institute gave the operation an aura of professionalism.

But difficulties soon arose. When federal funds were exhausted, the Center was required to move to the State Hospital to secure state funding. This location was far removed from the main areas of drunkenness arrests--about a 20- to 30-minute ride each way. The new center lacked the cordial atmosphere of St. Mary's. Increasingly, police were required to spend substantial time at the Center until a medical officer was available to check the inebriate. After all police districts were included in the program and as the rate of voluntary admissions increased, the limited number of beds were frequently filled. As a result, police training programs and official enthusiasm began to wane--there was essentially no organizational impetus for pick-up and delivery of inebriates to the Detoxification Center.[58]

An example of this change is police training, currently handled by the Greater St. Louis Police Academy. There has been some training in problems of alcoholism since 1962, and there were 6 hours devoted to the subject after the opening of the Detox Center.[59] Now less than 2 hours of a 640-hour training program are devoted to the subject. Even this figure is overstated since Detox procedures are taught in connection with the subject of Driving While Intoxicated.[60]

The primary methods of formal communication within the Department are:

(1) the Police Manual, consisting of General Orders and the rules and regulations issued by the Board;

(2) verbal communications at Commanders' meetings;

(3) Administrative Orders issued to all persons of the rank of sergeant or above;

(4) Bureau Orders issued by the bureau affected;

(5) Special Orders to all commissioned personnel for standardizing and formalizing procedures; and

(6) memoranda for a particular district or patrol area that are included in the station desk book and read at roll call.

A search of each of these revealed--with a few notable exceptions (primarily in 1963 and 1967 when Detox was open)--an absence of concern. There is nothing in the present Police Manual. An 8-year review (1963-1970) of the minutes of Commanders' meetings produced nothing for 1964, 1965, 1968, 1969, or 1970, and interviews indicated that the subject has not come up since that time. Nothing appears in Administrative or Bureau Orders from 1966 to the present. The procedures for processing public inebriates have been spelled out in Special Orders. Two Fourth District station desk books, which were reviewed for several winter and summer months, did not contain a single notation regarding public intoxication.

The extent to which the initial favorable police response and the subsequent period of disenchantment affected police arrest patterns remains to be discussed. But before turning to that subject, it is necessary to describe the citywide and police district (i.e., target district selected for this study) environment in which the St. Louis police operate. This includes police attitudes and behavior.

2. The Environmental Context for Policing. St. Louis, a city of 622,235 (1970 Census), ranks 18th in size in the nation.[61] Like most cities in the Midwest and East, it is an old city experiencing rapid deterioration, a shrinking population in the central city, an increasing proportion of older, poorer, and more unskilled persons, and a diminishing tax base. The city's black population rose from 29 percent to 44 percent in the 1960's.

The St. Louis City Planning Commission identified three characteristics of the urban population:

> "(1) a high percentage of households with a female head (21 percent citywide);
>
> (2) an unusually high proportion of elderly residents, 65 years and over (14.7 percent as contrasted to a national average of 9.8 percent); and
>
> (3) a relatively high proportion of households living in poverty (26.5 percent as contrasted to a national average of 19.1 percent)."[62]

All these characteristics are associated with a host of social problems, including high rates of illegitimacy, high numbers of dependent children, drugs, crime, anomie, and housing deterioration.

St. Louis has one of the highest crime rates in the nation. Crime has been increasing more rapidly than in the rest of the nation, even though the city has more police in absolute numbers (2,200 in 1970) than all but eight other cities. Police estimate that there are at least 3,500 heroin addicts in the city and 7,000 or more users of other illegal drugs. We were unable to discover any hard figures on the number of alcoholics in the city. The estimate of 100,000, based on the Jellinek formula, has been used by the Council on Alcoholism for the past 5 years.[63]

If one examines a map of St. Louis indicating the areas of highest crime, poverty, poorest health, urban blight, or almost any other urban social

problem, it will be plain that the prime problem areas lie in the central belt extending from the downtown area on the Mississippi River northwestward. The worst areas lie on either side of the Highway 40 corridor running down the center of the city. It is in this area that public intoxication arrests have always been concentrated. This area includes the historic skid row, located around the old courthouse and Eads Bridge riverfront. It should be noted that Highway 40 forms a rough demarcation line between St. Louis' white ethnic and black populations.

In an attempt to revive the central city, a major effort at urban renewal has been launched. Much of the downtown area bordering on the Mississippi River had been torn down and rebuilt as a tourist center. As a result, the concentrated skid row has been eliminated except for a small pocket bordering the tourist and business district. This does not mean, however, that the public inebriate or even the skid-row inebriate has disappeared from St. Louis. Rather, the skid-row public inebriate population is more diffused; many moved west of the downtown area. There is also substantial weekend drinking and public drunkenness by blue-collar whites and low-income blacks in their own residential areas. Finally, St. Louis continues to be a major transportation center, and the problem of transient public drunkenness is visible in the area surrounding the bus terminals and railroad yards.

The Fourth Police District. The Fourth Police District extends westward from the Mississippi River, at the center of the eastern border of St. Louis. It was in this area that the city was founded and spread outward. Prior to the 1940's, there was a shantytown area, home to a large number of homeless and semi-homeless persons, including many alcoholics. In the late 1940's, 1950's, and 1960's, the city undertook a major renewal effort in the area. Today, it is the center of the downtown business and entertainment area, city, state, and federal government offices, tourist attractions, the bus station, and the central sports arena.

Part of the old skid row remains, however. While luxury hotels and apartments border the Mississippi on the east side of the District, there are large areas of poor to very poor residential dwellings on either side of the business district. Urban renewal projects can be found in the western part of the District. Indicative of the poverty of much of the area is the fact that it has one of the highest tuberculosis and infant death rates in the city.[64]

In short, the Fourth District is an area of contrasts. Police encounter all classes of public inebriates from the skid-row alcoholic to the middle- and upper class inebriate leaving the downtown nightclubs and restaurants. It has always had the highest arrest rates for public drunkenness in the city.

The Third Police District. The Third Police District, containing the Soulard neighborhood and running westward from the Mississippi River, borders the Fourth and Ninth Districts on the south.[65] It is predominantly white ethnic, with the mixture of Slavic, Germanic, and Italian inhabitants retaining strong ethnic identification. Like the city generally, the Third District is old (in 1970, about 88.9 percent of the houses in Soulard had been constructed before 1939) with a declining population and an increasing proportion of older inhabitants. There is a high rate of property crimes.

It is primarily a lower middle-class residential area, although there are a number of factories including Anheuser Busch. There is also a poor, more transient area on the northern border of the District. For the most part, residents are blue-collar workers with an average income of $4,000 to $8,000 a year. The public inebriate in the Third District is generally a blue-collar worker out for a long weekend. Local neighborhood bars are plentiful.

The Ninth Police District. The Ninth Police District in the center of St. Louis extends westward from the western border of the Fourth Police District to Forest Park. It is predominantly black, with a mean income of less than $4,000 a year. There are numerous vacant buildings and a high level of unemployment. It is also an area of considerable transience. Street drinking and public drunkenness are common.

The Eighth Police District. This is an overwhelmingly black residential area and the only police district with a black commander. While it is characterized as low income, high unemployment, and fairly high infant mortality, it has a generally stable population. It also has the highest crime rate of the three downtown areas. In spite of indications of a substantial amount of public intoxication and the use of a patrol car to control public drunkenness, there are almost no deliveries to Detox and the yearly arrest rates for public drunkenness have been generally low.

3. Quantitative Impact. Figures 6 and 7 provide the General and Specific Research Frameworks on the impact of policy change in St. Louis. We hypothesized that, controlling for alternative explanations, the number of formal approved police pick-ups had dropped significantly. The complexity of police formal dispositional options in St. Louis as well as the lack of monthly data covering some of those options prohibited us from including this jurisdiction in our assessment of the material trend. Therefore, we begin our treatment of St. Louis by investigating this primary impact hypothesis.

FIGURE 6.--General research framework: St. Louis, Missouri

Policy goals (As defined in Detox Center Project Application, statements of actors)	Organizational reaction (1967 St. Louis MPD regulations)	Policy impact (Decreased formal intake of public inebriates)

FIGURE 7.--Specific research framework: St. Louis, Missouri

Alternative approved dispositions	Control factors	Policy outcomes
Deliver to Detox	Size of problem drinking population	Numerically less approved dispositions of PI's by police
Arrest for public drunkenness (protective custody??)	Size of public inebriate population	Nonapproved disposition of PI's by police
Self-admissions*	Migration from the jurisdiction	
	Recidivism rates: "The Revolving Door"	

*This is not a police option but it is an approved mode of intake of public inebriates to the public system.

In spite of the fact that St. Louis at the time of policy change in November 1966 was an old and fairly large urban area with a public drunkenness problem roughly comparable to that in similar cities, it has always had a very low level of arrests for public drunkenness. When Washington, D.C., a somewhat larger city, was averaging 40,000 arrests per year, St. Louis averaged 2,000 to 3,000. The arrest rates for the prechange period are indicative.[66]

TABLE 9.--Police drunkenness arrests, St. Louis, Mo., 1960-1965

1960	2,853
1961	2,768
1962	2,978
1963	7,847
1964	3,786
1965	2,488

A number of reasons might be given for this extremely low arrest pattern. As indicated above, St. Louis is an old city with a large ethnic population more tolerant of heavy drinking. The city's history as riverfront community would also support a cultural milieu more tolerant of public intoxication. Certainly, complaints about public drunkenness by the public and business concerns seem to have been far less than in other cities we studied. Further, the St. Louis MPD has always emphasized the high quality arrest and deemphasized the low quality arrest, perhaps because of its high crime rate. For example, in 1965 Washington, D.C. and Atlanta, Georgia reported an arrest rate approximately twice as high as St. Louis. However, when drunkenness, disorderly conduct, and vagrancy arrests (i.e., low quality arrests) are excluded, the St. Louis arrest rate exceeds that of the other two cities by a 3 to 2 margin.[67] With the single exception of 1 year, 1963, a low-quality crime like Drunk-on-Street was never given a high priority by the Department. This negative attitude was reinforced within the ranks. The amount of time for criminal processing of a public inebriate, including delivery to a public hospital since 1963, added another disincentive to formally processing such cases.

Whatever the reason, the low arrest rates are extremely important to the present study. The St. Louis MPD has always stressed nonaction or informal disposition of public inebriates.[68] If some action was required, it usually involved telling inebriates to go home or transporting them to their residence. Only when the situation indicated some type of medical emergency or when public disorder occurred was an arrest made. It should be noted again that all public inebriates had to be taken to the City Hospital before criminal processing--a time-consuming unpleasant procedure. The fact that the arrest rate for drunkenness in St. Louis could be doubled in a single year suggests that a substantial number of public inebriates were not being formally processed through the criminal justice system.

The fact that such a small number of inebriates were processed criminally--most likely, predominantly hard core emergency skid-row cases--and the substantial police support for decriminalization would suggest that, while arrest rates would decline, the total number of inebriates processed, at least in the period immediately after the change, should either remain constant or increase.

On the other hand, the move of the Detox Center to the state hospital grounds, the bureaucratic inertia that developed in the early 1970's, and decreasing command level interest in the Detox operation--all disincentives to active policing--led us to hypothesize a marginal decrease in the number of inebriates processed throughout the entire postchange period.

The retention of the arrest option in St. Louis following the change complicates the matter. This option is supposedly used only when Detox is filled or for those inebriates who have an outstanding warrant because they had previously left the Center "against medical advice (AMA)." This could be used to process nonskid-row inebriates.

The SLPD conducted their own study of the first-year impact of the detoxification project on policing.[69] Significant savings in criminal justice resources were reported. There was a 50.2 percent reduction in the time required by the police officer to process the inebriate (from 95.8 minutes to 47.7 minutes), a 54 percent reduction in the number of warrant applications, a 40.5 percent decrease in the number of warrants issued, a reduction of 34.5

percent in the number of Drunk-on-Street cases handled by the City Courts, a decrease of 38.7 percent in commitments to the Workhouse, and a 41.6 percent reduction in inmate days for the DOS charge.

The Final Report to the Law Enforcement Assistance Administration indicated a 53.5 percent decline in the level of drunkenness arrests in the city between 1966 and 1967. Our own longitudinal study confirms this decrease in the postchange period. Table 10 shows the arrest rates and Detox admissions for a 14-year period, from 1960 to 1974. Graph 9 indicates arrest rates for the 14-year period and shows that the postchange arrest rates are far below the prechange rates. The possibility that this difference could be merely a matter of chance is less than .001.[70]

TABLE 10.--St. Louis drunkenness arrests and Detox admissions by source, 1960-1974

	Arrest	Detox		Total
		Police	Voluntary	
1960	2,853			2,853
1961	2,768			2,768
1962	2,978			2,978
1963	7,847			7,847
1964	3,786			3,786
1965	2,488			2,488
1966[a]	1,719	60	-	1,779
1967	796	1,120	-	1,916
1968[b]	551	1,174	-	1,725
1969	333	946	-	1,279
1970[c]	540	1,251	215	2,006
1971	463	1,317	203	1,983
1972	300	1,301	217	1,818
1973[d]	168	1,449	533	2,150
1974	301	801	1,698	2,800

[a]First admission to Detox Center (St. Mary's Infirmary, November 1966).

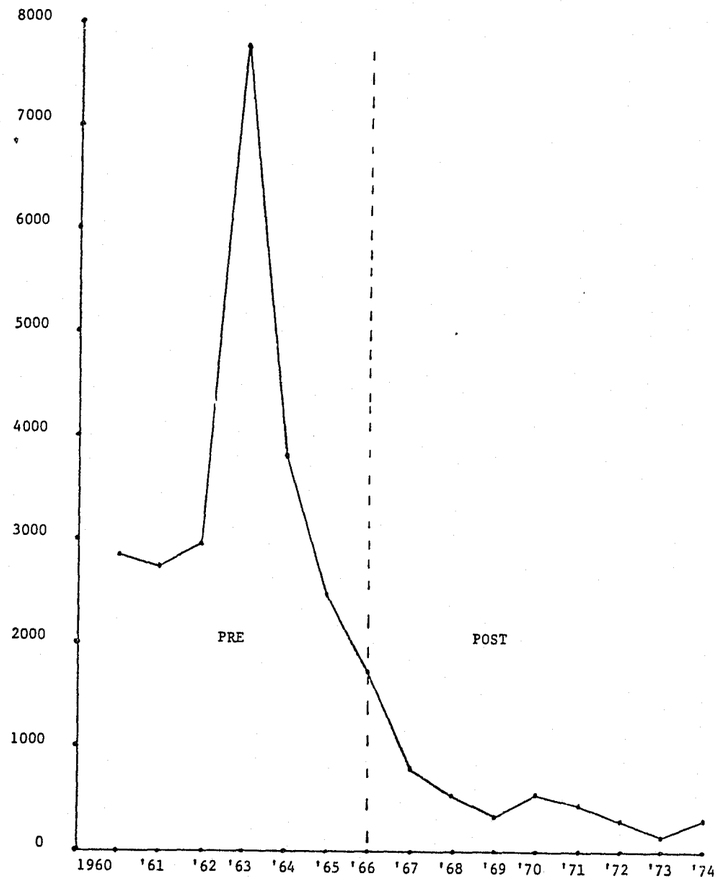
[b]Detox moved to St. Louis State Hospital in November 1968; 28-bed capacity.

[c]All police districts included. Detox begins setting aside four beds for walk-in, nonpolice cases.

[d]Bed capacity increased to 40 8/13/73. All patients accepted on first-come-first-serve basis--no beds reserved exclusively for patients brought in by the police.

Source: St. Louis MPD and St. Louis Detoxification Center.

GRAPH 9.--St. Louis drunkenness arrests, 1960-1974



Since the arrest rate had been dropping ever since the abnormally high 1963 rate, it is difficult to single out decriminalization as the critical factor. However, even assuming that the 1963 level would not be maintained, it could be expected that the rates would return to their pre-1963 level (i.e., in the 2,000 to 4,000 range). But by November 1966, decriminalization was an accomplished fact, and the arrest rates after November 1966 remained far below their prechange levels.

Graph 10 depicts arrest rates and police referral rates to Detox in the 14-year period, 1960-1974. The decrease from the prechange period is statistically significant.[71] Even when police deliveries to Detox are added to police arrests, the pick-up rates never reached the prechange arrest levels.

Graph 10 and table 11 also show that the rate of police referrals to the Detoxification Center dropped precipitously when the Detox Center was moved to the State Hospital grounds. This move entailed a 20- to 30-minute drive for police from the primary area of arrests and the locus of the major skid-row area, the Fourth Police District. Further, the atmosphere at the State Hospital, its location in a middle-class, Italian neighborhood, the changes in the staff, the diminishing command involvement, and the continuing presence of the same inebriates on the street despite the "promise" of rehabilitation were all disincentives to police delivery. However, the decline may also be due to reduced admissions while the Center was being moved and a decline in the number of beds available (from 30 to 26).[72] Raymond Nimmer, in his work, Two Million Unnecessary Arrests, noted the decrease in police delivery to Detox and claimed that it was accompanied by an increase in arrests and a much greater use of informal means to process the public inebriate.[73]

The second marked decrease in police referrals to Detox occurred in 1974 (in table 10) after 4 years of increasing or stable police admission rates. In mid-July 1973, Detox increased its bed capacity, but it also ended its practice of reserving beds for police cases. Prior to 1970, all beds had been reserved. After 1970, 24 of the 28 beds had been held for police cases. The 1973 action appears to have been taken because of controversy over the level of police support for the Center, financial and otherwise.[74] In any case, the arrest rate rose in 1974 while police deliveries to Detox decreased, and police officers reported that Detox was less available as a place for delivery (e.g., interviewees reported it was frequently filled).

Dr. Gupta, the director of Detox at that time, told newspaper reporters that he felt the enactment of a law requiring ambulance transportation of all sick persons picked up by police--patrol cars could not be used--was responsible for this decrease.[75] After 2½ months (July 1, 1974-mid-September 1974), the Board of Police Commissioners held that the law was not applicable to public inebriates if they were taken to Detox. An examination of the monthly Detox admission statistics (table 11) for 1974 does indicate a sharp drop in police admissions during the period that the law was in full operation. However, this decrease was only a small part of the total decrease for 1974, and the rate had been dropping ever since late 1973. Furthermore, the decrease in police admissions intensified in the first quarter of 1975, after the law was held inapplicable for inebriates transported to the Detoxification Center.

The police perception that Detox was frequently filled to capacity seems accurate. Records of refusals of admission were maintained by the Detox Center

GRAPH 10.--St. Louis drunkenness arrests and Detoxification Center police admissions, 1960-1974

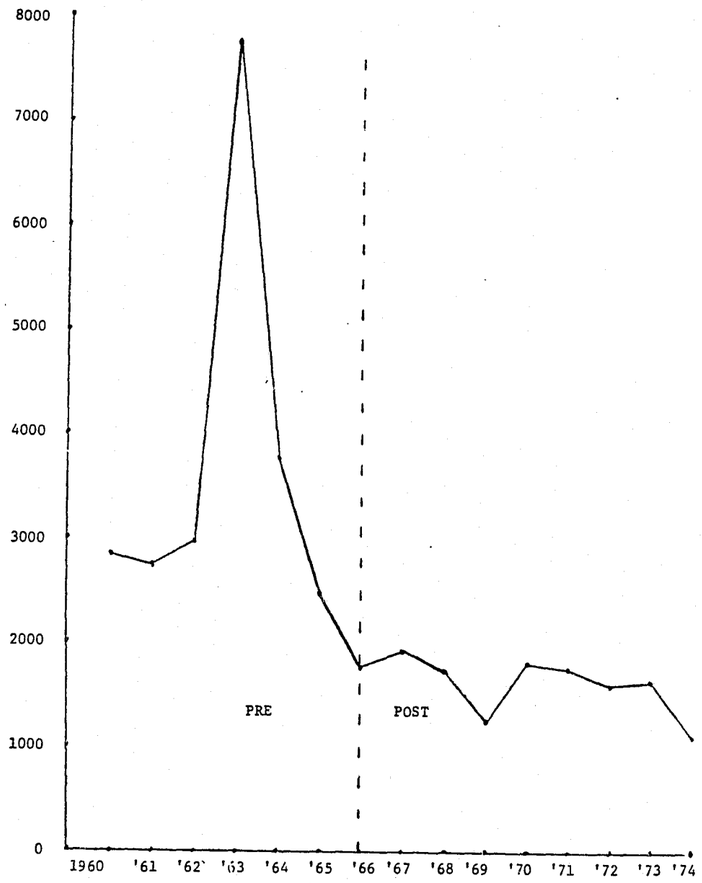


TABLE 11.--St. Louis Detoxification Center admissions, by source of admission January 1973 - April 30, 1975

	1973		1974		1975	
	Police	Self-Adms.	Police	Self-Adms.	Police	Self-Adms.
January	98	18	105	104	32	197
February	126	20	85	111	24	184
March	124	18	89	114	17	197
April	95	19	86	115	33	207
May	134	20	82	129		
June	126	21	72	135		
July	140[a]	23	49[b]	161		
August	165	92	38	187		
September	129	63	47[c]	164		
October	119	63	74	145		
November	108	80	37	167		
December	85	94	46	166		

[a]Bed capacity increased from 28 to 40. All patients accepted on a first-come-first-serve basis--no beds reserved exclusively for police cases.

[b]Law requiring ambulance and prohibiting use of police patrol cars to transport sick persons went into effect 7/1/74.

[c]Law interpreted to permit transportation of inebriates to Detox in patrol cars in mid-September 1974.

Source: St. Louis Detoxification Center, Monthly Activities Reports.

from April 1970 to July 1972. In 1971, there were over 368 persons refused admission because the Center was full; 196 or over 50 percent of these were police cases.[76] In May and June 1970, 90 and 82 police referrals, respectively, were refused because of overcrowding. In his monthly reports, Dr. Kendis, director of the Center prior to 1972, expressed concern on two occasions over the refusal rate and noted that two police cases had died following denial of admission. Center records for 1974 and 1975 indicate an average daily population of 36.6,[77] or operation at 92 percent capacity. This suggests that the Center is frequently filled to capacity. But now the population is composed primarily of self-admissions, and police officers cannot expect any beds to be reserved for their referrals.

There were two periods of significantly higher police delivery rates to Detox. The first occurred in 1967, following the opening of the project at St. Mary's. That year, the combined arrest and Detox delivery rate exceeded the previous year's arrest rate by 7 percent. Given all the positive incentives to formal police action, this was to be expected. In fact, it is surprising that the rate of increase was not higher. The 1963 arrest statistics

and estimates on the number of alcoholics in the city indicate that the pool of potential public inebriates was much larger than those picked up and that police command orders to increase pick-up rates can be effective. The low level of increase despite all the incentives present, tends to suggest police reluctance to use the Detox Center.

The police admission rate to Detox also increased in 1970 when all police districts were included in the Detoxification Center project. It is interesting to note that the 1970 increase occurred immediately after St. Louis newspapers publicized Nimmer's contention that Detox was not being used by the police.[78]

a. Alternative approved dispositions. Graph 11 includes all forms of admission to Detox. There is no longer any statistically significant difference between the pre- and postchange eras.[79]

Inclusion of self-admissions and the dramatic increase in such cases in 1974 clearly made the critical difference. In 1974, for the first time, Detox admission levels combined with drunkenness arrest rates reached prechange arrest rate levels. Of course, it is uncertain whether these self-admissions represent public inebriate cases, especially skid-row cases or whether there is an increased number of middle-class drinkers who would not ever have been criminally processed by the police. There can be no question that the rate of formal police admissions to the Detoxification Center has declined markedly. Indeed, as table 11 indicates, this decline continued into the first quarter of 1975. Whether this was replaced by informal police drop-offs, stepped up delivery by interested groups such as AA and Salvation Army, or an increase in nonaction and informal disposition is unknown. The public drunkenness arrest rate did increase in 1974 but not as much as the decline in police admissions to the Detoxification Center.

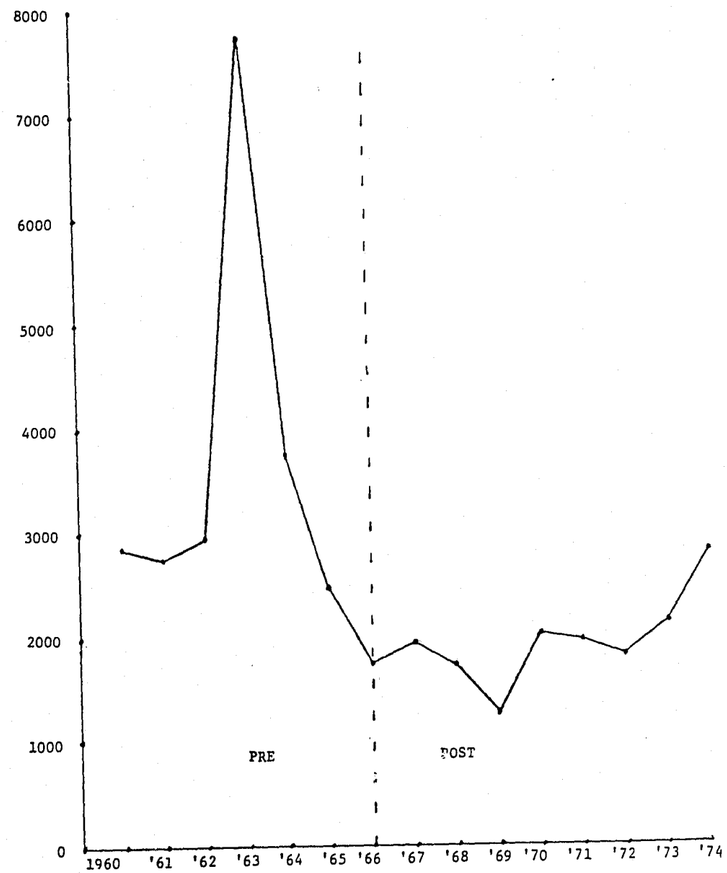
b. Control factors. An effort was made in St. Louis to explain the decrease in police pick-ups and find whether methods other than informally disposing of or ignoring inebriates were being used. Consideration was first given to the possibility that there are fewer intoxicated persons or fewer public inebriates in the city.

Unfortunately, the relatively hard data on alcoholism rates in D.C. were not available in St. Louis. However, the local Council on Alcoholism has made public estimates, apparently based on Jellinek's formula, of the number of persons having an alcoholism problem. In the mid-1960's, the estimates for the metropolitan area were approximately 55,000-60,000, with less than 10 percent being categorized as "skid-row" alcoholics.[80] In 1969-1970, there were approximately 75,000-80,000 persons labeled as alcoholics.[81] By 1972, the estimate was 100,000,[82] and it has remained at that level since then.[83]

Coupled with information from interviews and the growing concern of business and industry with lost workdays because of alcoholism problems, there is every reason to believe that the class of intoxicated persons has not decreased in the postchange period.

It is, of course, difficult to get any accurate assessment about the size of the public inebriate population. The longstanding tolerance of the police and the community for the practice makes the task even more difficult. Those

GRAPH 11.--St. Louis drunkenness arrests and Detoxification Center admissions from all sources, 1960-1974



interviewed did indicate that the problem of skid-row public drunkenness was less visible because of urban renewal. However, it was also noted that skid-row inebriates had dispersed into other low-income areas of the city--the numbers were as great, but the skid-row inebriate problem was less concentrated and therefore less visible. Further, unlike many other cities, there was, until recently, a marked absence of private and public facilities for middle- and upper class inebriates in St. Louis. The emphasis has been directed at the homeless inebriate. But business and industry are becoming involved, and private facilities are increasingly available. Finally, the public inebriate population in St. Louis has always been far larger than the numbers formally processed by the police. This suggests that the police have simply reduced their level of formal pick-up and disposition. It is possible that self-admissions to the Detoxification Center have filled the gap, but it seems highly doubtful.

We examined the arrest levels for public drunkenness in St. Louis County which includes the city of St. Louis on the Missouri side of the Mississippi River. We investigated whether public inebriates had migrated out of the central city to the county.

As indicated in table 12, only since 1972 have arrests by the county police for drunkenness reached the levels of the prechange period. Unfortunately, the arrest rates for all agencies in the St. Louis County area are not available for the period 1960-64. The 1965 arrest figure (a prechange year) is roughly comparable to the rates which prevailed before 1972. The dramatic increase in drunkenness arrests in 1975 has not been explained.

The data indicate that the drop in pick-ups for public drunkenness by St. Louis City Police was not accompanied by a corresponding increase in arrests by law enforcement agencies in the surrounding county. Indeed, the relative stability of those rates during the postchange period suggests that some phenomenon (i.e., opening and operation of the Detox Center) was having an impact on policing in the central city and that this impact was not operative in the surrounding jurisdictions.

In assessing the quantitative impact of decriminalization in St. Louis, the unit of analysis has been the "rate of intake." There is a possibility, however, that just as many individuals are being arrested or picked up and delivered to Detox in the postchange era as in the prechange period and that the decrease is due to a lower rate of recidivism.

A random sample of arrest cases was drawn for 2 criminal years (1963 and 1965) and 2 postchange years (1972 and 1974), and of Detox cases for 2 postchange years (1972 and 1974). These cases were reviewed to determine the frequency of arrest or admission during the study year.

Table 13 shows that the rate of recidivism did not decline in the postchange period. In fact, the term "revolving door" seems even more descriptive of the Detoxification Center than of the criminal justice system, at least in the more representative prechange year of 1965.

TABLE 12.--Arrests for drunkenness, St. Louis County, 1960-75

	Arrests by St. Louis County Police Dept.		Arrests by all agencies, St. Louis County	
	Adult	Juvenile	Adult	Juvenile
1960	143	0	Not available	
1961	161	0	Not available	
1962	150	0	Not available	
1963	116	1	Not available	
1964	209	1	Not available	
1965	162	2	663	9
1966	95	4	562	42
1967	107	5	562	39
1968	123	17	691	83
1969	83	14	572	86
1970	79	5	571	57
1971	101	6	651	53
1972	157	7	800	54
1973	195	8	907	42
1974	267	17	934	95
1975	585	70	1,456	256

Source: Bureau of Planning and Research, St. Louis County Police Department, January 29, 1974.

It might be noted that the 1963 recidivism rate suggests that the dramatic increase in arrests that year was achieved by more frequent arrest of the same individuals. This would support the thesis that the police carried out a different arrest policy for different classes of inebriates.

TABLE 13.--Comparison of public drunkenness recidivism rates between criminal and decriminalized periods

Year	No. of individuals	Rate
1963[a]	N = 162	4.84
1965[a]	N = 147	1.64
1972 (arrest)[a]	N = 424	1.07
1974 (arrest)[a]	N = 412	1.09
1972 (Detox)[b]	N = 149	3.07
1972 (Detox)[b]	N = 125	4.30

[a]Based on official arrest records of the St. Louis MPD.

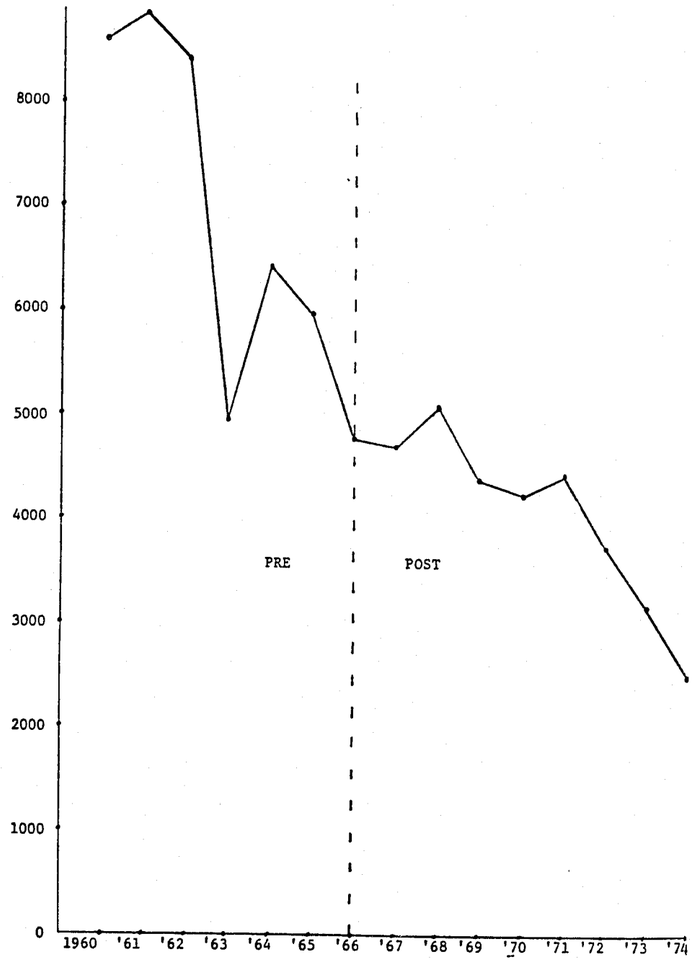
[b]Based on official case records of the Missouri State Hospital at St. Louis.

c. Nonapproved dispositions. An examination of these hypotheses does not explain the decline in formal approved police pick-ups of public inebriates after the introduction of St. Louis diversion program. This indicates that the public inebriate is ignored or handled informally by nonapproved means to an even greater degree in the postchange period than in the prechange era. This conclusion is especially significant when it is remembered that the St. Louis MPD has always emphasized the informal mode of disposition in handling public inebriates.

In exploring the nonapproved dispositions used in St. Louis, consideration was given to the possibility that the police were processing public inebriates for other offenses in the postchange period. To explore this possibility, we examined the level of arrests for disorderly conduct and vagrancy in the pre- and postchange periods. If the inebriate was being picked up and criminally processed for these offenses, an increase would be expected.

As graph 12 indicates, the arrest rates for disorderly conduct and vagrancy have declined markedly in the postchange period. There is, therefore, no basis for the hypothesis that police, either legitimately or illegitimately, are processing the inebriate by using other crime categories. Since public drunkenness remains a criminal offense in St. Louis, police could arrest an inebriate on that charge without having to find another criminal charge. Indeed, the drop in disorderly conduct and vagrancy arrests might suggest that "decriminalization" of public drunkenness also results in an informal "decriminalization" of disorderly conduct and vagrancy.

GRAPH 12.--St. Louis arrests for vagrancy and disorderly conduct, 1960-1974



Source: St. Louis Metropolitan Police Department.

An effort was also made to examine the uses of home delivery and other public facilities, neither of which is an approved mode of disposition under existing MPD regulations. Indeed, police are prohibited from using police vehicles except for emergency transport of ill persons to medical facilities (the exception permits transport of inebriates to the Detox Center). This prohibition is prominently displayed on MPD vehicles. But police interviews did suggest that a relative or a friend may be present or might be called to transport the inebriate home. No figures are available on the use of this option, and it is difficult to assess the frequency of home delivery as a non-approved informal mode of disposition.

Similarly, we were unable to secure hard data on the use of public hospitals and other facilities. Police indicated that delivery to a hospital was used only for inebriates clearly needing medical treatment--a condition that is estimated to exist in only about 3-6 percent of all cases in most cities. It should be noted that this option was available in the prechange period.

While it was not possible to identify with any precision the extent to which various modes of unapproved informal disposition are employed in St. Louis, it is clear that either ignoring the public inebriate or using such informal means is widespread. This type of response to the problem has intensified in the postchange period. Whether the dramatic increase in self-admissions to the Detox Center in the last few years will continue to fill this gap and whether these self-admissions represent the traditional police case inebriate in St. Louis remain open questions.

4. Qualitative Impact. It has been shown that in the prechange period the St. Louis police generally followed a policy of either ignoring or informally disposing of the public inebriate. The extremely low arrest rates suggest that formal intervention was used only in extreme cases when there were no friends or family to care for an inebriate needing emergency assistance. We have hypothesized that decriminalization produces a qualitative as well as a quantitative change in the inebriates formally processed. In St. Louis this means that the postchange population would be even more decidely skid-row than the prechange population. We anticipated difficulty in identifying such marginal differences.

A sample of police cases for the prechange years of 1963 and 1965 was compared to a sample of public drunkenness and protective custody arrests for the postchange years 1972 and 1974. We were able to evaluate the general background characteristics and assess at least two of the indicators generally associated with skid-row inebriates, low socioeconomic status and undersocialization. The higher rate of recidivism for the postchange Detox sample did suggest an increase in the skid-row "homeless man" type of inebriate.[84]

a. Background profile. The average age of those arrested in 1963 (N=124) and 1965 (N=127) was 45 and 44 years respectively, with 81 percent and 71 percent of each sample being comprised of whites. Over 90 percent of those arrested were male (1963 = 96 percent; 1965 = 91 percent). Our Detox sample for 1972 (N=149) and 1974 (N=125) produced essentially the same age distribution of 46 and 44 years, respectively, with a 75 percent white population each year. The Detox sample was slightly less male-dominated than the

arrest population (1972 = 90 percent; 1974 = 89 percent). It might be noted that the sample of those arrested in the postchange period was younger, ranging between 41 and 43.

There was little difference then in the general background characteristics of the two samples. Certainly, there is nothing to indicate a more skid-row population in the postchange period. However, demographic profiles drawn by the Detox Center itself in the early years of the Center's operation indicated an older population. In a profile of 1,854 persons admitted between 1966 and 1968, the average age was 48. There were also fewer blacks (17 percent) and fewer females (7 percent). It should be noted, however, that there has been increased pressure in recent years from representatives of the black community for increased black Detox admissions.

b. Low socioeconomic status. The occupational indicator that was used to compare samples from the pre- and postchange periods also provides only limited assistance in characterizing the respective populations. As indicated in table 14, the number of unskilled persons in the 1972 Detox sample is substantially higher than in the arrest samples. However, the 1974 sample reverses this comparison. The disparity between samples in the use of the categories none, unknown, and unemployed (16 percent in the 1974 Detox sample), makes any inferences dangerous. Further, the large number of self-admission cases to the Detox Center in 1974 might well skew the results.

TABLE 14.--City of St. Louis occupation of sample of persons arrested in 1963 and 1965, and all detox admissions in 1972 and 1974

	1963	1965	Detox 1972	Detox 1974
Unskilled	37.9% (47)	38.6% (49)	49% (73)	30.6% (38)
Skilled	25.8% (32)	17.3% (22)	-	21% (26)
None, unknown and unemployed	36.3% (45)	44.1% (56)	-	48.1% (60)

The Detox Center's own profile for cases admitted from November 18, 1966 to June 20, 1968 shows 52 percent of the patients as unskilled and 15 percent as elderly and disabled. Similarly, a profile of all admissions prior to December 31, 1970 (N=4,767) indicated that 53 percent were unskilled and 20 percent retired or disabled. These figures suggest that St. Louis police were referring a greater percentage of skid-row inebriates to Detox after the change than had been arrested in the prechange period.

c. Undersocialization. The most significant indicator of a change in the character of the pre- and postchange population in St. Louis was marital status. A profile of the Detox clientele showed a divorced/widowed/separated rate in excess of 60 percent. More importantly, the percentage of married

persons in the Detox sample and in the Detox Center's own patient profile was consistently below comparable data from the arrest sample (see table 15).

TABLE 15.--City of St. Louis, marital status of public inebriates arrested and admissions to Detox

	Arrest sample		Detox sample		Detox Center profile		
	1963 %	1965 %	1972 %	1974 %	1966-1968	Pre-1970	1967
Married	29 (36)	19.4 (25)	18.8 (28)	17.6 (22)	14	13	14
Divorced/ widowed/ separated	1.6 (2)	2.3 (3)	57 (85)	60.8 (76)	63	64	62
Single	68.5 (85)*	46.5 (60)	21.5 (32)	20.8 (26)	21	21	22
Unknown	.8 (1)	31.8 (41)	2.7 (4)	1 (1)	2	2	2

*Police apparently classified many "divorced/widowed/separated" persons as "single."

It is interesting to note that the percentage of those married in the 1972 and 1974 public drunkenness and protective custody arrest samples ranges between 28 and 31 percent. This is a somewhat more representative sample of the city's population than the Detox Center's sample population. Our interviews indicated that Detox is not perceived by city policy as a place for nonskid-row inebriates. When formal action is necessary for nonskid-row public inebriates, arrest is far more common.

d. Summary. The postchange police admission has those traits associated with the skid-row inebriate--male, mid-forties, unmarried, widowed, divorced, or separated, and unskilled. Those admitted to Detox are hardly representative of the estimated 100,000 alcoholics in St. Louis or even of the city's public inebriate population. Monthly reports of the Center in the early 1970's characterize the inebriate clientele as "marginal and submarginal poverty level." However, this may also be true of the arrest population in the prechange period. Since arrest was always a last resort for the St. Louis police and since the police pick-up rate has decreased in the postchange period, it is not surprising that the two populations are quite similar.

In any case, the public inebriates being processed at the Center are not the most likely to produce impressive rehabilitation statistics. It should be noted that while there were 1,818 admissions to Detox in 1972 and 2,800 in 1974, the 5-year recidivism rate for our sample in those 2 years was 3.07 and 4.30, respectively.[85] Whether the alcoholics and public inebriates who never get to the Center are ignored or are informally disposed of is not known.

What does appear certain is that there are two standards of policing for public inebriates in St. Louis.

5. Conclusions. The introduction of an alternative mode of disposition in St. Louis did not produce as immediate or dramatic a decrease in the number of public inebriates formally processed as in the District of Columbia. Indeed, the low rates of drunkenness arrests in the prechange period and the incentives for police action in the immediate postchange period made such a sharp decrease highly unlikely. Nevertheless, as the incentives to police action waned and the disincentives increased, the police arrest and referral rates did decrease significantly. These rates have never returned to the prechange arrest totals.

It is difficult to see any dramatic qualitative change in the character of the inebriate population being formally processed by the police. There is no doubt that the Detoxification Center population prior to 1975 was overwhelmingly composed of homeless, skid-row public inebriates. There is no indication that those arrested for Drunk-on-the-Street or for Protective Custody differ markedly from those sent to the Center, although they may be somewhat less the typical skid-row type inebriate.

Given the small number of inebriates who were arrested, every indication is that the typical police case before November 1966 was an emergency case involving a homeless skid-row resident. Any increase in the disposition of such cases in the postchange period is simply too marginal to be significant, given the weakness of the data and the adequacy of the skid-row indicators.

E. MINNEAPOLIS, MINNESOTA

Minneapolis was one of many jurisdictions influenced by concerted regional and national forces calling for the decriminalization of public drunkenness in the 1960's. Most of this reform constituency focused on the illegitimacy and impracticability of criminal processing in solving a social and public health problem; little attention was given to the reaction of police to such a change.

This section evaluates the impact of decriminalization on the performance of the Minneapolis Police Department and challenges the assumption of routine police support for this task. The evaluation begins with an analysis of the reform's legal context in Minnesota in order to pinpoint the intended goals of this change in policy.

1. The Legal Context. Like the District of Columbia, Minneapolis has experienced three legal phases in the handling of public inebriates: (1) a criminal phase, (2) a transitional phase, and (3) a public health phase. From 1889 until 1966, Minneapolis commonly applied the criminal directive of the Minnesota legislature in processing public drunks. Minnesota Statute 340.96 made it a criminal offense to become drunk "by voluntarily drinking intoxicating liquors. . . ."[86]

The first indication that Minneapolis would change its approach to public drunkenness came in action taken by Hennepin County Court Services. In 1966, the court organized the Pre-Court Screening Committee (formally, the Court Committee of the Task Force on Homeless Alcoholics) to review drunkenness cases and make recommendations for disposition to the bench.[87] The Committee

had about 12 members representing organizations geared to the provision of services for chronic alcoholics (e.g., Alcoholics Anonymous, Salvation Army). The majority of drunks interviewed by the committee were skid-row types who posed a revolving door problem for the local courts.[88]

Ground-breaking legislation was passed on May 22, 1967. The Hospitalization and Commitment Act[89] provides for voluntary, involuntary, and emergency hospitalization of and treatment for mentally ill and drug dependent persons, including intoxicated persons. For public inebriates,[90] the act specifies:

> ". . . A peace or health officer may take a person into custody and transport him to a licensed hospital, mental health center or other facility equipped to treat alcoholism. If the person is not endangering himself or any other person or property the peace or health officer may transport the person to his home.
>
> "Application for admission of an intoxicated person to a hospital, mental health center or other facility equipped to treat alcoholism shall be made by the peace or health officer taking such person into custody and the application shall contain a statement given by the peace or health officer stating the circumstances under which such person was taken into custody and the reasons therefore. Such person may be admitted to a facility specified in this provision for emergency care and treatment with the consent of the institution."

This act gave police officers an additional option for handling individuals intoxicated in public. No special treatment facilities for inebriates were authorized and the health officer clause in the legislation recognized the use of ambulance service as a means of transporting intoxicated persons. Such a mode of intake and delivery is seldom used for transporting public inebriates in Minneapolis.

The next legal attack on the criminal processing of public inebriates came from the Minnesota courts. On April 7, 1967, Bernard Fearon was arrested for violating Minnesota Statute 340.96. In his defense, Fearon argued that the statute did not apply to him because he was a chronic alcoholic who, by virtue of his condition, was incapable of controlling his consumption of alcohol. The Municipal Court of Ramsey County found Fearon guilty as charged.

Fearon appealed to the Supreme Court of Minnesota, again on the grounds that the statute was not applicable to his case. He also argued that the Eighth Amendment prohibition against cruel and unusual punishment barred application of the statute to the chronic alcoholic who appears intoxicated in public. On March 21, 1969, the State Supreme Court held that the statute did not apply to the chronic alcoholic.[91] By so ruling, the Minnesota courts recognized that chronic alcoholism is a disease to be treated, not a criminal offense to be punished. The court based its decision on five grounds:

- "Voluntary drinking," as defined under 340.96 means drinking by choice. Therefore, the statute does not apply to the chronic alcoholic whose drinking is caused by his disease and, as such, cannot be controlled.[92]

- Like the reasoning applied in Easter, a person cannot be convicted of committing a crime when the necessary mens rea is lacking. This would preclude conviction even if "voluntary" were omitted from the statute.[93]

- Although the United States Supreme Court upheld a drunkenness conviction under a similar Texas statute (Powell v. Texas, 391 U.S. 514), it did so with serious reservations. These reservations indicate substantial legal doubt as to the constitutionality of such statutes.[94]

- The court in Fearon followed the contemporary position of most acknowledged authorities regarding the treatment of chronic alcoholics.[95]

- The Minnesota Legislature by adopting the Hospitalization and Commitment Act of 1967 intended that the chronic alcoholic be considered as a person in need of care, not criminal treatment.[96]

While the Fearon decision held that the Hospitalization and Commitment Act did supersede 340.96 in the case of chronic alcoholics, it did not invalidate local ordinances. In Minneapolis, police continued to use City Ordinance 37:9.[97] Thus, like Easter in the District of Columbia, the Fearon ruling was viewed by municipal criminal justice officials in Hennepin County as a shift in emphasis rather than a cessation of criminal justice involvement.

On March 29, 1971, the Minnesota Legislature ended criminal processing for public inebriation by repealing Statute 340.96 and passing 340.961. The new law provided that drunkenness was not a crime and repealed municipal ordinances prohibiting public intoxication. As of July 1, 1971, law enforcement personnel could apply only the provisions of the Hospitalization and Commitment Act to public inebriates:[98]

- take the person into "custody" and transport him to a facility equipped to treat alcoholism and provide for emergency care or treatment (72-hour limit to involuntary treatment); or

- take the person home if he is not endangering himself, other people, or property; or

- leave the person where he is found.

The legislation went beyond decriminalization by committing resources to the establishment of an alternative care and treatment system. Each mental health board throughout the state was made responsible for providing one or more detoxification centers for the custody, care, and treatment of inebriates and drug dependent persons.[99] Hennepin County opened its first facility on July 1, 1971, the date decriminalization became effective.

On May 23, 1973, the permanent statutory machinery for treating inebriates was approved by the legislature.[100] The legislation outlines the permanent administrative structure and concentrates on broadening the services available to individuals with alcohol problems. It also explicitly sanctions civil pick-up of public drunks[101] and the use of an all-civilian Detox van.

During the criminal era in Minneapolis, the principal institutions charged with implementing the policy toward public drunkenness were the Minneapolis Police Department (arrest and transportation), the City Jail (detention), the Hennepin County Court (judicial disposition), and the Minneapolis City Workhouse (confinement). The institutions required to implement the new mandates for public drunkenness also include a mix of city and county agencies, representing two different professional fields, criminal justice and public health. The intake of public inebriates is principally the responsibility of the Minneapolis Police Department, although in the First Police Precinct, a civilian van picks up public drunks during a single shift (4 PM to 12 midnight), 6 days a week.[102]

Hennepin County's Alcoholism Receiving Center (ARC)[103] serves as the city's primary treatment and referral facility under decriminalization. A secondary facility is located in the largely native American model cities area (Police District Six). This facility, the Southside Detox, accepts police deliveries as well as self-admissions and referrals from the Indian Neighborhood Club. Like ARC, the center receives its funding from Hennepin County.[104]

As in the District of Columbia, the formulation of Minnesota's decriminalized approach to public drunkenness was due largely to the intensive efforts of an identifiable and overlapping set of individuals and groups (a policy subsystem). It was not, for the most part, an issue that caught the attention of a large segment of the public.

Still, the reform took place in an era when public drunkenness was a national political issue, especially in the criminal justice community. The federal judiciary was considering the issue of decriminalization[105] and several prestigious national associations and commissions[106] were calling for decriminalization as part of an overall package to reform the criminal justice system. Major newspapers throughout the country were printing feature articles on public drunkenness, usually from a reform point of view.[107]

In Minnesota the policy subsystem included the following forces: the traditional alcohol reform lobby (e.g., clergy, Alcoholics Anonymous); state commissions and associations (e.g., Minnesota Commission on Alcohol Problems, Governor's Commission on Crime); civic groups (e.g., the League of Women Voters); legal professionals; and mental health professionals.[108] Individuals who pressed for decriminalization were often affiliated with more than one of the active forces. For example, in Minnesota, members of Alcoholics Anonymous work with professionals in the state and country bureaucracies that serve alcoholics.[109] Beginning in 1954, the state structured its alcoholism treatment posts so that recovered alcoholics could serve as therapists and care givers.

The reformers directed their efforts at three levels of the governmental process: the courts, the state legislature, and county governing bodies. Even prior to decriminalization, their efforts were instrumental in informal approaches to the noncriminal handling of public drunks in local jurisdictions (e.g., the Hennepin County Court's Screening Committee). Their activity in local jurisdictions also accounted for Hennepin County's smooth transition from a criminal to a treatment jurisdiction. A citizen's task force with professional liaisons was appointed by the county commissioners in anticipation of decriminalization. The task force and its professional staff conducted a

search for the first receiving center, acquired staff for the center, and made the necessary material acquisitions, all prior to July 1, 1971.[110]

The individuals affiliated with this policy subsystem also established close contact with other activists throughout the country. For example, Ms. Doris Bradley, Director of Washington, D.C.'s Detoxification Center, reported to the citizen's task force on the District's development of a receiving center.[111] Mr. Peter Hutt (the legal architect of the Easter decision) visited Minneapolis and discussed the Fearon case with Philip Hansen, then Chairman of the Minnesota Council on Alcohol Problems.[112] The forces behind decriminalization in Minnesota maintained contacts throughout the state and the nation as they pressed their measures before the state legislature and courts.

Since traditional alcohol reform groups, public health professionals, and judicial personnel dominated the movement for decriminalization in Minneapolis, it is not surprising that the following three goals emerged from the legislation: (1) ending authority of local courts over the problem; (2) improving emergency services for the public inebriate; and (3) increasing the opportunities for resocialization. The public health concern was further emphasized since the department assigned to implement decriminalization was a broad-based agency dominated by public health professionals (i.e., the Department of Mental Health, Mental Retardation, and Chemical Dependency (MH/MR/CD)).

While early efforts to divest the criminal justice system of the public inebriate problem focused on the most destitute cases,[113] the final legislation defined a broader constitutency for public attention: ". . . any inebriate person unable to manage himself or his affairs or unable to function mentally or physically because of his dependence on alcohol."[114] Therefore, the law applies the goals of emergency care and resocialization to the entire public inebriate population. Those formulating the legislation failed to recognize the potential conflict between goals when they assumed that all inebriates are viable clients for both emergency care and resocialization efforts.[115] More recently, public health officials have questioned the efforts to resocialize chronic skid-row inebriates.[116]

The Minneapolis Police Department, like its counterpart in Washington, D.C., was only marginally involved in deliberations about decriminalization.[117] Thus, no member of the policy subsystem had a concern for or a vested interest in the critical "community-valued" goal of keeping the streets clear of inebriates. Before discussing the response of police officers to this omission and assessing the overall impact of decriminalization on police intake of public inebriates, consideration is given to the characteristics of the city and how they influence the policing of public inebriates.

2. The Environmental Context for Policing. Minneapolis is the principal city of a thriving county and metropolitan area. While many central cities have populations quite different from their metropolitan regions, the Minneapolis area shows considerable homogeneity. Despite this homogeneity, Minneapolis has a greater concentration of poor and nonwhite people than does the entire metropolitan region.

TABLE 16.--Population characteristics of Minneapolis, Hennepin County, and the Minneapolis-St. Paul SMSA, 1970[a]

	Minn.	Hennepin Co.	SMSA
Race[b]			
White	406,414	928,507	1,765,769
Black	19,005	20,044	32,118
Mean income	$13,501	$11,127	$13,147
% Families below poverty level	7.2	4.7	4.6

[a]Based on 1970 Census of Population and Housing: Minneapolis-St. Paul SMSA, U.S. Department of Commerce, 1972.

[b]The Native American population is included as part of the white population. Statewide, there are 23,128 Native Americans and 34,868 blacks. Like the black population in Minnesota, a large number of Native Americans reside in Minneapolis.

In regard to alcohol use, Hennepin County is considered to have a more serious problem drinking population than the state and its neighboring county (Ramsey County), but much less of a problem than many eastern metropolitan areas (e.g., Greater Washington, D.C.). Based on the Jellinek Formula, the state estimates the Minnesota problem drinking population to be 146,256 in 1970. Below are the estimates for Hennepin and Ramsey Counties for the same year:

TABLE 17.--Problem drinking populations: Hennepin County and Ramsey County, 1970[a]

	Hennepin Co.	Ramsey Co.
Total population	960,080	476,255
% of state	22.6%	12.2%
Adult population	536,443	309,130
Estimated problem drinkers	38,346	18,612
% of state	26.2%	12.7%
% of area adult	7.1%	6.0%

[a]Based on Minnesota State Factfinder, Rockville, Maryland: National Clearinghouse on Alcohol Information, 1974, p. 93.

Until the implementation of downtown revitalization projects financed largely by federal urban renewal and model city funds, Minneapolis had a clearly defined skid row area with a high concentration of problem drinkers.[118] While a small "hobo haven" was located on property owned by the Greater Northern Railroad in Police Precinct One, the greatest number of problem drinkers resided on Nicollet Island. This area had been unofficially set aside for skid row types. It had flophouses, shacks, and liquor stores. The city is presently redeveloping the Island as an outdoor recreational facility. In recent years, the most publicized problem-drinking population has been concentrated in two police precincts--First Precinct (downtown) and Sixth Precinct (Model Cities).[119]

The First and Sixth Police Districts. Four distinct types of individuals make up the public intoxicant population in these precincts: Native Americans (recent arrivals from rural areas), young whites (new residents from small towns and rural areas), blacks (small population of poverty-level blacks), and chronic "skid row" individuals ("old-timers" from the "hobo" area).[120] The First Precinct (Headquarters) is relatively small, but includes both the major downtown business and thriving commercial areas as well as the "Times Square" of Minneapolis, the Hennepin Avenue corridor.

Along this corridor, the police focus on the many bars, "adult" theatres, and flophouses that attract transient individuals.[121] They also patrol the railroad yards and open areas that are occasionally frequented by the remaining destitute inebriates. The Hennepin County Alcohol Receiving Center (ARC) operates its Civil Pick-up Van in the First Precinct. ARC's employees patrol from 4:00 p.m. to 12:00 a.m., 6 days a week, and they are in continuous contact with the police through a two-way police radio hookup.

The Sixth Precinct (i.e., Model Cities Precinct) encompasses approximately 11 percent of the city's land mass and its officers patrol the area of the city with the highest concentration of poverty.[122] While retail and neighborhood commercial establishments are located along Lake and Nicollet Streets, the bulk of the structures in the precinct are multiple-dwelling houses and older apartment buildings. Although poor by Minneapolis standards, the Sixth Precinct is not comparable to the ghetto areas in major eastern cities.

The precinct command began experimental police programs as early as 1970, emphasizing community services tasks. Currently, the precinct assigns individuals to the position of community service officer, maintains a citizen advisory committee, and has a storefront precinct headquarters that resembles a community center more than a traditional station house.

With 25 percent of the city's reported felony cases occurring in this precinct, much of the population is transient (i.e., residing in one location for only a few months). Although most of the residents in Model Cities are white, the city's largest concentration of poor blacks and Native Americans reside in the many multiple-dwelling structures in the precinct. The police give considerable attention to both "street drinking" problems and drinking-related disturbances occurring in and around the many local bars. Officers can use either the Alcohol Receiving Center or Southside Detox, which emphasizes emergency care and treatment for Native Americans and is located in the precinct.

The Second and Fifth Police Districts. The Second Precinct has traditionally experienced the lowest incidence of reported crime and its drinking population seldom receives any police attention.[123] It includes a large geographical section of the city and is made up of single-family dwellings, warehouses, and factories. Within the precinct, it is not unusual to have one car policing an area the size of the entire Sixth Precinct.

The community is made up primarily of homeowners from the working and middle classes. These residents are the white ethnics of Minneapolis, predominantly of Scandinavian, Polish, and Italian origin. They are considered politically "conservative" and very interested in preserving the ethnicity of their neighborhoods.

The Fifth Precinct covers approximately one-third of the city and services a very heterogeneous population.[124] On one end, it borders the Model Cities Precinct where its officers encounter public intoxication problems similar to those of the Sixth Precinct. But its officers are also responsible for patrolling the wealthiest sections of Minneapolis, particularly around the Lake of the Isles. Near the Guthrie Threatre, there are many multiple-family units occupied by young professionals and students from the University of Minnesota. Along the southern border of the precinct, there are many single-family homes of white middle-class professionals.

Despite this diverse population, little police time is devoted to public intoxication.[125] Most drinking occurs in homes and most of the communities are of a stable rather than transitory nature.

3. Quantitative Impact. What, then, has been the impact of decriminalization on the police intake of public inebriates? Quantitatively, we have already shown that police deliveries to the Alcoholism Receiving Center (ARC) are significantly lower than the arrest rates for drunkenness during the criminal era. However, because of the increased number of intake options available under the legal change, we do not hypothesize an overall decrease in the approved dispositions of public inebriates. As for the qualitative impact of decriminalization, we anticipate a slight decrease in the policing of nondestitute public inebriates. We believe that the decrease will be less significant than in Washington, D.C. because the police have traditionally focused their attention on the "downtown drinking problem." While the ARC staff has made some effort to broaden their clientele, the civilian van is concerned primarily with destitute, skid row inebriates.

Before turning to an analysis of the data bearing on these hypotheses, it is important to have some additional background on the organization for policing public drunkenness in Minneapolis. Only against this background do the attitudes of the city police take on their full importance.

Comparison of departmental decisionmaking before and after decriminalization has shown only minimal interest in this issue, and what interest there was revolved around the desire to avoid community harassment. This "low profile" has led to street decisionmaking that includes a heavy reliance on disorderly conduct charges to solve "street cleaning" problems in precincts with high concentrations of destitute and transient inebriates.

In 1953, the Minneapolis Police Department put together a complete set of the rules and regulations then in force, a copy of which was given to each officer. Although certain sections were amended over time, the section relating to public drunkenness arrests was left intact until 1967.[126] During the criminal era, that section allowed police officers to arrest public inebriates on a violation of the municipal disorderly conduct ordinance and the state statute on drunkenness. In practice, arrests for drunkenness differed from other arrests in only two ways. First, a special, shorter arrest form, called the "drunk show-up," was used in place of the standard police arrest form. Second, whenever possible, the inebriates were transported in police wagons rather than patrol cars.[127]

When a public drunk was reported or spotted, the officer had one major goal--to get him off the street. There were three routine methods of accomplishing this goal once the officer decided he wanted to act.[128] First, the officer could see that the inebriate got home safely, although the officer was not to deliver the person home. This was accomplished by:

(1) encouraging a person to call a friend;

(2) hailing a cab (if the inebriate had money); or

(3) allowing the individual to walk if he seemed able.

Most of these options would apply to the non-skid row inebriate.

The second option applied for the most part to emergency cases. If the inebriate was seriously ill or injured, the officer could call an ambulance and have him taken to the hospital.

Third, the officer could arrest the inebriate and usually call a wagon. Few arresting officers used their own vehicles because this would take them away from their assigned beat and possibly require them to clean their car afterwards.

Of course, many times an officer would decide not to intervene. A variety of factors influenced the decision about whether or not to make an arrest. Among the more obvious were:

(1) the inebriate's ability to care for himself;

(2) the likelihood of his harming others;

(3) his mental and physical condition;

(4) the possibility of his being a victim of a crime;

(5) his attitude toward others, especially the police officer(s) present; and

(6) the weather.

A number of additional, somewhat more subtle considerations found their way into the process. For example, a drunk was much more likely to be picked

up by an officer walking a beat than by one in a car. Police action was also more likely if a radio call or a citizen complaint had been received. In addition, the sex of the offender was important. According to several officers, the police did not (and still do not) like to pick up women. A number of years ago they had serious problems with women claiming they had been raped, although no charges were ever substantiated.

Finally, massive arrests of skid row inebriates would occur when inebriates gathered in large and disruptive groups.[129] Officers reported that they would occasionally make 40 to 50 arrests during a single shift in the old skid row areas (e.g., Nicollet Island) when the inebriates became "unruly."

The Hospitalization and Commitment Act gave the police an additional option; they could transport an intoxicated person to a hospital for treatment instead of making an arrest. According to interviews,[130] the police rarely (almost never) used this option, despite the fact that the Minneapolis Police Department's Rules and Regulations were amended in 1968 to include a section dealing with the intake of public inebriates under the Act and setting out requirements for transporting an inebriate to the hospital.

In 1969, Fearon was handed down, invalidating the state's drunkenness statute. Interviews indicated that the decision had little effect because officers often used the city's ordinance even before the court decision.[131] The officers were first informed of the change to decriminalization in a Minneapolis Police Bulletin dated May 19, 1971. In two sentences, they were told of the repeal and assured that they would receive new guidelines prior to the effective date. They were further ordered to "charge for intoxication offenses as usual."[132]

The new guidelines came in the form of a memorandum from the Chief of Police, dated June 29, 1971, just 2 days before the repeal was to go into effect. The officers were again informed of the repeal and told about their duties, responsibilities, and options under the Hospitalization and Commitment Act. Several portions of the memo warrant specific mention and emphasis. The memo is very careful to point out that the Act is permissive--the decision about whether to transport an intoxicated person and where is discretionary. It is also made clear that an officer acting in good faith and pursuant to the Act will not be subject to liability for his actions.

In addition, the officer is informed of several criteria he might use in making his decision. These included: speech, clothing, odor of breath, manner of walking or position, hazard to himself or others, physical condition, appearance of eyes and face, ability to understand and answer questions, ability to identify self, surrounding conditions and circumstances, and what was said or admitted. While these criteria may appear unbiased, a closer look reveals a bias in some of them (e.g., surrounding condition, clothing) that make it more likely for police to pick up destitute and transient inebriates. Interpretation of the criteria and consideration of other factors are left to the officer's "own experience and judgment." Once the officer has made his decision to transport the inebriate, that decision is final. No consent is necessary, and "such force as is reasonably necessary" may be used.

In 1972 and 1973, two classes of police cadets were put through the training academy. According to the syllabus developed by ARC, the officers

received instructions explaining ARC's role in handling inebriates.[133] Since 1973, the Department has held no training session on public drunkenness. Thus the only routine interaction between the Minneapolis Police Department and the Alcoholism Receiving Center is now between the patrol officers and the intake officers at the receiving center. There are no interorganizational ties between the command structure of the MPD and the officials of ARC.

a. Alternative approved dispositions. While we hypothesized and confirmed above a decrease in approved formal dispositions by the police (at least if the "take no action" option is excluded), we also anticipated an overall maintenance in the number of public inebriates disposed of by means approved by the "law on the books." The variety of formal options available to the police suggested such a result, particularly if the "take no action" option is included. (See figure 8.) But the more important factor for our expectations was the creation of a civilian van option which was unavailable in the other test jurisdictions. The combination of these factors led us to believe that a quantitative decline in pickup and delivery rates would not accompany decriminalization even though formal approved police pick-ups (sans "taking no action") did decline.

b. Police delivery to public health facilities. Is it possible that officers of the Minneapolis Police Department are using other public health facilities or delivering inebriates to their homes at a rate that compensates for the observed reduction? Under the law,[134] such options are available to police departments throughout the state.

Interviews with officials of the Hennepin County Department of Mental Health, Mental Retardation, and Chemical Dependency (MH/MR/CD)[135] as well as with members of citizen groups involved in the alcoholism problem[136] revealed that the only alternative institution in Hennepin County serving as a major receiving or intake facility for public inebriates is Southside Detox. Mr. Marvin Monnypenny, Director of Southside Detox, reports that since August 1974 they have been receiving referrals from patrol officers in the Sixth Precinct at a rate of about 500 a year.[137] This rate of police intake fails to explain the quantitative decline in police processing of public inebriates following decriminalization.

Since the 1950's, police officers have had the option of encouraging public inebriates to go home--but not of transporting them to their places of residence. According to Captain Rollow Mudge, such encouragement could be given in a number of ways: allowing the person to call a friend; calling a cab for the inebriate with enough money; and permitting the inebriate to walk home if his residence was a short distance.[138] No formal departmental elaboration on or expansion of this option accompanied decriminalization. Our interviews indicate that this disposition remains a viable and sometimes preferred discretionary alternative when the officer is confident that the inebriate is both capable of[139] and willing to take[140] advantage of it. Nevertheless, we found no indication of increased use of it after decriminalization.

These findings indicate that police officers have reduced their pick-ups of public inebriates since decriminalization. However, it does not establish that inebriates are being left on the street, ignored, or being handled by informal, unapproved means. In Minneapolis there is an alternate means of pick-up and delivery of public inebriates not found in other jurisdictions.

FIGURE 8.--Specific research framework: Minneapolis, Minnesota

Alternate approved dispositions	Control factors	Policy outcomes
Police delivery to Detox	Size of the problem drinking population	Numerically less approved police disposition of P.I.'s
Policy delivery to public health facilities/home	Size of the public inebriate population	Equal or more approved disposition of P.I.'s*
Self-admissions and civilian van deliveries+		
Take no action	Recidivism rates--the "Revolving Door"	Increase in nonapproved police disposition of P.I.'s

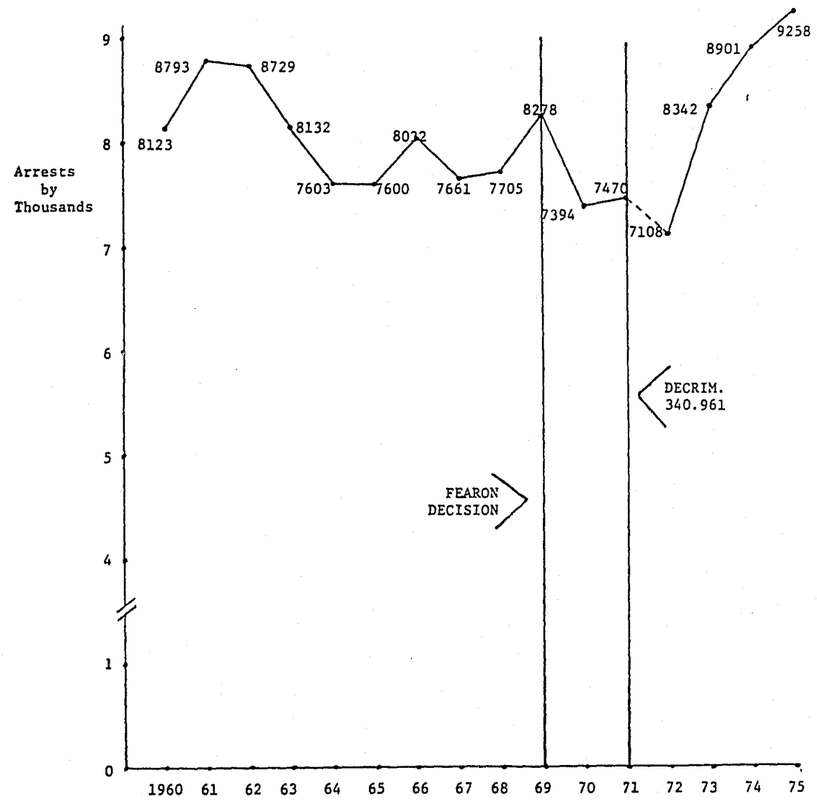
*Based on approved dispositions excluding "take no action," an informal mode of police disposition.

+This is not a police option but it is an approved mode of intake of public inebriates to the public system.

c. Self-admissions and civilian van deliveries to ARC. Unlike other public health facilities that rely almost entirely on the police for the delivery of public inebriates, ARC has aggressively sought other ways of attracting clients to the center.[141] The development of the Civil Pick-up Service was designed to reduce pressure on the Minneapolis Police Department in the downtown section of the city (First Precinct) where street inebriate problems are most acute.[142] An effort was also made to encourage self-admissions by problem drinkers from more stable socioeconomic backgrounds through advertising and by working closely with businesses and government agencies.[143] Such involvement by the public health community might compensate for the reduction in police attention to the problem.

Graph 13 shows that the public health initiatives of civilian pick-up and encouragement for self-admissions do indeed compensate for the decrease in police intakes.[144] Prior to the existence of the Civil Pick-up Service, ". . . the Minneapolis Police Department accounted for 40% of the total admissions and 60% of admissions from 4:00 pm to 12:00 pm."[145] After this option was implemented, "the Pick-up Team transported almost 50 percent of the total admissions to the Center and 80 percent of police and team admissions combined . . ."[146] during the same hours.

GRAPH 13.--Public drunkenness arrests[a] and all referrals to Alcoholism Receiving Center[b], Minneapolis, Minnesota, 1960-1975



[a]Figures are total drunkenness arrests, Official Statistics of Minneapolis Police Department, Annual Reports, 1960-1975.

[b]Figures are all police deliveries, civil pick-ups, self-admissions, and other means of intake, from Monthly Intake Comparison Statistics, Alcoholism Receiving Center, 1971-1975.

In fact, statistics collected by ARC show that the use of this option has increased total admissions while reducing police involvement. For example, in June through August of 1974, ". . . the total number of admissions to the Center increased 17% (from 2299 to 2689) while police referrals were reduced from 844 to 480 admissions."[147] Based on total admissions for the first 8 months of 1974, Civil Pick-up admissions increased from 19 percent to 27 percent while police admissions declined from 23 percent to 17 percent.[148] The van is very visible in the downtown area. The civilian team focuses on persons who are quite intoxicated and poorly dressed.

The following examples represent the types of cases that the civilian team encounters.[149]

1. As the van left the library, the driver noticed a person sleeping on the grass by the side of the library. He stopped the van and the staff went over to the person. They recognized the person and asked: "Got a place to go?" He got up quickly and answered that he had a place. He then began to walk away. He seemed to have his senses and knew where he was going. The staff decided that he would be all right if left alone. No police were on the scene and this was a busy commercial street.

2. A call over the police radio notified the van staff that a man was sleeping on the sidewalk in front of a business. No police were on the scene when the van arrived. The staff woke him by calling his name and shaking him. They asked if he wanted to go to detox and told him that he could not sleep on the sidewalk. There was a hotel nearby and they asked if he was living there. He answered yes and then said no. They asked where he lived; he responded that it was close by. At first he appeared unconscious and very drunk. He did not want to go to detox. The staff was undecided about the seriousness of his condition and decided to let him go on his way. Once in the van they talked over the situation--still unsure of what the proper action should have been. They then followed the person to make sure he could get around without causing trouble. As he walked, he staggered but kept going in the general direction of his home. He went down an alley and across a vacant parking lot. The decision of the staff was that he would make it. However, after two blocks he came to a corner. He stumbled and nearly fell. The decision to pick him up was made at this point. While crossing the intersection he appeared to bother a motorist. This confirmed the decision to pick him up. On the form to admit him, they wrote that he was moderately intoxicated and disturbing people.

3. As they were driving down an alley behind a bar (Dolly's) frequented by Native Americans, the driver stopped since there was a man on the ground with about three people around him. The man had been beaten severely and possibly stabbed around the eye. The staff called for an ambulance, which arrived within a few minutes. The van staff mentioned that this bar generally had incidents similar to this one.

4. The van pulled up to a man called Tony. He was at a busy intersection, unsteady on his feet. They asked if he wanted to go to detox; he declined the invitation. About an hour later the van went by the same intersection and Tony had made it to the opposite corner.

5. A police call came in from the "Bear's Den" bar. This bar is on Franklyn Ave., in the heart of the Native American section, and its clientele is mostly Native American. The van pulled up and the staff saw two men in front and immediately recognized Francis "S." The "S" family, about four of them, are regular clients at detox. Francis is the worst of them, according to the staff. Since Francis was unconscious, they picked him up and put him in the van. The bar's manager, a white man, came out and appeared thankful that the van had come. He explained that the pint bottle that the second man had belonged to Francis. The second man was conscious and fairly well-dressed. He was very belligerent. The staff asked if he wanted to go to Detox. He asked them if they wanted to take him--it seemed he was implying that he would put up a fight. Then his wife came out of the bar. She wanted him to keep his mouth closed and every time he mouthed off to the staff she would yell at him, ("Do you want them to take you?"), and slap him in the face. The staff decided to leave him with her. Although he was drunk it appeared that his wife could take care for him. The owner looked like he wanted both of them picked up.

6. A police call to a commercial area brought the van to the scene of an incident involving Bernard. Bernard is a Native American who was helped into the van by the police. He seemed to believe that the police and the staff were picking on him because he was an Indian. On the ride to detox he screamed and kicked.

Self-admissions and the introduction of a civilian van do appear to compensate for the quantitative decline in the number of public inebriates processed by the police following decriminalization. But to make sure that the observed decline in police pick-ups is accurate and to support the premise that it is self-admissions and the civilian van that provide the compensating elements, we explored the various control factors.

d. The size of the target population. We introduced two controls dealing with the size of the target population:

- has the class of intoxicated persons decreased enough in the post-ARA period to reduce the potential for police pick-up of publicly inebriated individuals?

- has the public inebriate population decreased significantly enough to lower the potential for intake?

We first addressed the issue of the entire population of individuals who are commonly called "potential problem drinkers." If this population has shown a significant decline since decriminalization, then we would need to weigh this variable's possible influence on police intake of public inebriates. Public inebriates are a subdivision of intoxicated persons. If the entire set decreases, then the subdivision may shrink.

Mr. Robert Olander, Research Sociologist for the Department of MH/MR/CD,[150] applied the standard Jellinek Formula to Hennepin County's adult population from 1965 to 1970 to estimate the size of the problem-drinking population during the criminal era. He found a yearly average of 37,346 potential problem drinkers for that period.

He applied the same technique to the adult population figures from 1971 to 1975 to establish a comparative figure for the decriminalized era. For this period, Mr. Olander reported a yearly average of 38,390 potential problem drinkers or an increase of 2 percent in the target population during a time when Hennepin County registered a slight decrease in population. Thus, the potential problem-drinking population has remained virtually the same since decriminalization. More important, in the absence of any decrease in the size of the potential problem-drinking population, there is no reason to expect any decrease in the size of the public inebriate population.

While there is no precise statistical data on the size of the public inebriate population over time, we conducted a number of interviews with individuals closely associated with the public inebriate problem in Minneapolis.[151] They reported that while the skid row population has stabilized over the last decade, Minneapolis most probably experienced an increase in the overall size of its public inebriate population. They identified two classes of public inebriates that have probably increased in recent years--young adult drinkers[152] and Native Americans who consume alcoholic beverages. None of those interviewed saw any decrease in the overall size of Minneapolis's public inebriate population.

e. The recidivism rates--the "revolving door." The unit of analysis for the foregoing analysis has been "rate of intake" without consideration given to the number of "individuals" who are picked up in each period. Thus, one could argue that as many individuals are being picked up by police in the postdecriminalization period as in the criminal era and that there was a lower rate of recidivism after decriminalization.

Table 18 gives our estimates of the recidivism rate for public drunkenness in two criminal years (i.e., 1967, 1970). For each criminal year, we drew a random sample of 200 individuals arrested that year for public drunkenness, reviewed their respective police records, and recorded the number of times each individual had been arrested for public drunkenness during that year.[153]

TABLE 18.--Comparison of public drunkenness recidivism rates between criminal and decriminalized periods in Minneapolis, Minnesota

Year	No. of individuals	Estimated recidivism
1967[a]	N = 145	3.79
1970[a]	N = 179	3.94
1972[b]	N = 176	4.71
1974[b]	N = 151	5.03

[a]Based on Official Arrest Records, Minneapolis Police Department, Bureau of Identification.

[b]Based on Official Records, Alcoholism Receiving Center, Department of MH/MR/CD.

The table also gives our estimates of the recidivism rate for individuals admitted to the Alcoholism Receiving Center in 2 decriminalized years (i.e., 1972 and 1973). We followed the same procedure, drawing a random sample of 200 individuals admitted to ARC during the year, reviewing their permanent records, and recording the number of times each individual was admitted to ARC that year.[154]

As demonstrated in table 18, the revolving door argument fails to explain the discrepancy in pick-up in the two periods. In fact, recidivism is a more serious problem in the decriminalized era at least partially because of the statutory limit of 72 hours for involuntary[155] treatment and the reported overcrowding at ARC.[156]

f. Nonapproved dispositions. We again explored the possibility that the police are involved in the intake of public inebriates through the use of minor criminal offenses in the decriminalized period. Officials of the Department of MH/MR/CD have felt that since decriminalization the police have been picking up a considerable number of public inebriates and arresting them for disorderly conduct.[157]

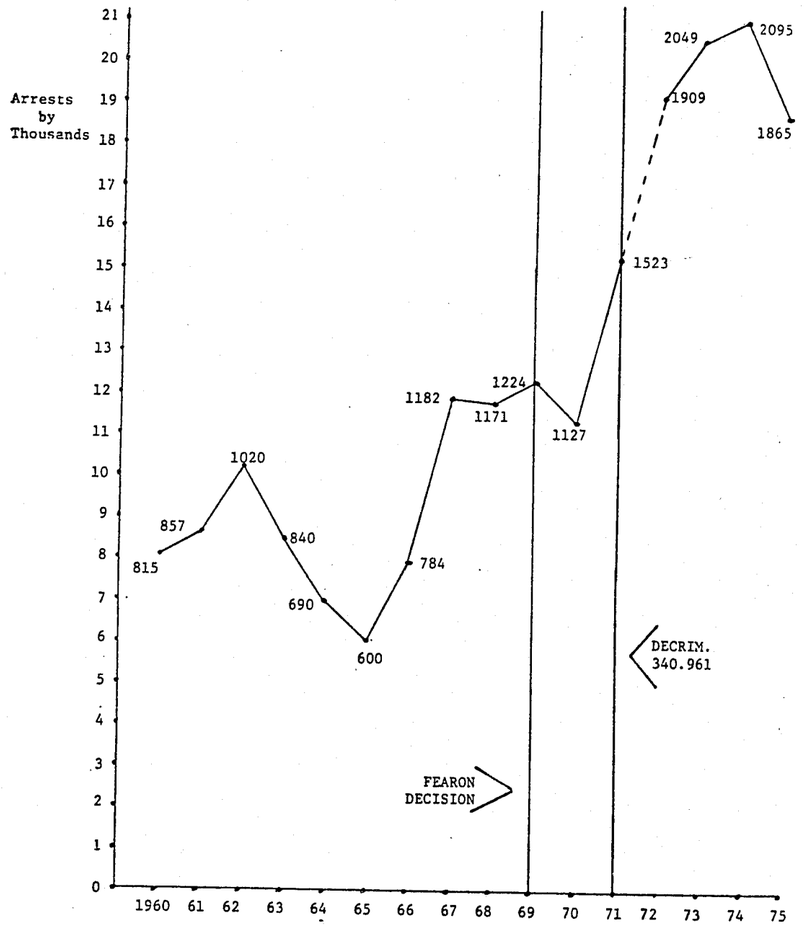
We obtained official police statistics from the Minneapolis Police Department to investigate this possibility and focused on disorderly conduct and vagrancy offenses. The findings shown in graph 14 strongly suggest that the police are using disorderly conduct charges to arrest public inebriates. While vagrancy has shown a steady decline since 1960, the use of disorderly conduct provisions has increased significantly[158] since decriminalization. From 1960 to 1966, the yearly average for disorderly arrests was 697; during the transitional period[159] it increased to 1,167, and since decriminalization (1971-1975) the average has jumped to 1,875. It is certainly possible that, in trying to keep the streets clear of public inebriates, the Metropolitan Police Department has used disorderly conduct as an unapproved means of disposition.

Our analysis of alternative hypotheses shows that the combination of public health involvement in pick-up and the department's increased reliance on disorderly conduct charges to process public inebriates does explain the observed discrepancy between police arrest rates in the criminal era and police deliveries to ARC under decriminalization. In fact, the overall rate of public inebriate intake, if disorderly conduct and vagrancy cases are included, is considerably higher since decriminalization (see graph 15). Even with the higher recidivism rate accompanying decriminalization, it is likely that as many public inebriates are now experiencing governmental intervention as under criminal mandates.

4. Qualitative Impact. What types of problem drinkers received public attention prior to decriminalization, and how does this compare with those currently being processed by the police and staff of ARC? We hypothesized an increase, although marginal, in the incidence of destitute skid row inebriates after the change. To test this hypothesis, we studied existing reports on the public intoxicant population, interviewed knowledgeable individuals, and collected data on pre- and postdecriminalization inebriates.

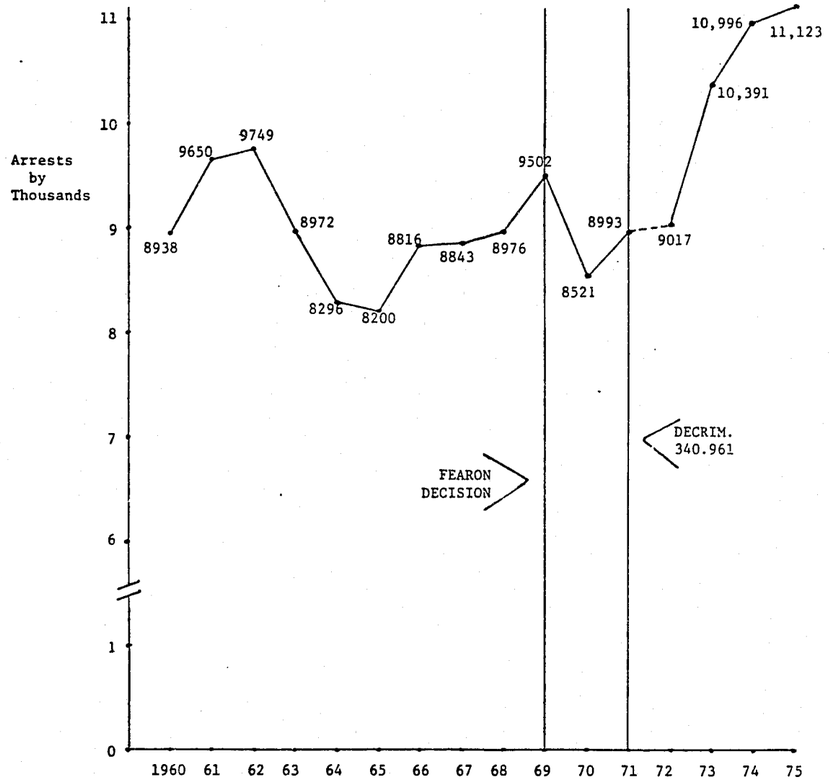
Very little statistical information exists on the characteristics of the public inebriate population in the criminal era. But Mr. George Spano, a probation officer assigned to the Hennepin County Municipal Court, reported that

GRAPH 14.--Disorderly conduct and vagrancy arrests combined[a], Minneapolis, Minnesota, 1960-1975



[a]Figures are yearly statistics, Official Statistics of the Minneapolis Police Department, Annual Reports, 1960-1975.

GRAPH 15.--Public drunkenness arrests, disorderly arrests, vagrancy arrests[a], and all admissions[b] to the Alcoholism Receiving Center, Minneapolis, Minnesota, 1960-1975



[a]Figures are total yearly arrests, Official Statistics of Minneapolis Police Department, Annual Reports, 1960-1975.

[b]Figures are all police deliveries, civil pick-ups, self-admissions, and other means of intake, from Monthly Intake Comparison Statistics, Alcoholism Receiving Center, 1971-1975.

the vast majority of public inebriates coming before the Pre-Court Screening Committee were chronic alcoholics and transient problem drinkers who were well known by the committee members.[160] Similarly, Judge James Rogers of the Hennepin County Municipal Court stated that the vast majority of individuals charged with public drunkenness were revolving door inebriates whom he knew from continuous encounters.[161] He also pointed out that the proportion of Native Americans charged with public drunkenness far exceeded their proportion in the community.

We also drew a random sample of individuals arrested for public drunkenness from the police records for 2 criminal years--1967 and 1970.[162] The characteristics of these arrested were compared with the population statistics maintained by the Alcoholism Receiving Center on its clients. Thus, we created a comparative background profile of inebriates from both periods, and developed indicators of two characteristics often associated with destitute or skid row inebriates--low socioeconomic status and undersocialization.

a. Background profiles. The mean age of those arrested for public drunkenness was 40 (N=245) and 95 percent of those arrested were men (N=249). The racial composition of those arrested was: 62.1 percent white, 29.4 percent Native Americans, 7.5 percent black, and 1 percent other (N=248). Of those admitted to the Alcoholism Receiving Center, 42 percent ranged from 41 to 55 years old and 19 percent ranged from 56 to 64 years old.[163] Males represented 88 percent of the clientele and females 12 percent. The racial composition was 72.5 percent white, 20 percent Native American, and 2.4 percent black. Thus, the institutionalized public inebriate in the decriminalized era is more likely to be white and older than the criminally processed intoxicant. Since decriminalization, women have been more likely to receive institutional attention.

b. Low socioeconomic status. The indicator for this characteristic is employment status. Among those reporting their job situation from the criminal sample (N=190), 66.7 percent said they were unemployed. It is reasonable to assume that many of those who failed to inform the police officer of any occupational status were also unemployed. For ARC's clientele, 71 percent indicated they were unemployed, while over 21 percent stated that they were employed on a full-time basis.[164] Thus, the vast majority of both populations suffer from job instability and chronic unemployment.

c. Undersocialization. Another primary characteristic of destitute public inebriates is "undersocialization,"[165] with the key indicator being a lack of or a broken family relationship. Seventy-six and one-tenth percent of those arrested for public drunkenness reported that they were divorced or separated (N=159). The Alcoholism Receiving Center's clientele is also overrepresented by individuals who have little family stability or cohesiveness. Eighty percent of those entering ARC are divorced or separated.[166]

d. Summary. Destitute or transient inebriates dominate the population of problem drinkers who have been exposed to government intervention in both periods. Despite some efforts on the part of the Alcoholism Receiving Center's staff to encourage the admission of nondestitute inebriates, such individuals rarely find their way into the facility. In fact, our comparative findings indicate a possible increase in the size of the destitute skid row population receiving institutional attention in the decriminalized period.

Obviously, the primary intake agents in the decriminalized era (i.e., police officers and civilian van operators) continue to follow the pattern established during the criminal period of focusing on the downtown street inebriate. Such individuals are very often of Native American descent.

5. Conclusions. At least three factors are working against full cooperation between police officers and public health officials in the handling of public inebriates under decriminalization.

First, decriminalization advocates created a set of conflicting public health goals while giving no consideration to the problem facing patrol officers--keeping inebriates off the streets. This problem is further exacerbated by the public health community's recent recognition of the need to reduce services to chronic inebriates and to focus on rehabilitation.

Second, the lack of communication between the police and public health officials precludes efforts to deal with common problems and restricts the opportunity for cooperative arrangements. This problem is related to a third problem, the low priority given to the public inebriate problem by the command structure of the Minneapolis Police Department.

The net result of these factors is street decisionmaking which puts community pressures on officers in the precincts with high concentrations of public inebriates. This pressure is somewhat relieved by the existence of the civilian pick-up van in the First Precinct and the community service orientation of the Model Cities precinct. Still, reliance on disorderly conduct charges has become an escape hatch that runs counter to the goals of decriminalization.

NOTES--CHAPTER 2

1. See J. Wilson, Varieties of Police Behavior: Management of Law and Order in Eight Communities 49 (1971).

2. Departments have often given credit for such arrests in much the same way they award credit for making other misdemeanor and traffic arrests. Washington, D.C.'s former police chief, Jerry V. Wilson, discusses the importance of this incentive in "Executive Control of Policies for Police Handling of Public Inebriates," (unpublished paper, The American University College of Law, Project on Public Inebriation, 1975).

3. See Levine, Musheno, and Palumbo, The Limits of Rational Choice in Evaluating Criminal Justice Policy, in S. Nagel, ed., Policy Studies and the Social Sciences 94-99 (1975).

4. See D. Campbell and J. Stanley, Experimental and Quasi-Experimental Designs for Research (1966).

5. See G. Glass, V. Wilson, and J. Gottman, Design and Analysis of Time-Series Experiments 20 (1975). [hereinafter cited as G. Glass, V. Wilson, and J. Gottman].

6. By "high-arrest jurisdiction," we mean a jurisdiction whose police department has given high priority to public drunkenness by making a large number of arrests over time.

7. By "low-arrest jurisdiction," we mean a jurisdiction whose police department has given only limited priority to public drunkenness by making a relatively low number of arrests over time.

8. Lempert, Strategies of Research Design in the Legal Impact Study: The Control of Plausible Rival Hypotheses, 1 Law & Soc. Rev. 121 (1966).

9. Observation requirements for sophisticated analysis are discussed in G. Glass, V. Wilson, and J. Gottman, supra note 5.

10. Fortunately, Professor Gene V. Glass of the University of Colorado has developed a computer program, CORREL, which computes autocorrelations and partial autocorrelations for raw data. CORREL also includes a seasonal option for identifying cyclic series. He applied his program to our data for Washington, D.C. and Minneapolis, Minnesota. The data was analyzed as a p=o, d=1, g-1 (integrated moving averages) with a seasonal component (cycle=12). For Washington, D.C., this analysis produced a T=3.20, significant at .001 with 106 degrees of freedom.

11. T=-4.84, significant at .001 with 102 degrees of freedom.

12. Professor Gene V. Glass advised that visual scanning of the control jurisdictions' data in graphs 3 and 4 adequately establishes that no similar effect is taking place in these criminal jurisdictions.

13. Supra note 15, chapter 1.

14. U.S. Department of Health, Education, and Welfare, First Special Report to the U.S. Congress on Alcohol and Health viii (1971).

15. Easter v. District of Columbia, 361 F.2d 50 (D.C. Cir. 1966); D.C. Alcoholic Rehabilitation Act P.L. No. 90-452, 82 Stat. 618 (1968) (codified at D.C. Code Secs. 24-501 to 514, 25-111a, 128 (Supp. 1976)).

16. Commissioners on Uniform State Laws, Uniform Alcoholism and Intoxication Treatment Act (1971).

17. Interview with Mary Kidd, Executive Director of the Washington Area Council on Alcoholism and Drug Abuse, in Washington, D.C., July 1974.

18. See Robinson v. California, 390 U.S. 669 (1969) (statute creating the status of drug addiction constitutes cruel and unusual punishment in violation of the 8th Amendment to the U.S. Constitution, made applicable to the states through the due process clause of the 14th Amendment).

19. See, e.g., A. Fritschler, Smoking and Politics: Policymaking and the Federal Bureaucracy 2-4 (1969).

20. None of the members of the coalition focused on the goal of keeping the streets clear of "transient" inebriates once decriminalization was introduced. We have found that this goal is often ignored in the formulation of a decriminalized approach. Yet, it becomes a significant problem for police departments once the business community and residents begin to lodge complaints.

21. The overview is based largely on figures from the 1970 Census that are compiled in Office of Planning and Management, District of Columbia Government, The People of the District of Columbia (1973) [hereinafter cited as The People of the District of Columbia].

22. The Alcoholism-Jellinek Formula is based on yearly deaths for cirrhosis of the liver. The data were supplied by Dr. Dorothy Mindlin, Director of Adams Mill Alcoholism Center, Washington, D.C.

23. Health service areas are demographic zones into which the city is divided in order to depict variations in social, economic, and physical characteristics as a basis for providing municipal services.

24. T=14.42, df=14, prob=(off the table).001.

25. Research and Statistics Division, Office of Planning and State Agency Affairs, District of Columbia Dept. of Human Resources, Follow-Up Study of the Five Hundred Public Inebriates 2 (1974).

26. However, in that we failed to create a "no occupation" category for researchers recording the post-ARA data, we suspect that much of the missing data represents individuals who claim no occupational skill and should have been recorded as such.

27. Few efforts have been made by public health officials or police officials to "educate" police officers as to the potential for the Detoxification Center to serve such a purpose.

28. This problem is exacerbated by the low priority the city government gives to the building of adequate facilities to house and treat the District's inebriate population.

29. St. Louis Code, sec. 769.010, as amended, provides that "No person shall be in a state of intoxication or drunk on any highway, street, alley, thoroughfare, or other public place." Section 769.020 provides that the misdemeanant shall be fined not more than $500 or be imprisoned for not more than 90 days, or both. State law, Mo. Ann. Stat. §562.260, also makes public drunkenness a crime.

30. St. Louis Code, sec. 769.030.

31. St. Louis Code, sec. 769.060-.070. Chronic alcoholism was made an affirmative defense to a charge of public drunkenness by an amendment to the Code on November 22, 1967, 1 year after the Detoxification Center began operations (sec. 769.040). "Chronic alcoholism" is defined as "The chronic and habitual use of alcoholic beverages by a person to the extent that he has lost the power of self-control with respect to the use of such beverages" (sec. 769.050(c)).

32. St. Louis Metropolitan Police Dept., The St. Louis Detoxification and Diagnostic Evaluation Center 12-14 (1970) (final project report submitted to LEAA) [hereinafter cited as Final Report and Final Report--Evaluation]. The Evaluation contained in the Final Report provides an excellent history of the St. Louis experience prior to 1970. See St. Louis Globe-Democrat, Oct. 19, 1968. (All newspaper reports cited are on file at the American University, College of Law, Project on Public Inebriation.)

33. Final Report--Evaluation, supra note 32, at 16-17. The St. Louis Metropolitan Police Department (St. Louis MPD) indicates that it was a common practice since 1958 to convey inebriates to a hospital for an examination prior to jailing. Id. at 16.

34. St. Louis MPD, Bureau of Field Operations, Drunk-on-Street--Pilot Program, in Final Report supra note 32, at 81-83.

35. It was claimed that the Kendis lectures produced a "perceptible shift in the attitudes of officers" and a less officious street behavior toward inebriates. Final Report--Evaluation, supra note 32, at 18.

36. The project was dropped because of manpower shortages. Final Report--Evaluation supra note 32, at 17. Arrest rates returned to their pre-1963 levels.

37. St. Louis MPD Memorandum 1 (March 4, 1968): Final Report--Evaluation, supra note 32, at 19-20.

38. Final Report, supra note 32, at vi.

39. Id. at v.

40. St. Louis MPD, Drunkenness Arrests--Detoxification Center Procedures, (Special Order 71-S-10, (Apr. 22, 1971, superseding 67-S-8, 67-B-3, and 1963 Pilot Program orders)). See letter from Eugene J. Camp, Chief of Police, to Ms. Sharon E. Shanoff, Kurxman and Goldfarb, Mar. 29, 1971, outlining the approved procedure.

41. The voiding of the summons rather than the use of nolle prosequi was approved by the City Counselor. Detoxification Center, Second Quarterly Report, 4.

42. There are no statutes, ordinances, or regulations detailing protective custody procedures. See Final Report, supra note 32, at 11-12.

43. President's Comm'n on Law Enforcement and Adm'n of Justice, Task Force Report: Drunkenness, App. C, at 51 (1967) [hereinafter cited as Drunkenness Report].

44. It appears that the St. Louis MPD was greatly influenced by the decisions in Easter v. District of Columbia, 361 F.2d 50 (D.C. Cir. 1966) and Driver v. Hinnet, 356 F.2d 761 (4th Cir. 1966), and the expectation that the Supreme Court would accept those decisions. It was urged that the implementation of the Detoxification Center project would better prepare the Department to manage the impact of that expected decision. See, e.g., Grant Application in Drunkenness Report supra note 32, 50; St. Louis Globe-Democrat, May 24, 1966, Oct. 3, 1967. The possibility of decreasing crimes committed against inebriates was noted in the Grant Application, Drunkenness Report, supra note 43 at 51, and by Dr. Pittman. Globe-Democrat, May 24, 1966.

45. The final project report cites two goals for the experiment:

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

Final Report, supra note 32, at iii. Pittman and Gordon's book, stressing the rehabilitative potential, was a major source of impetus and ideas for the project. The book argued:

> "A Treatment Center should be created for the reception of the chronic drunkenness offender. This means that they

should be removed from the jails and penal institutions as the mentally ill in this country were removed from the jails during the last century. Given the present state of knowledge concerning alcoholism, the time is ripe now for such a change. The present system is not only inefficient in terms of excessive cost of jailing an offender 30, 40, or 50 times, but is a direct negation of this society's humanitarian philosophy toward people who are beset by social, mental, and physical problems."

D. Pittman and C. Gordon, Revolving Door--A Study of the Chronic Police Case Inebriate 141-142 (1958) [hereinafter cited as D. Pittman and C. Gordon].

For comments reflective of the emphasis on savings of criminal justice resources, see St. Louis Globe-Democrat, May 24, 1966, estimating an average of 3 hours and 10 minutes of officer time per arrest. The rehabilitation theme is exemplified by Col. Dowd's comment that the St. Louis MPD expected "that through it many persons who would have wasted years in their lives will become productive, normal citizens again." St. Louis Globe-Democrat, Oct. 7, 1966. Similarly, Laura Root, in a paper, "Designing a Detox Center Utilizing Research Studies, at 2 (unpublished paper on file at American University College of Law) [hereinafter cited as L. Root], described the goal: "to establish a facility for treatment. . . in a reasonable length of time which could be expected to have a beneficial effect. . . ."

46. The original procedures provide that 1 or 2 days would be spent in the eight beds used for acute care. The remainder of the stay, the patient would be under self-care in one of the 22 beds reserved for that purpose. Grant Application, Drunkenness Report, supra note 43, at 52; St. Louis Detoxification and Diagnostic Evaluation Center, First Quarterly Report, Oct. 1-Dec. 31, 1966, at 5.

47. At another point, Drunkenness Report stated that "The St. Louis Metropolitan Police Department believes that the chronic police case inebriate is salvageable." Drunkenness Report, supra note 43, at 54.

48. The grant proposal notes the need that the inebriate "be detoxified, built up physically, and exposed to an alcoholism treatment milieu at the center." Drunkenness Report, supra note 43, at 51. It notes the need for "medical treatment" as well as rehabilitation. The fact that a "minority" that might not be rehabilitated might be more humanely treated was recognized also in The Revolving Door:

> "A program of treatment must strike at (the chronic police case inebriate's) dependency needs and recognize his needs for human approval and self-respect. The program must therefore be administered by persons who are professionally competent to minister to his needs, who can create an environment of human warmth and who are personally interested in the inebriate as a human worthy of respect. Within such a context the goals for rehabilitation must be realistic. We may eventually find that the rehabilitation of only a majority of the

group is a notable achievement. Even so, if the remaining minority are simply maintained according to standards consistent with morality and decency in our time, it will do credit to the community which first makes such a contribution."

49. D. Pittman and C. Gordon, supra note 45, at 146. Final Report--Evaluation, supra note 32, at 31. See also, L. Root, supra note 45, at 1. It was estimated that the skid row population constituted about 8 to 10 percent of those persons with an alcoholism problem in St. Louis. Final Report, supra note 32, at 1. It was estimated that there were 56,000 persons in the city and the county who were "problem drinkers." St. Louis Post-Dispatch, June 26, 1966.

50. Interview with Ms. Fannie Price, St. Louis Detoxification Center, St. Louis, Mo. (June 1975). By comparison, in the Center's third quarterly report, it was stated:

> "The numbers who choose to return to their 'revolving door' pattern of life were substantial. It is anticipated, however, that they will be picked up again by the police, and it is evident in the philosophy of the Center's staff that we will help them to accept some help on their subsequent admissions."

St. Louis Detoxification and Diagnostic Evaluation Center, Third Quarterly Report, April 1-June 30, 1967, at 16.

51. In a memorandum from Dr. N. C. Gupta, Director of the Center to Dr. P. Gannon, Superintendent of the State Hospital, July 11, 1972, this change was directly attributed to lack of police support for the operation:

> "(U)nless we received the full cooperation of the St. Louis Metropolitan Police Department, including restoration of their full funding for detoxification services, I see no way that we can continue to reserve 24 beds for police use. Without Police Department support we should seriously consider offering detoxification services on a first come, first serve basis for the general public."

Dr. Gupta also complained in the memorandum about a growing breakdown of communication between the St. Louis MPD and the Detox Unit and the State Division of Mental Health.

52. Interview with Ms. Fannie Price, St. Louis Detoxification Center, St. Louis, Mo. (June 1975).

53. See Table 1, Chapter 2, "Problem Drinking Population, District of Columbia, 1960-1972." [hereinafter cited as Table 1].

54. Interview with Dr. Gupta, St. Louis, Mo. (June 1975).

55. Interview with police officers of the Second Police District, where the Detox Center is located, St. Louis, Mo. (June 1975).

56. See Table 1.

57. Interview with Sgt. Joseph Tazarak, Planning Dept., St. Louis MPD, St. Louis, Mo. (June 1975).

58. The police desire to transfer responsibility for the Center to medical authorities is indicated in a St. Louis MPD memorandum from Capt. Mateker to Chief Brostron, April 30, 1968:

> "Recognizing that medical treatment of the public alcoholic is a public health responsibility, not a law enforcement responsibility, and that the Detox Center is a successful project that should be continued, not cancelled, the responsibility for the financial support, administrative function, and patient treatment should be transferred to the Mo. Div. of Mental Diseases."

It was estimated that the Center had direct costs to the police of $180,000 per year, indirect costs of $45,000 annually, and the future costs were projected to be $225,000 per year or as high as $675,000 annually in 10 years.

In a meeting of July 18, 1968, the Commander of the Police Bureau of Services reportedly commented that "the operation of a detox hospital is not a police function and the police department needs its funds and manpower for the rising crime rate."

Some indication of the decline in departmental enthusiasm in the early 1970's is suggested by its contributions to the Center's operations.

12-1-68 to 3-31-69	$25,000
5-1-69 to 4-30-70	80,000
5-1-70 to 4-30-71	80,000
5-1-71 to 4-30-72	60,000
5-1-72 to 4-30-73	30,000

The contribution subsequently returned to $80,000.

59. Final Report, supra note 32, at xiv. In addition, an officer from each participating police district served as liaison officer to the Center. Each attended alcoholism education program provided by the Center. St. Louis Detoxification and Diagnostic Evaluation Center, Second Quarterly Report, Jan. 31-Mar. 31, 1967, at 4.

60. Interview with Allen Wagner, Asst. Director of the Police Academy, St. Louis MPD, St. Louis, Mo. (June 1975).

61. Unless otherwise indicated, citywide demographic material is derived from St. Louis Plan Commission, St. Louis Development Program (1975) [hereinafter cited as St. Louis Plan Comm'n].

62. St. Louis Plan Comm'n, supra note 61, at 33.

63. See p. 80 infra.

64. City of St. Louis, Health Division, Annual Report 1970 in St. Louis Statistical Abstract 95 (Krash ed. 1972).

65. J. Corzine and I. Dabrowski, Soulard. (Wash. U., Ethnic Heritage Studies Program) (Oct. 1974), provides some basic data on the Third Police District.

66. The arrest data from 1960 to 1965 was derived from the annual reports of the St. Louis MPD. It was estimated that the arrest rate between 1957 and 1962 averaged less than 3,500 arrests annually. Final Report--Evaluation, supra note 32, at 14.

67. Final Report--Evaluation, supra note 32, at 15.

68. Nimmer provides a useful background on this traditional mode of policing the public inebriate in St. Louis. R. Nimmer, Two Million Unnecessary Arrests 82-83, 87-89 (1971) [hereinafter cited as R. Nimmer]; Nimmer, St. Louis Diagnostic and Detoxification Center: An Experiment in Non-criminal Processing of Public Inebriates. 1970 Wash. U.L.Q. 1, 13-15 [hereinafter cited as Experiment in Non-criminal Processing].

69. Final Report, supra note 32, at 9-56, R. Nimmer, supra note at 92-98, is critical of the methodology used in the Final Report.

70. T = 4.51, df = 13, prob. = (off table) .001.

71. T = 2.68, df = 13, prob. = 02.01.

72. See Holden Denies Detoxification Plan Failing by Non-Use, St. Louis Globe-Democrat, Jan. 15, 1970. However, the decline in beds would be relevant only if the center were frequently filled, which Raymond Nimmer claimed was not the case. R. Nimmer, supra note 68, at 92.

73. R. Nimmer, supra note 68, at 89-92; Experiment in Non-Criminal Processing, supra note 68, at 15-19.

74. See note 51 supra.

75. St. Louis Post-Dispatch, June 11, 1974. See generally, Use of Ambulances for Drunks Debated, St. Louis Post-Dispatch, July 14, 1974.

76. The data are derived from the monthly activities report sent from the director of the Center to the Superintendent of the State Hospital.

77. The average daily occupancy rates indicated in the monthly Detoxification Center's activities reports from 1970 through April 1975 are:

	1970	1971	1972	1973	1974	1975
Jan.	--	26.4	24	24	35	36
Feb.	--	23.5	22	24	37	36
Mar.	24	24	24.5	24	36	37
Apr.	26.5	25.5	25	21	38	37
May	26.5	25	23.5	26	38	

	1970	1971	1972	1973	1974	1975
June	26	24	24.5	25	38	
July	26.5	24	23.5	27	36	
Aug.	--	25	22	34*	38	
Sept.	27	21	24	35	37	
Oct.	24	25.5	25	36	36	
Nov.	23	25	24	35	36	
Dec.	24.5	25.6	24	34	35	

*Capacity increased to 40 beds.

78. See Holden Denies Detoxification Plan Failing by Non-Use, St. Louis Globe-Democrat, Jan. 15, 1970; More Use of Drunk Center Sought, St. Louis Post-Dispatch, Jan. 15, 1970.

79. $T = 1.82$, $df = 13$, $p = .1.05$.

80. St. Louis Post-Dispatch, June 26, 1966.

81. St. Louis Post-Dispatch, Jan. 23, 1969.

82. 500,000 Trapped by Alcohol, St. Louis Globe-Democrat, Mar. 23, 1972; Alcoholism, St. Louis Globe-Democrat, Aug. 12, 1972.

83. Interview with Helen Madden, Greater St. Louis Council on Alcoholism, St. Louis, Mo. (June 1975).

84. See p.84 supra and p.87 infra.

85. The 5-year recidivism rates for the arrest years, 1963 and 1965, were 4.84 and 1.64 respectively. The reason for this disparity is unknown.

86. Minn. Stat. Ann., sec. 340.96 (repealed by 1971 Minn. Laws, ch. 90, 2 and replaced by Minn. Stat. Ann., sec. 340.961 (1972) (drunkenness not a crime).

87. Based on interview with Mr. Jim Pearson, CD Program Specialist, Hennepin County Alcohol and Inebriate Program, Minneapolis, Minn. (June 9, 1975).

88. Based on interview with George Spano, Probation Officer with Court Services, Hennepin County Municipal Court, Minneapolis, Minn. (July 3, 1975).

89. Minnesota Hospitalization and Commitment Act, Minn. Stat. Ann. sec. 253A.01-.21 (1971 and Supp. 1977) (enacted in 1967).

90. The term "inebriates" does not include individuals who are merely intoxicated in public. Rather, the term implies that the individual is a chronic alcoholic: "'Inebriate person' means any person incapable of managing himself or his affairs by reason of the habitual and excessive use of intoxicating liquors, narcotics, or other drugs." Minn. Hospitalization and Commitment Act, Minn. Stat. Ann. sec. 253A.02(4) (Supp. 1977).

91. State v. Fearon, 238 Minn. 90, 166 N.W.2d 720 (1969).

92. 166 N.W.2d at 722-23.

93. 166 N.W.2d at 722.

94. 166 N.W.2d at 724.

95. 166 N.W.2d at 724-25.

96. 166 N.W.2d at 725.

97. Minneapolis, Minn. Ordinance ch. 37:9 (disorderly conduct).

98. Minn. Hospitalization and Commitment Act, Minn. Stat. Ann. sec. 253A.04.

99. Minn. Stat. Ann. sec. 245.68(h)-(k) (Supp. 1977) (clause (h), providing for grant application deleted by 1976 Minn. Laws ch. 2, sec. 83).

100. Treatment for Alcohol and Drug Abuse Act, Minn. Stat. Ann. sec. 254A.01-.17 (Supp. 1977).

101. Minn. Hospitalization and Commitment Act, sec. 253A.04(2) (Supp. 1977).

102. Under the supervision of the Alcoholism Receiving Center, Hennepin County Dept. of Mental Health, Mental Retardation, and Chemical Dependency (MH/MR/CD).

103. Also, under the direction of the Hennepin County Dept. of MH/MR/CD.

104. Also, funded through the Hennepin County Dept. of MH/MR/CD.

105. See Powell v. Texas, 392 U.S. 514 (1968); Easter v. District of Columbia, 361 F.2d 341 (D.C. Cir. 1966); River v. Hinnant, 356 F.2d 761 (4th Cir. 1966).

106. In the mid-1960's, three prestigious commissions (the United States and District of Columbia Crime Commissions, and the Cooperative Commission on the Study of Alcoholism) rejected the criminal approach to public drunkenness and recommended the substitution of a public health approach. In 1969, the American Bar Association and the American Medical Association collaborated on model legislation for divesting public intoxication of its criminal status.

107. See, e.g., Prosecution of Alcoholics, edited, Washington Post, July 19, 1964, at E6; Does the Drunk Have a Right to Treatment, Washington Post, Aug. 30, 1964 at E2.

108. Interviews with Mr. Jim Pearson, Chemical Dependency Program Specialist, Minneapolis, Minn. (June 9, 1975), and with Mr. Dale Simonson, Attorney at Law, Minneapolis, Minn. (June 17, 1975).

109. Interview with Mr. Paul Thorne, Director of Alcoholism Receiving Center, Hennepin County Dept. of MH/MR/CD, Minneapolis, Minn. (June 4, 1975).

110. Interview with Mr. Jim Pearson, Chemical Dependency Program Specialist, Minneapolis, Minn. (June 9, 1975).

111. Interview with Rev. Philip Hawsen, Executive Director, Chemical Dependency Treatment Program, Northwestern Hospital, Minneapolis, Minn. (July 1, 1975).

112. Id.

113. State v. Fearon, 238 Minn. 90, 166 N.W.2d 720 (1969).

114. Treatment for Alcohol and Drug Abuse Act, Minn. Stat. Ann. sec. 254A.02 (5) (Supp. 1977).

115. For specific discussion of this conflict, see D. Aaronson, C. Dienes, M. Musheno, Progress Report III, The Impact of Decriminalization on the Intake Process for Public Inebriates, 272-73 (Law Enforcement Assistance Administration Grant #74NI-99-0055). For more general discussion on the "conflict of goals" problem, consult Musheno, Palumbo, and Levine, Evaluating Alternatives in Criminal Justice: A Policy Impact Model, 22 Crime and Delinquency 265, 266-68 (1976).

116. Patient Differences Should Influence Choice of Therapy, in Alcohol and Health Notes 2 (Nat'l. Clearinghouse for Alcohol Information, ed.).

117. In Kansas City, Missouri, the Kansas City Police Department plays a central role in the formulation of a noncriminal alternative. In fact, a member of the police department sits on the Board of Directors of the "Sober House" alternative facility.

118. Interviews with Sgt. Robert Havenstein, Planning and Research, Minneapolis Police Department, Minneapolis, Minn. (June 1975) and Mr. Bruce Peterson, Associate Director, Planning and Research, Minneapolis Police Department, Minneapolis, Minn. (June 1975).

119. Id.

120. Id.

121. This description is based on ride-alongs as well as with police officers of the First Precinct (June 1975) and civilian employees of Alcoholic Rehabilitation Center's Civilian Intake Van (June 12, 1975). Notes of Richard Conboy, Senior Research Associate, Project on Public Inebriation.

122. Interview with Captain Bruce Lindberg, Commander, Sixth Precinct, Minneapolis Police Department, Minneapolis, Minn. (June 11, 1975).

123. Interview with Captain Nordlund, Commander, Second Precinct, Minneapolis Police Department, Minneapolis, Minn. (June 17, 1975).

124. Interview with Captain Jack McCarthy, Commander, Fifth Precinct, Minneapolis Police Department, Minneapolis, Minn. (June 13, 1975).

125. The most serious crime problems in the precinct are burglaries and rapes. Interview with Sgt. Jim DeConcini, Fifth Precinct, Minneapolis Police Department, Minneapolis, Minn. (Sept. 21, 1976).

126. Interview with Mr. Reis Mitchell, Legal Advisor, Minneapolis Police Department, Minneapolis, Minn. (June 2, 1975).

127. Interview with Captain Holt, Planning and Research, Minneapolis Police Department, Minneapolis, Minn. (June 2, 1975).

128. Interview with Sgt. Robert Havenstein, Planning and Research, Minneapolis Police Department, Minneapolis, Minn. (June 3, 1975).

129. Id.

130. Interview with Captain Rollow Mudge, Minneapolis Police Department, Minneapolis, Minn. (June 14, 1975).

131. Id.

132. Minneapolis Police Dept. Minneapolis Police Bulletin (May 19, 1971).

133. Interview with Ms. Sandra MacKenzie, Nursing Supervisor, Alcoholism Receiving Center, Minneapolis, Minn. (June 6, 1975).

134. Minn. Hospitalization and Commitment Act, Minn. Stat. Ann. sec. 253A.04 (Supp. 1977).

135. Interview with Mr. Jim Pearson, Chemical Dependency Program Specialist, Minneapolis, Minn. (June 9, 1975).

136. Interview with Mrs. Meredith Hart, League of Women Voters, Minneapolis, Minn. (July 3, 1975).

137. Interview with Mr. Marvin Monnypenny, Director of Southside Detox, Hennepin County Dept. of MH/MR/CD, Minneapolis, Minn. (July 7, 1975).

138. Interview with Captain Rollow Mudge, Minneapolis Police Department, Minneapolis, Minn. (June 14, 1975).

139. For example, if the officer is sure the inebriate clearly explains where he lives, the inebriate may be given this option. Based on interview with Sgt. Jim DeConcini, Fifth Precinct, Minneapolis Police Department, Minneapolis, Minn. (May 30, 1975).

140. If the inebriate is cooperative and nonthreatening, he may be given this option. Based on interview with Sgt. Robert Havenstein, Planning and Research, Minneapolis Police Department, Minneapolis, Minn. (June 3, 1975).

141. Interview with Mr. Leonard Boche, Director, Hennepin County Dept. of MH/MR/CD, Minneapolis, Minn. (June 3, 1975).

142. Hennepin County Alcoholism Receiving Center, The Public Inebriate: An Innovative Approach to the Transporting of Clients to a Detoxification Center 4 (paper presented to No. American Conf. on Alcohol and Drug Problems, Dec. 16, 1974) [hereinafter cited as The Public Inebriate: An Innovative Approach].

143. Interview with Mr. Paul Thorne, Director of Alcoholism Receiving Center, Hennepin County Dept. of MH/MR/CD, Minneapolis, Minn. (June 5, 1975).

144. T = .16, df = 11 + 5 - 2 = 14, p = N.S. Thus, there is no significant difference in pickups between the two periods when one adds the intakes generated by the efforts of the Alcoholism Receiving Center's staff.

145. The Public Inebriate: An Innovative Approach, supra note 142, at 1.

146. Id. at 2.

147. Id. at 4.

148. Id. at 4.

149. Based on ride-alongs and interviews with members of the van unit by Mr. Richard Conboy, Senior Research Associate, Project on Public Inebriation, Minneapolis, Minn. (July 1974).

150. Interview with Mr. Robert Olander, Research Sociologist, Hennepin County Dept. of MH/MR/CD, Minneapolis, Minn. (Sept. 22, 1976).

151. Interviews in Minneapolis, Minn. with the following members of the Hennepin County Dept. of MH/MR/CD: Mr. Leonard Boche, Director of Alcohol and Drug Program (June 3, 1975); Mr. Paul Thorne, Director of Alcoholism Receiving Center (June 5, 1975); Rev. Philip Hansen, Executive Director of Chemical Dependency Treatment Program (July 1, 1975); Mr. Marvin Monnypenny, Director of Southside Detox (July 7, 1975).

152. National studies indicate an increase in problem drinking among young adults. See, e.g., Gallup Poll Indicates Most Citizens View Youth Drinking as Serious Problem in Nat'l Clearinghouse in Alcohol Information, NIAA Information and Feature Service 1 (May 25, 1976).

153. Specifically, the recidivism rate was computed for each year by: finding n (the number of individuals in the respective sample whose police record was intact); printing a frequency distribution of arrest dispositions for the sample; multiplying each frequency category by the number of individuals in the respective category; summing these values; and dividing the sum by n.

154. The recidivism rate for the Alcoholism Receiving Center was calculated by the same means we used to compute recidivism for the criminal years. See note 20 supra.

155. Hospitalization and Commitment Act, Minn. Stat. Ann. sec. 253A.04 (Supp. 1977).

156. Interview with Mr. Paul Thorne, Director of Alcoholism Receiving Center, Minneapolis, Minn. (June 5, 1975).

157. Interview with Mr. Leonard Boche, Director of Hennepin Cty. Alcohol and Drug Program, Minneapolis, Minn. (June 3, 1975).

158. T = 2.61; df = 14; P = .02.

159. Transitional Period: Pre-Court Screening to Decriminalization: 1967-1970.

160. Interview with Mr. George Spano, Probation Officer, Court Services, Hennepin County Municipal Court, Minneapolis, Minn. (July 3, 1975).

161. Interview with Judge James D. Rogers, Hennepin County Municipal Court, Minneapolis, Minn. (June 30, 1975).

162. Based on Official Arrest Records, Bureau of Identification.

163. Comprehensive Detoxification Program for Hennepin County, Dept. of MH/MR/CD, Minneapolis, Minnesota, 1975, 4.

164. Id.

165. S. Manos, Jamming the Revolving Door: New Approaches to the Public Drunkenness Offenders, in World Dialogue on Alcohol and Drug Dependence 263-76 (1976) (on file at The American University College of Law, Project on Public Inebriation).

166. Comprehensive Detoxification Program for Hennepin County, supra note 163, at 4.

CHAPTER 3

POLICE DISCRETION

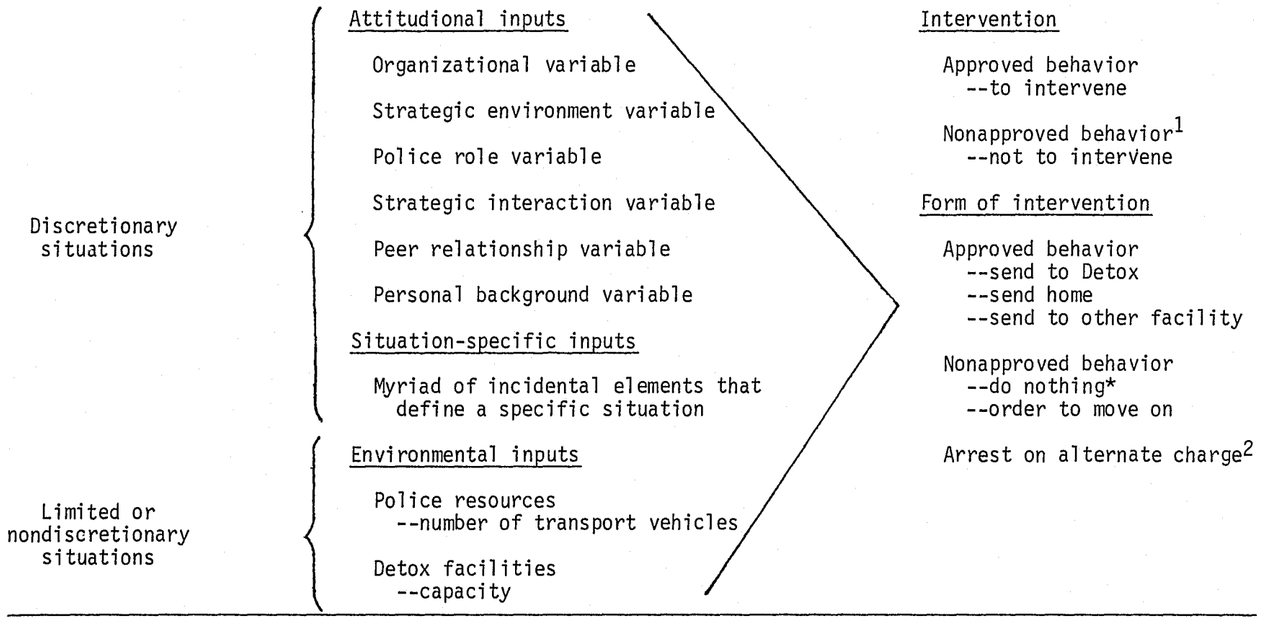
Why do police officers in decriminalized jurisdictions routinely fail to perform the drunkenness intake tasks assigned to them? Our research indicates that the answer lies in the impact of decriminalization on police attitudes and in the influence of these attitudes on police discretion in picking up public inebriates. The evidence is that decriminalization introduces a mass of disincentives to formal police pickup and delivery of inebriates to designated facilities. In the absence of specially designed programs and compensating incentives, police officers will be disposed to take no action in public inebriation cases, or to deal with inebriates in informal ways.

Our research was premised on the recognition by the social sciences that attitudes can play a vital role in influencing human behavior. Since decriminalization was accompanied by alterations in police behavior in the formal pickup and delivery of the public inebriate, we postulated that decriminalization might well have some effect on the attitudes of the patrol officers toward the task--on the decision whether or not to intervene and the mode of intervention (i.e., the disposition of the public inebriate). We were concerned with the relation of attitudes on whether the officers would behave in conformity with the law on the books.

Six influences on attitudes have been identified as having potential relevance to police handling of public inebriates: organization, role, peer, strategic environment, strategic interaction, and personal background (see figure 9). In addition, consideration was given to the myriad of particular factors that impact on every individual encounter involving public drunkenness. The influence of these situation-specific factors was viewed as secondary to the focus of our study. Our interest has been on the factors predisposing police behavior. Nevertheless, we did try to identify some principal variations in factual patterns that may affect police street decisions when encountering public inebriates. Of the six variables reflecting police attitudes, only the personal background variable did not emerge in this study as valuable in understanding police response to public intoxication. This doesn't mean that the variable is generally unimportant in analyzing police discretion or even that it is unimportant in evaluating police behavior in the drunkenness context. Simply, it did not produce many significant findings in our study.

Examination of the attitudinal and situation-specific factors that might potentially influence police behavior and the probable effects of decriminalization in relation to them suggested the relevance of incentives and disincentives in explaining the resultant police behavior. Controlling for environmental factors, police intake rates using formal means approved by the legal norm will vary in response to changes in incentives and disincentives. The

FIGURE 9.--Discretion model on police pickup behavior



1. This may vary for some jurisdictions. Nonintervention or nonaction may be an approved mode of response.

2. The legitimacy of such an arrest will be dependent on the presence of the elements required for the charged offense.

amount of variation will depend on the nature and intensity of the incentives-disincentives introduced in the system through the various attitudinal variables. The resulting model is presented on the preceding page.

Incentives and disincentives resulting from policy changes impact on police departments to produce fluctuations in their street activities. Decriminalization itself is such a policy change. In the absence of compensating incentives, which depends primarily on affirmative action by the police bureaucracy communicated to the patrol officers, police attitudes will be negatively affected and patrol officer behavior will be negatively influenced. Among the incentive-disincentives associated with the six elements of patrol officer discretion identified above, we probed the following: economic (e.g., credit for picking up inebriates), information (e.g., training on the new law), communication (e.g., reports concerning business community desires regarding removal of public inebriates), authority, and power (e.g., command directives on intake policy).

A. ORGANIZATIONAL VARIABLE

> Police organizations generally give a low priority to the public drunkenness problem. Our findings produced few marked differences between officers in criminal and decriminalized jurisdictions in their perception of the organizational priority being placed on this policy issue.

The organizational variable did not prove to be an especially good indicator of police attitudes toward public drunkenness in criminal and decriminalized jurisdictions. This is not surprising given the low organizational priority accorded the problem by police departments generally. Where differences were found, they were generally unexpected and more often a product of factors unique to the jurisdiction studied.

While we found a significantly higher level of attitudinal conformity with organizational directives in the criminal cities, this may be more a product of the jurisdictions selected for study. It may be that jurisdictions which have resisted the national movement toward decriminalization have a more authority-oriented police system.

Officers in criminal jurisdictions also perceive themselves as being better trained to handle public drunkenness than are their decriminalized counterparts. There is, therefore, an informational incentive offered in criminal jurisdictions concerning the task of handling public inebriates. Indeed, police are trained in the process of handling criminal offenders, if not in the particular needs of the inebriate. But in decriminalized jurisdictions, where the mandate is for medical processing, the police receive little training other than that provided in the general orders. In the decriminalized target jurisdictions there were almost no training programs on handling the special needs of the public inebriate.

Officers in all of the decriminalized jurisdictions believed the department viewed public drunkenness as a low priority item. Indeed, the common reaction was to question why were we even bothering to study the subject. While there were directives issued by the department defining the procedures to be used in handling the public inebriate, these were part of the general orders. Occasionally, there would be a notation of a businessman complaining about drunks

hanging about his establishment. But daily orders and other means of regular command communication seldom contained references to public intoxication, or expressions of support for the treatment system, encouragement or directives to cooperate. While an individual or two in the command structure may have been aware of the medical subsystem, there were seldom any regular formal (or even informal) communication linkages. Power and authority incentives to action were lacking.

Line command (i.e., captains, lieutenants, sergeants) seemed to have little or not interest in the problem. In fact, if an officer became too active in dealing with public drunkenness, there would be concern about his wasting time. Handling of public inebriates seldom results in credit toward pay and promotion or even good performance evaluations. Commendations are generally not made for handling public inebriates. Simply, the police organization is generally not using its potential power and authority incentives to induce increased intake.

The potential for such an influence is suggested by the early development of the St. Louis diversion project. Well before the commencement of St. Louis' diversion project, police command officials developed close communication with key figures in the treatment subsystem. The organization was closely involved in formulating the project and the chairman of the Board of Police Commissioners publicly expressed support for the program. Detailed orders were issued. Substantial training for recruits and in-service personnel was given by treatment specialists thus providing informational incentives for cooperation. Communication linkages between the treatment and law enforcement interests were maintained. In short, full organizational support for diversion was obvious. The early history of the program was marked by mutual good feelings and an assessment of goal achievement.

As police organizational involvement in the program waned, a quantitative decline set in. Negative perceptions of the Center appear to have spread among the officers. Training programs terminated. While financial support is still grudgingly provided by the police department, a negative relationship between the police and the treatment center now exists in St. Louis. Disincentives for involvement were clearly present.

The District of Columbia Metropolitan Police Department has, from the outset of decriminalization, maintained a general detachment from the treatment program. Nevertheless, there are incidents which demonstrate the ability of the command to use the incentives at its disposal to influence intake rates. For example, during the prechange period, arrest rates for public drunkenness were tabulated and included in assessing credit toward promotion--an economic incentive was employed to increase patrol action in handling public drunkenness. Officers who were on the street at the time recounted how it was common to walk down certain streets where inebriates concentrated and add numerous arrests to a day's totals, or to use a wagon to pick up large numbers. Again, in 1969, when Police Chief Wilson decided to reduce the incidence of public drunkenness downtown, he began requiring the First District to submit monthly reports on police deliveries to the Detoxification Center. The intake rate rose sharply for at least the short term.

In San Francisco, we personally observed police response to businessmen's complaints about public drunkenness in the downtown business area. A sergeant,

exercising normal line authority, simply took a group of men out with a wagon and rounded up over 20 inebriates.

Training in handling public drunkenness, an informational incentive/disincentive, also seems to be a fairly good indicator of organizational policy. In the District of Columbia and St. Louis, no training program is maintained. On the other hand, Minneapolis did offer training to two classes of cadets (1972 and 1973) on symptoms of alcoholism and the handling of public inebriates and the role of the Alcoholism Receiving Center Officers in Minneapolis did differ significantly in attitude from officers in the District of Columbia.

Of course, if organizational communication is to affect line officer behavior, officers must be responsive to organizational incentives/disincentives. We sought to probe the officers' attitudes on the extent to which a highly regarded officer's conduct conforms to what the department wants done. In all jurisdictions officers agreed that conformity is part of a competent police officer's work orientation. On the other hand, St. Louis police officers rejected this premise to a greater degree than officers in the other jurisdictions. Emphasis on personal street decisionmaking and informal dispositions has characterized the practical operations of the SLPD toward the public inebriate.

Conformity with departmental directives is thus generally accepted by line officers. While there are jurisdictional variations, such as the greater emphasis on discretion in St. Louis, conformity is the accepted norm. There is at least the foundation, therefore, for organizational incentives to influence line officer behavior toward policy objectives in the field of public drunkenness. Indeed, it could be argued that this is presently being accomplished. Officers perceive that the department places public drunkenness as a low priority item for formal attention--a negative cue is provided--and they respond by giving it low priority treatment.

B. ROLE VARIABLE

> Officers in decriminalized jurisdictions perceive a discrepancy in their law-enforcement-oriented role expectations and the task of formal pickup and delivery of public inebriates. While this discrepancy is also present in criminal jurisdictions it is significantly less. There is, therefore, a marked disincentive in terms of role expectations produced by decriminalization.

While the organizational variable did not produce notable variations between criminal and decriminalized jurisdictions, the role variable proved especially valuable in producing differences relevant to the task of handling public inebriates. In assessing these results, it is important to note that officers in all five target jurisdictions showed a strong law-enforcement orientation. Very substantial rejection of a "community services" characterization of their role preference was common. In fact, this conforms to previous findings on police role preferences.

It became highly relevant, therefore, that officers in therapeutic jurisdictions, where the task of handling public inebriates is a "medical social welfare" job, reacted much more negatively to the community services indicator than officers in criminal jurisdictions where the job remains, nominally at least, a matter of law enforcement. Similarly, officers in criminal

jurisdictions find the job of removing public inebriates from the street to be a more appropriate task for the police than do their counterparts in therapeutic jurisdictions. This is fortified by analysis of interview data indicating that officers in criminal jurisdictions consider picking up inebriates as more important than do officers in noncriminal cities.

Both indicators thus suggest a strong disincentive to police processing of public inebriates in terms of the role expectation resulting from decriminalization. In a criminal jurisdiction, public drunkenness remains a "law enforcement" or, at least, an "order maintenance" problem. In a decriminalized jurisdiction, it becomes a "medical" or "community services" problem. Continued police responsibility for this "medical" job produces conflict with role expectation and preference.

> There are marked differences in role orientation among the therapeutic jurisdictions toward the task of removing public inebriates from the street. St. Louis Police have the greatest degree of law enforcement role orientation and the greatest conflict in handling public drunkenness. On the other hand, officers in the District of Columbia experience role conflict to a lesser degree than officers in the other therapeutic cities.

While officers in therapeutic cities have a more negative role orientation to the task of processing the public inebriate by legally designated means than do their criminal jurisdiction counterparts, there are some important variations between the therapeutic cities. The extent to which role conflict will result from decriminalization then may be expected to vary depending on the character of the police department.

The St. Louis police department, for example, emerges from this study having a strong law enforcement-oriented police department deemphasizing problems such as public drunkenness. Indeed, the SLPD has always emphasized the quality arrest, perhaps because of the city's high incidence of major crimes. In any case, nonaction or informal handling has characterized the police street response to minor crimes.

The officers in the St. Louis Police Department (SLPD) manifested a law enforcement orientation to a greater degree than officers in any other jurisdiction, although only the difference from Washington, D.C., was statistically significant. St. Louis officers showed the highest level of agreement that it is hard to remain idealistic in the police department, differing significantly from both Houston and the District of Columbia.

St. Louis police officers showed greater agreement with the proposition that removing public inebriates from the streets makes the police officer too much of a social worker and the differences between St. Louis and other jurisdictions were statistically significant, except for Minneapolis. Similarly, SLPD officers disagreed to a greater extent than officers in other jurisdictions that police are an appropriate agency to handle the task of removing the public inebriate. Again, only Minneapolis' mean score was not statistically different. The attitudinal basis for refusal to process a public inebriate to the St. Louis Detoxification Center is clearly present.

As indicated, the officers in the District of Columbia differed significantly from St. Louis in their law enforcement orientation. Officers in the MPDC do not experience the same role conflict as their counterparts in the other therapeutic jurisdictions. Role expectation does not appear as serious an internal impediment as in the other cities.

Two reasons may be suggested for this lesser role conflict in the District. First, the MPDC, compared to departments of similar size, has a long history of high formal intake rates for public inebriation and, despite the significant decline accompanying decriminalization, this remains true. There are still some 10,000 public inebriate police cases handled by Detox annually. Second, the MPDC has a high ratio of "new officers" (e.g., racial minorities, women) that are considered by most students of police behavior to be more community service-oriented than the traditional officers.

C. PEER VARIABLE

> While police officers in therapeutic jurisdictions perceive their peers as having a negative attitude toward the task of removing inebriates from public places, this attitude is not present in criminal jurisdictions. In fact, officers in criminal jurisdictions perceive a positive orientation on the part of their fellow officers toward the job. To the extent that officers respond to cues from their fellow officers, it follows that a strong disincentive is introduced when a jurisdiction decriminalizes.

We had expected that officers in all jurisdictions would perceive their peers as having a negative orientation toward the task of handling public inebriates but that this negativism would be significantly greater in decriminalized jurisdictions. While the latter expectation proved correct, the former did not. The difference between the jurisdictional categories was far greater than we had anticipated--officers in criminal jurisdictions generally perceived a positive response to the job from their peers. This suggests that officers dealing with a "crime" or "crime prevention" do respond very differently than their counterparts dealing with a "medical" problem, or at least, are perceived as responding differently. In any case, the negative incentive is clearly present in the decriminalized jurisdictions and is not present in criminal model jurisdictions.

While officers in therapeutic jurisdictions disagreed with the proposition that fellow officers do not mind removing inebriates from public places, officers in criminal jurisdictions unexpectedly agreed. The difference was statistically significant.

Similarly, officers in criminal jurisdictions perceive their partners as having a more positive orientation toward the job of removing public inebriates to a significantly greater degree than do their counterparts in therapeutic jurisdictions. We did not find the general view that partners view the job as unimportant that we had expected. The differences between the jurisdictional categories were greater than expected.

There was unexpected general disagreement in all jurisdictions with the statement that veteran officers view the handling of public drunkenness as a

waste of time. Apparently veteran officers are not as hostile to the task as expected. In any case, the more significant finding is that officers in criminal jurisdictions perceive veteran officers as having a positive orientation toward the task to a significantly greater extent than do officers in therapeutic jurisdictions. Veteran officers are in a position to provide informational and power incentives/disincentives to newer officers.

The peer variable then, is a valuable tool for distinguishing attitudes in the two classes of jurisdictions. All three indicators of the peer variable point in the same direction. A negative orientation among peers is perceived to a significantly greater degree in the therapeutic jurisdictions. Given the recognized importance of peer communication in influencing the formation of one's own attitudes and one's behavior, the disincentive toward task performance accompanying decriminalization retards implementation of any legal mandate of full enforcement.

> In St. Louis, peer influences appear to be especially important. The perception of police officers regarding the attitudes of other officers on the task of handling public inebriates provides a negative predisposition toward the job.

The case studies of three therapeutic jurisdictions did not produce any marked findings regarding the peer variable with the exception of St. Louis. As already indicated above, the SLPD emerges from this study as a strong law enforcement-oriented department. This characterization is reinforced by the findings on the peer variable.

Fellow officers in the SLPD were perceived as objecting to the task of removing intoxicated persons from public places to a significantly greater degree than in any of the other jurisdictions. Similarly, there was greater agreement within the Department that veteran officers consider the job of handling public inebriates to be a waste of time. The SLPD officers perceived their partners as considering the task as unimportant, differing significantly from both criminal jurisdictions.

Neither of the other two therapeutic jurisdictions produced similar significant differentials. There seems to be an especially strong attitude in the SLPD toward this low priority.

D. STRATEGIC ENVIRONMENT VARIABLE

> Police officers in all jurisdictions share the attitude that institutions charged with handling public inebriates release the inebriate too quickly. This reaction is significantly greater in therapeutic jurisdictions. This more pronounced bias against the public institutions with which the officer must work produces still another disincentive to formal processing in decriminalized jurisdictions.

Interviews with police officers in all jurisdictions produced a common complaint against the rapidity of turnover for public inebriates. They constantly see the same faces back on the street; in many cases, an inebriate reappears shortly after having been picked up and sent to an appropriate facility.

This complaint was especially prevalent in the therapeutic jurisdictions where the inebriate is delivered to a detoxification facility for a stay of 2 to 7 days. Apparently, some inebriates are released immediately upon sobering up, which may be a few hours. On the other hand, criminal arrest is often followed by a jail sentence, at least for the chronic offender (more specifically, often the skid row chronic offender), thus removing the inebriate from the streets for a longer duration. Even in criminal jurisdictions, however, complaints are prevalent that prosecutors do not pursue drunkenness cases and courts are more frequently releasing those arrested. Court diversion of the inebriate to private alcoholism-treatment groups may provide part of the explanation.

The questionnaire did produce general agreement in all jurisdictions that the inebriate was being released too quickly. This response was significantly greater in the therapeutic jurisdictions. Coupled with the negative role orientation toward the task and the negative perception of peer attitudes, the basis for nonaction or informal disposition is strengthened.

> The negative reaction in therapeutic jurisdictions toward the rapidity of turnover of the public inebriate by the public institutions charged with handling him is only part of an overall negative reaction to the public health treatment subsystem. Criticism of the detoxification center and its personnel is common among police officers in decriminalized jurisdictions.

The disdain for the speed with which public inebriates are returned to the streets was common in all three decriminalized jurisdictions. It was most intense in the District of Columbia where the turnover appears to be especially rapid. But even in Minneapolis and St. Louis where the prescribed stay is longer, the perception of excessive haste in release is shared.

This attitude is only part of the negative reaction of the officers to the detoxification centers and their personnel. There was general acceptance, with no statistical differences among the therapeutic jurisdictions, that the Centers returned inebriates to the streets without really helping them. Indeed many officers interviewed expressed the belief that inebriates were better off physically under the former criminal system since the forced detention at a workfarm assured that they would dry out and recover physically. Given the fact that detox is often sold to the public and the police in rehabilitation terms, the officers' response indicates that they perceive the centers as failing to achieve their objective. Seldom was any information incentive present introduced to challenge these perceptions.

Another common criticism was that the officers often found the detoxification center filled. The centers generally, with the exception of those located in major hospital facilities (e.g., Salem, Oregon, where a detox center is in the state hospital complex) have very limited capacity. If a full enforcement policy were to be implemented by the police or even if police admissions were to increase significantly, it is doubtful that the centers could handle the influx. The problem is complicated by the sporadic character of the demand. On weekends, the Centers often fill early. At certain times of the month, usually when welfare checks arrive, the Centers again are overflowing. At other times, beds are readily available. But the street problem cases do not end when the detoxification center fills. What is the police officer to do then?

In St. Louis, the problem arose almost from the outset since the Center was smaller than desired because of financial difficulties. When bed space was increased the problem eased. More recently, however, the bed problem seems to have intensified. With the influx of voluntary admissions, the police again report frequently finding the Center filled. It is interesting to note that the arrest rate in St. Louis has shown some recent increase coincident with the sharp upturn in voluntary cases, although it is too early to make any real assessment. In any case, police regulations provide that if detox is filled, criminal arrest and prosecution are the appropriate options. It hardly seems proper that the treatment of the police case public inebriate should turn on such considerations.

Another common complaint among police officers interviewed concerned the attitude of treatment personnel toward hardcore cases and especially those chronics who leave the Center against medical advice. Many detox centers maintain lists of persons whom they refuse to accept. This is often justified by the lack of bed space and is especially common where the rehabilitation goals are emphasized--detox is only a step in the treatment process.

But the police officer is unable to make such choices under the law. Hard cases are often the very cases most requiring police intervention and formal disposition. When criminal handling is no longer available, what is the officer to do with the hard case that detox will not accept? Detox refusal to admit such persons adds to the resentment of the officer toward the medical subsystem and his forced involvement with it.

Officers situated in police districts in precincts having the highest concentration of public inebriates experience negative attitudes to the treatment centers more intensely than officers elsewhere in the decriminalized jurisdiction.

While officers in the decriminalized jurisdictions share the negative response to the medical subsystem, and the detoxification centers in particular, there are interdistrict variations within the jurisdictions. Officers in the high intensity drunkenness areas where the problem is most visible and most acute, articulate this view more intensely.

In all three therapeutic jurisdictions, for example, officers in the heavy concentration police districts said that detox returns inebriates to the street too quickly. Regardless of the validity of the attitude, its prevalence among the police directly responsible for pickup and delivery is a matter of concern.

The greater intensity of the negative attitude toward the medical subsystem is also indicated by another questionnaire finding in St. Louis. The perception that the detox center was "no help" to the inebriate was significantly greater in the high concentration Fourth Police District. Yet this is the police district that produced over half of the public drunkenness arrests prior to the diversion program and which remains the principal area for public drunkenness.

Police officers in criminal and decriminalized jurisdictions alike generally possess a negative view of the public inebriate which increases the reluctance to intervene in public drunkenness cases. In criminal jurisdictions, however, the officer perceives the drunkenness situation as more serious in order to

justify his/her intervention as a law enforcement officer. This countervailing impetus supporting action is not present in a decriminalized jurisdiction. By removing this justification for intervention, decriminalization removes an incentive to intervene.

Interviews with police officers left little doubt that they look on public inebriates in a highly negative manner. They are reluctant to touch them, handle them, or carry them in their vehicles. Frequently, drunks are hostile to officers verbally and even physically. In observing a police van sweep of public inebriates in San Francisco, we noticed a number of the officers wore gloves when handling the inebriates. Officers in all cities commented on the presence of filth, lice, urination, etc. In participating in police ride-alongs, we observed the verbal abuse an officer undergoes, the physical difficulty of handling an inebriate, the occasional flailing arms striking an officer (often more common among blue and white collar and upper class inebriates than the skid row case). As we expected, officers in all jurisdictions characterized the inebriate as messy, belligerent and in three of the jurisdictions studied, threatening. When this reaction to the inebriate is coupled with the general negative orientation toward the job previously described, the attitudinal predisposition for nonaction or informal disposition is clearly present.

But in criminal cities we found an important compensating factor. Officers tended to perceive the public drunkenness situation in more serious terms. The officer sees himself as enforcing the criminal law and involved in a potential arrest and therefore as justifying intervention by a law enforcement officer. He will rationalize his role.

Thus, as would be expected, officers in all jurisdictions perceived the inebriate as a bother, a potential victim of mugging and in need of protection from the weather (although pickup rates tend not to increase in cold months). And, in each case, officers in the criminal jurisdictions shared this perception to a significantly greater degree than officers in decriminalized jurisdictions. We had also expected that officers would view the inebriate as generally able to get along without assistance. In fact, this attitude was present only in the decriminalized jurisdictions. Officers in the criminal cities viewed the inebriate as needing assistance and the difference was significant.

Results of the questionnaire on the need of the inebriate for medical care, however, were ambivalent. There was only marginal agreement that few intoxicated persons need medical assistance and officers in Washington, D.C., disagreed. Although we expected the "need for justification" thesis to hold, it did not. There was no significant difference between criminal and decriminalized jurisdictions. Perhaps, a perception of medical needs would provide a basis for a medical-oriented intervention--a community service--rather than arrest response from a law enforcement officer.

In criminal jurisdiction, then, there is a perception of a justification for police intervention which somewhat compensates for the distasteful task of formally handling public inebriates by approved means. Decriminalization tends to remove this self-justification and thus removes an incentive for police action. The negative role orientation to the task is reinforced. Nonaction and informal disposition of the inebriate became more acceptable alternatives.

St. Louis police officers have a more negative reaction to the public inebriate than officers in other jurisdictions. This is consistent with the negative task orientation generally manifested by SLPD officers toward the police handling of public drunkenness.

As had been noted, St. Louis has always had an extremely low arrest rate for public drunkenness. The quality arrest has been emphasized and the low quality police tasks such as public intoxication have been downplayed. Discussion of the effect of organizational, role and peer attitudes indicated that this orientation has continued following initiation of the city's diversion project. But the police bias against active involvement in handling public inebriates is even more marked in the officer's reactions to the public inebriate himself.

More than in any of the other jurisdictions, the inebriate in St. Louis is perceived by officers as messy (differing significantly from Richmond), belligerent (differing significantly from Richmond and Washington, D.C.) and as a threat (again, differing significantly from Washington and Richmond). It is perhaps also notable that the St. Louis police disagree to a significantly greater degree from officers in all other jurisdictions that it is important to them that publicly intoxicated persons are properly cared for (there is, however, marginal agreement).

There is some evidence that reactions to the public inebriate will vary between police districts or precincts within a jurisdiction.

There were significant differences between the various police districts within Washington, D.C. and St. Louis in attitudes toward the public inebriate. It is difficult, however, to identify a consistent pattern.

Perhaps the most notable item is the tendency of officers in the business, tourist area where skid row inebriates panhandle to perceive the inebriate as a bother to other citizens. In both cities, officers in the central police district, containing the business, tourist, and major skid row areas, differed significantly from their counterparts in other police districts. This is reinforced by the fact that the same officers agreed to a significantly greater extent that tourism makes it important to remove inebriates from the streets.

There were also significant differences in some cases between officers in the central district and the other districts in their perception of the frequency of muggings among public inebriates (highest in both cities but not significant), the need of the inebriate for assistance in order to get around (officers in St. Louis' central district perceived this as a significantly greater problem) and the need for medical attention for public inebriates (D.C. central district officers saw this as a significantly greater problem). It is also interesting to note that officers in St. Louis' central police district agree significantly more that well-dressed persons generally do not require police intervention while poorly dressed persons do need police intervention. Generally police officers indicated on the questionnaire that both classes need police attention, although street police behavior indicates that a distinction is drawn. But the central police district experiences both classes to a much greater extent, which might explain their reaction.

Additional research is needed to explore these differences in attitudes between police districts in the same city. Certainly there are strong indications from our data that individual police districts often become miniature police departments responsive to their own problems and needs.

E. STRATEGIC INTERACTION VARIABLE

There was general uniformity among jurisdictions regarding the primary sources of pressure for increased pickup of public inebriates. The greatest sources of pressure for increased pickup and the most important are provided by the business community and the general public. This is a critical source of incentives/disincentives affecting police behavior in handling public drunkenness.

As will be indicated below, one of the environmental factors affecting police handling of public drunkenness cases is the location of the inebriate. If he is located in a visible place like a shopping area, as opposed to a less visible area like a vacant lot or alley, there is an increased probability of some police action. This relates closely to an element observed in ride-alongs with the police and noted by police in all target jurisdictions--the importance of the complaint of businessmen or the general public as an incentive for directing police behavior.

When a complaint from a citizen or businessman is communicated, especially by radio where a record of disposition is maintained, the police officer perceives a need to take action. The complaint must be handled or it may reoccur--the nuisance must be abated. However, this is no assurance of formal approved action. Often, informal handling such as an order to move on or a relocation of the inebriate will suffice.

But the business community and the public are only two of the possible sources of incentives for increased police handling of public inebriates. We expected rather substantial pressure from interest groups dealing with the alcoholism problem. On the other hand, we did not expect that officers would perceive such pressure from political leaders, court or detox personnel, liquor store owners, or the public inebriates themselves (in spite of comments by some officers on the desire of public inebriates to be picked up).

As expected, the ranking of the sources of power and communication incentives remained constant in all jurisdictions. The most important sources of pressure are the business community and the general public. Incentives from political leaders were greater than we had expected, ranking higher than even the alcoholism interest groups. As we expected, the police do not perceive incentives from court or detox personnel for increased police intake. In many cities, police reported that these actors didn't want increased pickup of inebriates. And, as expected, police generally reported no perception of pressure from public inebriates to be picked up more frequently.

But the most important finding is the degree of uniformity between jurisdictions on this variable. While we found significant differences between the criminal and decriminalized jurisdictions in the perceived pressure from the alcoholism interest groups (greater pressure in criminal jurisdictions) and the public inebriates (less pressure in criminal jurisdictions), this may be more a

product of the cities studied. The mean scores for the five cities studied are as follows:

	Wash.	St.L.	Minn.	Rich.	Hous.
Businesses	2.75	2.30	2.32	2.21	2.45
General public	2.59	2.64	2.22	2.28	2.26
Political leaders	2.96	2.91	2.41	2.67	2.74
Alcoholism groups	3.41	3.27	3.08	3.14	2.96
Liquor store owners	3.47	3.57	3.27	3.43	3.24
Court or Detox personnel	4.06	3.42	3.70	3.53	3.39
Public inebriates	3.99	4.73	4.75	4.64	5.11

There is some evidence in the decriminalized cities that police officers perceive detox personnel as hostile to increased police delivering of public inebriates. A disincentive for formal action is being communicated.

While Washington, D.C., differed significantly from the other therapeutic jurisdictions in the level of disagreement that detox officials want increased police delivery of inebriates, the perception of disincentives from detox was generally common. In the District of Columbia, officers in interviews were especially caustic concerning the rapidity of turnover at the detox center. In St. Louis complaints of detox being filled and hard cases being turned away were frequent. In short, there is some evidence that detox personnel may communicate a disincentive to police admissions. Certainly there is little evidence of a positive, encouraging stimulus from the detox officials. This could well be expected to have a depressant effect on police willingness to process inebriates to the detox centers.

This is just another indication of a problem that we constantly encountered. There is a very real strain in relations between the law enforcement and treatment-oriented institutions. Inadequate communication, lack of regularized interactions and minimal mutual support generate hostility and ill-will. Whatever the goals of a city regarding the public drunkenness, this indifference or hostility would seem to be a major impediment to effective policy implementation.

The perception of pressure for increased pickup varies between police districts or precincts within the jurisdiction. A greater police sensitivity to business, community, and political influences tends to be present in areas where people tend to congregate, e.g., business districts, tourist areas. There is some evidence of a higher public tolerance of public inebriation or at least less police perception of pressure in low income areas.

Officers in St. Louis' Fourth Police District perceived business and community pressure for increased intake of public inebriates to a significantly greater extent than officers in the city's other police districts. Similarly, in Minneapolis' precincts one and six, the officers indicated a higher perception of business, community, and political pressure for increased intake. Washington's First Police District also produced significantly greater differences from other police districts in the city in regard to the business community and public official power and communication influences.

All of these findings indicate the selective character of the pressures for public drunkenness pickup. It is generally in the areas of heavy public inebriate activity that the pressure is most intense on police officers for effective handling of the public drunkenness problem--again, the nuisance must be abated.

On the other hand, officers in districts with heavy concentrations of low income residents tend to perceive less public pressure for active enforcement of public drunkenness laws. In St. Louis' Eighth District, for example, which is a predominantly low income, high unemployment, black residential area, officers indicated a generally low level of pressure generally. Police in such districts indicate a higher tolerance level toward public drunkenness. Whether this is only a matter of police perception or an accurate reflection of community attitudes remains an open question. In any case, a communication and power-authority disincentive is present.

F. SITUATION-SPECIFIC VARIABLE

While the study did not focus on the influence of the characteristics of the particular situation on police intervention and disposition, interview, and observational data suggest it is of major importance. The condition of the inebriate, his/her location, and the intensity of the radio traffic are examples of such situation-specific factors that influence police behavior in particular cases.

We did not seek to identify the myriad of particularistic factors that impact on every situation involving public drunkenness. Our emphasis has been on the factors predisposing public officers to take action or to avoid an encounter, to choose from among the many formal and informal options available. However, in the interview, we tried to delineate some of the factors that might bear on a particular street encounter.

How important was the severity of the inebriate's condition to the officer's response? Ride-along observations indicated that the condition of the inebriate did influence the mode of police disposition. Discussions and open-ended interviews suggested that when police interventions with public inebriates decrease, greater importance is placed on the condition of the inebriate in determining whether to act and the character of response. Only when police intervention became a practical necessity would police intervene. The following principle emerges from the interviews: As the severity of the situation increases, there is an increased probability that the officer will deliver an inebriate to a public institution such as jail, detox, or a hospital. Correspondingly, there is less likelihood that the officer will do nothing or take informal action such as telling the inebriate to move on or sending him home.

This tends to support the proposition that a quantitative decline in the numbers of inebriates picked up tends to focus police action on the emergency case where some meaningful police response is essential.

Another situation-specific indicator of interest was the location of the incident. Interviews and ride-alongs had suggested that a complaint from business or government officials tended to produce police action and that the police were more likely to intervene when the inebriate was hanging around businesses or government offices than if he were moving or in a nonintrusive location, e.g. a vacant lot. When officers were presented with hypothetical situations in the interviews, the location factor did emerge as important. The officer is less likely to ignore an inebriate who is in the area of a business or a government building. While the police may only use some informal means of getting rid of the potential nuisance, they are more likely to take some action.

One other situation-specific factor emerged as important in the interviews. Some 86 of 131 officers interviewed indicated that the number of radio calls they were receiving made a difference in how they would react to a public drunkenness incident. If the level of radio traffic is heavy and the officer is preoccupied with higher priority matters, nonaction for incidents of public drunkenness is an attractive option.

An effort was also made to determine whether it made a difference to the officer that the inebriate was a wino and whether or not he knew the inebriate. A majority of officers indicated whether the inebriate was a wino (128 of 165) or was known (92 of 163) made no difference in deciding what to do. Of course, some hesitancy in admitting the influence of these factors is to be expected. The situation-specific variable does emerge as a potentially important factor affecting whether an officer will intervene and the mode of the intervention.

G. LINKING ATTITUDES TO BEHAVIOR

We had serious doubts about our ability to demonstrate the linkage of police attitudes to policing behavior. The questionnaire attempted to measure frequency of different forms of police behavior but this was a subjective evaluation by the officer of an extremely low priority behavior, and would reflect all of the natural limitations of memory and perception. If an objective measure of behavior was used from police pickup reports, this could not be connected with the particular questionnaire instrument without forcing disclosure of the officer's identity, which might well bias the results. In any case, we doubted that meaningful results would be obtained and we were generally correct. Other efforts to probe the relationship of attitude behavior also proved generally unavailing. Some findings of potential importance should at least be noted.

The concern of the officer with the well-being of the inebriate is more likely to result in formal institutional action.

Perhaps the most relevant citywide finding is the importance of the police officer's concern for the well-being of the inebriate to his behavior. In both St. Louis and Minneapolis, we found that those officers who are most concerned about the well-being of the public inebriate are most likely to take formal approved, institutional action. This at least suggests the kinds of officers who

would most likely be responsive to the policy objective of promoting proper care for the inebriate.

In the District of Columbia, the personal background factor of race is important. Black officers are more likely to take institutional action.

Personal background factors generally did not prove important in any phase of this study. But, in the District of Columbia, the race of the police officer did prove to be relevant to the type of action taken by the officer. Black officers are more likely to take institutional action such as delivering the inebriate to the Detoxification Center. Washington is, of course, a predominantly black city whose public institutions are often controlled by blacks. The director of the men's detox, however, is white. Perhaps a possible explanation lies in the greater community service orientation of the "new black officer" in the city's police force.

In St. Louis, officers in patrol areas with more inebriates take less action but take more inebriates to detox. Officers from poorer patrol areas take less action while officers from wealthier areas take more action.

St. Louis provided two additional citywide findings of interest. The relationship of the character of the inebriate handled to the mode of policing has been suggested frequently in this study. In St. Louis, we found that the more skid row inebriates in the officers district, the less the amount of action taken but the greater the number taken to the Detoxification Center. As has been indicated, taking no action or taking informal action tends to be the dominant mode of policing public drunkenness in St. Louis and this finding supports that conclusion. The use of Detox for the skid row inebriate also confirms our finding that the St. Louis police (as do police in most cities) perceive detox as a place for "winos," not for middle or upper class inebriates--the police admission to the center tends to be the "homeless man."

There was also a citywide relation between the economic class of the police officer's patrol area and the frequency of action in St. Louis. The poorer the officer's district, as perceived by the officer, the less the officer takes action. Conversely, the wealthier the district, the more the officer takes some action, although not necessarily arrest or delivery to detox, i.e., legally approved actions. Since these non-skid-row inebriates are not being taken by the police to detox and are apparently not being arrested to any greater degree than the skid row inebriate, the use of the informal disposition, e.g., send or take home, is indicated. In low-income areas of the city, the inebriate is generally tolerated--no action is taken. Once again, the dual system of policing public drunkenness is evident.

The relation of the officer's concern with the well-being of the inebriate varies by district.

The relevance of interdistrict variations has been noted frequently in this study. This also proved to be the case when attitudes were linked to the officers' behavior. Even when a factor proved significant citywide, there were wide variations between police districts within the city.

In St. Louis' central district, the greater the concern of the officer with the inebriate's well-being, the greater the amount of action, approved action, and the greater the number taken to the Detoxification Center. It is in this central police district that the problem of public drunkenness is greatest--it is an ever-present visible reality for the officers. While there were significant relationships in the other districts between the "caring" of the officer and his behavior, in no other district did we find all of the expected relationships.

In Minneapolis, the relationship between humanitarianism and behavior was most pronounced in the Sixth Precinct, containing the model cities area. In this precinct, community services are most strongly emphasized as a proper police task by the police organization.

> In St. Louis, officers in the central police district who perceive groups as wanting increased pickup of public inebriates will take more action.

The importance of the environment in which policing occurs has already been frequently noted. Police do tend to respond to pressures, especially from the public and the police community. It is not surprising that the relationship would be most critical in the central police district where business, tourist, entertainment, sports, and government offices are concentrated.

In St. Louis' Fourth Police District, officers who agreed that groups (consisting of business, general public, and political leaders), wanted increased pickup of public inebriates tended to take more action. This does not necessarily mean they arrested or delivered inebriates to detox but only that some action was taken. Informal disposition is far more common.

> In the District of Columbia, there is a direct relation between the officer's perception that Detox is too "far away" and the frequency with which she/he delivers inebriates to the Detoxification Center.

Interviews with police officers indicated that the location of the detoxification center is often an important factor in their willingness to use it. In St. Louis, for example, a trip to the center might involve a 20- to 30-minute trip each way, plus time for the admissions process. Such a commitment of time for such a low priority item which is perceived as inconsistent with the officer's role orientation is not surprisingly a major impediment.

In the District of Columbia this relationship of distance from detox to the frequency of detox deliveries also proved significant. The further away an officer is from the treatment center, the less often he will deliver to Detox. Since detox is located in the most intense human services area, spatially removed from more affluent and more stable areas of the city, there is still another impetus toward a selective policing pattern and a skid-row oriented detoxification center.

H. CONCLUSION

This analysis demonstrates not only the usefulness of our discretion model but also the significantly greater disincentives at work in the decriminalized/

therapeutic jurisdictions regarding the formal pickup and delivery of public inebriates to appropriate facilities. The officer in a therapeutic jurisdiction perceives: (1) a low organizational priority for the problem; (2) pickup produces a role conflict with his preferred role of law enforcement officer; (3) his peers have a negative reaction to the task; (4) he personally has a negative reaction to the medical treatment facilities with which he must now deal; (5) the inebriate is perceived as a threat, belligerent, and messy; and (6) the officer lacks the support provided in a criminal jurisdiction by opinions about the need for police intervention.

These attitudes almost compel nonaction or informal disposition in a decriminalized jurisdiction in the absence of any special incentives designed to offset these effects. While the situation-specific will vary, the attitudes of the officers are carried from encounter to encounter and affect the character of policing.

These findings pose a serious dilemma for policy planners seeking to decriminalize the offense of public drunkenness. If police are retained as the agent for pickup and delivery of the public inebriate to a detoxification center, and no ameliorative action is taken to overcome the disincentives introduced by the change, there is serious doubt that the articulated goals of decriminalization can be met.

CHAPTER 4

POLICY ALTERNATIVES

In 1913, Eugene Ehrlich wrote that "the center of gravity of legal development lies not in legislation, nor in juristic science, nor in judicial decision, but in society itself."[1] Our studies of decriminalization of public drunkenness show that Ehrlich's thesis is still valid today. The law relating to public intoxication is not limited to statutes and ordinances, court decisions, nor even the administrative rules and regulations of those charged with enforcing the laws. It turns on the character of society in general. In this instance, it involves the day-to-day decision-making of the primary actor in enforcement of the legal policy relating to drunkenness. The patrol officer exercises his street discretion in a manner that truly defines the operative legal policy. The desired public policy goals can be best pursued through the manipulation of that judgment by the use of incentives and disincentives.

In this study we have probed the myriad of public policy goals that drunkenness laws are designed to serve and the potential conflicts with organizational (bureaucratic) and individual (self-interest) goals. Decriminalization introduces new goals into the scenario, but this does not necessarily mean that the objectives of the criminal justice system, such as crime prevention and street cleaning through the removal of the public inebriate, are eliminated. Instead, the new therapeutic aims are blended into the already existing mix of policy goals. As might be expected, conflict of policy goals is far more real than is compatibility.

It is to this mixture of objectives that the police officer, as pickup and delivery agent, is asked to respond. How does he reconcile the varied and inconsistent demands? How can his behavior be directed along desired lines once policy priorities are defined? What alternative mechanisms, police and nonpolice, are available to better achieve these administrative goals?

Decriminalization introduces another, relatively autonomous, bureaucracy--the public health agencies--into the system. This enlarges the potential for organizational and self-interest antagonism. Consequently, it may also become a source of disincentives for police to handle public inebriates in the manner designated by the "law on the books." How can state and local governments move toward a more effective blending of therapeutic programs with criminal justice responsibilities? Can reliance on guidelines and rulemaking alone provide an effective response? These are the questions we attempt to confront in the last part of this book. We begin by discussing methods of police pickup of public drunks involving exclusive reliance on the street

officer as the agent. To suggest ways in which police officers might become more effective in handling public inebriates, we discuss a range of incentives and disincentives that may influence police discretion. We conclude by analyzing innovations in public inebriate pickup that involve the use of civilian pickup agents, primarily the civilian van pickup system.

We first focus on public policy goals and their implications for public service bureaucracies--i.e., the police and public health intake personnel--in implementing legislative, judicial, or administrative mandates to pick up public inebriates. We then further explore a major finding of this study--the existence of basic conflicts among public policy purposes and the use by police officers and public health workers of informal, often not legally sanctioned practices, to cope and adjust to resulting tensions or strain. Alternative methods of police pickup of public drunks involving exclusive reliance on the street officer as the pickup agent are discussed and their potential for improved responsiveness to public policy goals are considered. To suggest ways in which police officers might become more effective in handling public inebriates, we discuss a range of incentives and disincentives that may influence police discretion. We conclude by analyzing innovations in public inebriate pickup that involve the use of civilian pickup agents, primarily the civilian van pickup system.

A. PUBLIC POLICY GOALS AND IMPLICATIONS FOR PUBLIC INEBRIATE PICKUP

One of the conclusions that emerges most clearly from an examination of the criminal justice and therapeutic models for handling the problem of drunkenness is the diversity of objectives involved. Several public interest or public policy goals, differing administrative or organizational objectives, and individual or self-interest goals can be preliminarily identified.[2] Public interest aims and priorities may differ among persons who comprise the criminal justice-public health subsystem in a particular jurisdiction (e.g., legislators, planners, administrators, police officers, public health workers, and others). Building a broad consensus about the aims and priorities in the pickup and delivery of public inebriates is the prerequisite to fashioning a system that will be fully responsive to those goals. The pickup agent, the method of pickup and, ultimately, which street inebriates are picked up and where they are delivered--i.e., the level of enforcement--may vary, depending on which ends are emphasized. Table 19 shows the diversity of goals.

Public policy goals for handling public inebriates are likely to receive different emphases in different parts of any city and in the same location at different times. For example, in criminal jurisdictions it is important to make clear that although the legally stated objective may be to arrest and prosecute public drunks, underlying aims may also be to keep the streets clear of derelict alcoholics, provide emergency care for inebriated persons, steer alcoholics toward rehabilitation programs, or diminish or prevent disorders. Since public policy goals do not necessarily apply to all persons intoxicated in public, efforts need to be made to identify the types of public inebriates to which they apply.

1. Removing Public Inebriates from the Streets. Questionnaires to patrol officers and interviews with patrol and command level officers as well as personal observation revealed the pressure placed on police departments by individual residents, businesses, business associations, and other

TABLE 19.--Diversity among public inebriate objectives

Goal categories	Alternative goals
Public policy goals	1. Deal with a public nuisance by clearing the streets (maintaining intake levels) 2. Minimize the expenditure of scarce criminal justice resources 3. More humane handling of public inebriates, especially emergency cases 4. Improve longer term rehabilitation or resocialization of public inebriates 5. Prevent crime by and against public inebriates
Organizational goals (illustrative)	1. Increase in size, status, budget, and authority of police and public health officials 2. Improve relations with significant public and private community groups 3. Reduce time and resources devoted to administration and overhead 4. Increase the quality of arrests and quantity of designated arrests 5. Improve response to certain requests for assistance and citizen complaints 6. Improve recruitment, training, and retraining of police officers and improve communications within the Department 7. Maintain a proper image with the media
Individual or self-interest goals (illustrative)	1. Increase income and fringe benefits 2. Obtain promotion or transfer to new assignment 3. More flexibility and freedom in use of time 4. Minimize paperwork and unpleasant bureaucratic procedures 5. Improve job performance and more efficient use of time 6. Minimize time spent on unpleasant and unimportant police tasks 7. Enhance education and knowledge

groups for the removal of drunken persons from the streets and other public places. The goal of removal of a "public nuisance" from public places is more likely to be emphasized in downtown business districts where large numbers of skid row public inebriates often reside.

To achieve the goal of clearing the streets of public inebriates requires a substantial commitment of personnel and transportation for the pickup and delivery of intoxicated persons, and, therefore, this aim is usually emphasized only in particular areas of a city. The limited capacity of most detoxification centers and related health facilities, compared to drunk tanks and work farms in the earlier criminal era, impedes the implementation of the street-clearing objective. Further, detoxification centers return chronic skid row drunkards to the streets more rapidly. Retaining this goal in decriminalized jurisdictions thus increases pressures for informal dispositions and substitution of other criminal charges, such as disorderly conduct, urinating in public, drinking in public, begging, and the like.

The goal of clearing the streets of inebriates was a dominant policy in Washington, D.C., during the criminal era, producing from 40,000 to 50,000 arrests a year during the early 1960's. It is presently emphasized in Houston, Texas. During our visit to Houston, increased attention to improving the downtown business area resulted in a special effort to concentrate on public inebriates--informally dubbed "Operation Sparkle." In San Jose, California, dissatisfaction with the decriminalization approach resulted in an intensive drive to clear the streets of drunkards in January 1975.[3] The police used an assortment of criminal charges for arrest. The effect was an immediate drop of about 30% in detoxification center admissions and an overflow of the jails. The special police activity was in response to pressure on the City Council by downtown San Jose merchants. In an interview, the police chief stated that the special activity was discontinued due to inadequate police resources. The renewed dissatisfaction of downtown merchants with the presence of inebriates on the streets was very evident during our visit in the summer of 1976.

When the goal of clearing the streets in a particular district results in a very high level of enforcement, the result may be that the intoxicated population will disperse to other districts. In San Francisco several years ago, a police captain decided to arrest all public inebriates in one district. The resulting dispersion produced a more difficult problem for police to handle. It was concluded that a controlled response might be more effective than a very high level of enforcement and that it was preferable to contain inebriates in a particular area.[4]

2. Conserving Criminal Justice Resources. Removing inappropriate cases from our criminal justice system releases scarce resources for allocation to higher priority law enforcement tasks. The criminal stigma is removed from conduct which is merely a manifestation of an illness. Such principles are an essential part of the rationale for decriminalization, and are repeatedly emphasized in varied therapeutic jurisdictions. However, the illness rationale is insufficient since the decriminalization approach is extended to the pickup of publicly intoxicated persons irrespective of an underlying illness. Many, if not most, publicly intoxicated persons are not chronic alcoholics and include both skid row and non-skid row public inebriates.

It would be virtually impossible to administer a program that required the police or courts to discriminate on a case-by-case basis among chronic and nonchronic public inebriates. The Uniform Alcoholism and Intoxication Treatment Act,[5] which has been used as a model for other state statutes, refers to both "alcoholics" and "intoxicated persons," effectively decriminalizing the act of public intoxication.[6] But in Powell v. Texas,[7] the United States Supreme Court in 1968 narrowly rejected the claim that the constitutional guarantee against cruel and unusual punishment requires that chronic alcoholism be recognized as a defense against a criminal charge of public drunkenness.

In jurisdictions where options for both criminal and therapeutic processing exist (e.g., St. Louis and Kansas City, Missouri, and San Francisco, California), emphasis on the goal of conserving criminal justice resources requires that those public inebriates who otherwise would have been processed criminally, be picked up and delivered to therapeutic facilities. Detoxification centers, such as the one in St. Louis, which encourage extensive voluntary admissions may not be focusing on arrest-prone public inebriates. This situation is also evident in San Francisco. The Mobile Assistance Patrol, an innovative pickup service using civilian counselor-drivers, has as its primary objective a reduction in public drunkenness arrests by 25 percent and as its secondary objective diminished expenditure of police and court time. One evaluator assesses why this objective has not been met:

> "Examining the 'public inebriate' population concerned, we note that it can be divided into two groups: problem drinkers (alcoholics) and drinkers who are causing a problem. The Mobile Assistance Patrol is mainly concerned with the former; the Police, depending upon the district, and the viewpoint of the officers who patrol that district, are concerned with the latter, the former, or both. Thus, the Mobile Assistance Patrol is not necessarily concerned with the equivalent population that is arrested for 647f (public intoxication)."[8]

Thus, jurisdictions emphasizing this goal must carefully analyze the target population to be served by the pickup agent.

All the therapeutic jurisdictions we visited support the goal of minimizing the use of criminal justice resources without formally considering whether the cost of having other government agencies treat the public inebriate would be the same, more, or less than the anticipated savings. It is apparently assumed that criminal justice resources that are not consumed will represent a net saving. But preliminary indications are that therapeutic programs often are more expensive than their criminal justice counterparts and that the impact of freeing criminal justice resources has been smaller than anticipated.[9] However, two jurisdictions visited, Kansas City, Missouri, and Erie, Pennsylvania, may have been successful in achieving at least a short-run net reduction in resources allocated to handling public inebriates.

There are several problems involved in determining the degree to which the adoption of therapeutic approaches will save criminal justice resources. These problems have not been adequately addressed in existing studies and

program justifications.[10] Also, arguments for cost-effectiveness that may influence local officials are often based on a distinction between local costs and outside expenditures by other units of government. Federal funding has been a major stimulus to innovation in the processing of public inebriates.[11] For example, Law Enforcement Assistance Administration funds provided the initial spur for the first detoxification center in St. Louis. Federal funding generally supports the initial project stages, but other sources of financing must be found to ensure the project's survival beyond the experimentation period. In St. Louis, when federal monies were exhausted, the detoxification center had to be moved from an informal setting in a central location to a more distant location in a state hospital in order to secure state funds.

3. Humanizing the Handling of Public Inebriates. The head psychiatric nurse of a detoxification center we visited stated: "The detoxification facility is an attempt to substitute a more humane kind of revolving door.[12] The stigmatizing effects of involvement with the criminal law are avoided."[13] A basic rationale for the detox center is to provide a more humane form of detoxification than the drunk tank. Rehabilitation may be the next step in the therapeutic process, but it is not a substitute for the detox process itself. Several jurisdictions we visited emphasized the goal of providing improved short-term services to street inebriates. The more limited the bed capacity of detoxification centers, the greater the need for discrimination in determining which people to pick up. Many jurisdictions which emphasize this objective could serve more people simply by reducing the length of stay at the detox center.[14] The primary target for pickups in such jurisdictions is the emergency situation public inebriate, including persons who are unconscious, injured, affected by bad weather, or suffering from hunger or malnutrition.

The Manhattan Bowery Project in New York, in part because of unique environmental factors in the Bowery, emphasizes emergency services. Although intoxicated persons occasionally find their own way to the Project, they are rejected in favor of those on the street who are incapable of getting to the center.

In Salem, Oregon, police formally process only a small number of public inebriates. Police directives call for nonintervention in most cases, informal disposition of most cases requiring intervention, and delivery to the White Oaks Detoxification Center of the Oregon State Hospital of those who are unable to take care of themselves. This procedure seems to provide emergency care to those most needing it.

Civilian, rather than police, pickup programs in Salem, San Francisco, Erie, and Minneapolis, are especially responsive to the goal of more humane handling and care. The civilian pickup agents appeared to be dedicated, understanding persons. In San Francisco, we saw police officers push and throw drunkards into a tight, hot wagon. In Salem, on the other hand, we saw a member of the Mobile Assistance Patrol help an inebriate into a clean, airy, Volkswagen van, following a warm, understanding conversation. The difference was dramatic. Further, civilian car drivers in Salem carry a stethoscope, blood pressure-reading devices, and first aid kits, and are able to render simple medical assistance.

None of this occurs in a Salem police pickup and delivery, although there is no reason why police pickup, in either a therapeutic or a criminal jurisdiction, should be less compassionate than civilian pickup. The critical issues may be what type of individual is selected to perform the intake function, the type of training provided, and how the incentive-disincentive structure is used to reconcile conflicting public policy, organizational and self-interest goals. Suffice it to say that we also observed rough handling and abuse of inebriates by a civilian counselor.

In similar fashion, there is no reason for drunk tanks of the criminal model to be less humane than detox centers. Drunk tanks can be provided with bed sheets, access to medical personnel, and other services available at detox centers. In cities such as Pittsburgh and Philadelphia, thousands of skid row and non-skid row drunkards have been released from drunk tanks within 4 to 8 hours after sobering up. This raises a difficult question. Is it more humane to be picked up and held in a comfortable therapeutic detox center than to be picked up and released from a traditional drunk tank immediately upon sobering up?[15]

It may be argued that the criminal approach of the drunk tank and the work farm is more sympathetic than the detox center with limited followup facilities. Several persons interviewed in Washington, D.C., San Jose, California, and other cities observed that the physical condition of inebriates generally has deteriorated since decriminalization. Although people momentarily sober up in a detox center, they do not dry out, as they must do while serving a 30- to 90-day sentence on the work farm. Jurisdictions emphasizing the short-term goal of a more humane alternative to the drunk tank should not be surprised at resulting high rates of recidivism. A 72-hour detox facility cannot be expected to reverse the "revolving door" syndrome.

4. Improving Longer Term Rehabilitation. Jurisdictions that emphasize rehabilitation, resocialization, or reintegration tend to see the pickup and delivery of public drunks to detoxification centers as the first phase in a continuum of care. Detoxification is the beginning of the rehabilitation process, which also includes longer term treatment facilities.[16]

Jurisdictions emphasizing rehabilitation should determine the target population that is most likely to respond to the types of restorative facilities available. This generally implies that voluntary rather than involuntary pickup techniques should be used, and that civilian pickup agents are to be preferred over police.

The detoxification center may serve as a replacement for the drunk tank, but not for the work farm. Recognizing this, Santa Clara, California, initiated a special program for hard core recidivists in May 1975--the Arrested Drinking Program (ADP). The program provides for 30-day referrals from the detoxification center, with the possibility of 30-day extensions. Since the program began, the average number of admissions to the detoxification center has declined.[17] Although the staff makes an effort to convince clients to accept ADP, the voluntary nature of the program is emphasized.[18]

The aim of reintegration into the community assumes that correction or cure is possible. But, as noted earlier, restoration may be less likely in therapeutic than in criminal jurisdictions for public inebriates who are most receptive to rehabilitation programs--non-skid row street drunkards.

In the therapeutic jurisdictions that we visited, police officers generally viewed the detoxification center as a place primarily for skid row types.[19]

The objective of rehabilitation for the skid row public inebriates has generated controversy. In most jurisdictions, inadequate resources and facilities make longer term care impossible. Basically, it is argued that the primary needs of skid row inebriates are for housing, food, and the like rather than treatment of alcoholic problems. In several cities, those interviewed emphasized the need for drop-in centers to keep intoxicated persons off the streets. The high recidivism rates in all therapeutic jurisdictions visited provide some evidence of the limited success of the rehabilitation goals.[20]

Nonetheless, questionnaires and interviews with police officers suggest that they perceive the rehabilitation of public inebriates as a primary goal of therapeutic processing and relapses as an indicator of lack of rehabilitation. When police officers see the same inebriates back on the street time and time again, many develop a negative attitude toward the detoxification center.[21]

5. Preventing Crime Either by or Against Public Inebriates. Crime prevention may be an objective of the public inebriate pickup program. An officer must exercise judgment on a case-by-case basis to determine which pickups are likely to deter commission of a crime.[22] Questionnaires and interviews with police suggest that the non-skid row public inebriate is more likely to engage in fighting and assaultive behavior, especially when confronted by police officers, than his skid row counterpart.[23]

Intoxicated persons taken to therapeutic facilities are more likely to be potential victims than offenders, since detox centers are not generally used for non-skid row inebriates, and because unduly disruptive persons are seldom taken to detox. Potential offenders are more likely to be arrested for related offenses, especially for disorderly conduct, than for public drunkenness. In Minnesapolis and Erie, we found that disorderly conduct arrests increased following the introduction of therapeutic programs.[24]

We have found that the objectives emphasized in different jurisdictions vary widely. What accounts for these variations? Important factors include differences in: (1) the number, types, and location of public drunkards; (2) perceptions of the consequences of the presence of inebriates on the streets; (3) the availability of funds and personnel amidst competing claims for funding of other alcohol and public health programs; and (4) the attitudes and influences exerted by community members, especially certain elite community groups.

B. CONFLICTS AMONG PUBLIC POLICY GOALS

A major finding of this study concerns the existence of basic conflicts among public policy purposes and the use by police officers and public health workers of informal, often not legally sanctioned, practices to adjust to the resulting tensions. The resolution of conflicting objectives falls primarily to the police officer on the beat, not the top levels of police administration where public policy directives are issued. Individual discretion is exercised in deciding whether to intervene, whether to take formal or informal

action, and the precise form of action to be taken. Likewise, public health workers who control the gatepost, or intake of detoxification centers, decide which public inebriates will be admitted for treatment. The ends emphasized by police and public health workers may be very different.

The underlying assumption of the therapeutic approach is that public inebriates can be removed almost entirely from the criminal justice system and that the streets can, at the same time, be kept free of "public nuisances" and situations likely to lead to more serious breaches of the peace. It is further assumed that humane care and rehabilitation can be provided at relatively modest costs (or even savings). Those formulating and administering public policy in the jurisdictions we visited generally failed to recognize goal conflicts that significantly influence street-level decisions. We observed two major sources of conflict among public policy objectives, the first between the aims of traditional order maintenance and decriminalization, and the second among decriminalization goals themselves.

1. Traditional Order Maintenance vs. Decriminalization Goals.

a. Clearing the streets vs. humane services. These two aims appear to cut in opposite directions. Providing emergency services is a selective process directed toward picking up people who are in serious trouble. Clearing the streets is an indiscriminate process aimed at removing all drunkards. In most cities, detoxification facilities are more limited in capacity than jails or drunk tanks. Indiscriminate pickup and delivery to detoxification centers overwhelms this limited capacity and prevents the use of therapeutic resources for those most in need. In cities such as Washington, D.C., St. Louis, and San Francisco, we heard police complaints that detox centers often have no beds available.[25]

To keep the streets clear of public inebriates, police emphasize that detoxification centers should be able to provide bed space 24 hours a day, 7 days a week. Occasionally, detoxification personnel complain that police deliver some skid row derelicts who are either not intoxicated or just barely so.

Various approaches are used by pickup agents both to clear the streets and to provide service to emergency case skid row inebriates. Not only police officers, but the whole system tacitly accepts informal norms for processing inebriates. Non-skid row inebriates may be sent home, while non-emergency skid row cases may be confined to parks and other places where they are neither bothersome nor visible. In San José, police use the jail for overflow when detox is filled to capacity. The inebriate is held under "protective custody" and not booked.[26] Protective custody pickups are widely used in other jurisdictions as well.[27] Some beat officers use even more informal tactics, removing inebriates to out-of-the-way places, sometimes in the territory of another officer's beat.

The model used in Kansas City appears especially worthy of consideration by jurisdictions that desire to emphasize both the goals of clearing the streets of "public nuisances" and providing more humane services to emergency case public inebriates. Subject to certain limitations, street inebriates picked up by the police have the option of arrest for public drunkenness or voluntary delivery to Sober House, a short-term nonmedical

sobering-up facility with counseling and referral services, managed by the Salvation Army in the downtown area. An individual in obvious need of medical attention is taken to a participating hospital and then transferred to Sober House in a Sober House vehicle. A person is free to leave Sober House at any time.

With these options, a police officer can readily handle both the cooperative and the unruly inebriate. The two goals of clearing the streets and providing more humane care are served. There are problems with this model, including the criteria for determining which inebriates are taken where, and the fact that under such police diversion programs the pressure for decriminalization may be reduced. But this mixed model may be a viable approach for cities unwilling or lacking resources to implement decriminalization fully.

A variant of the mixed model within a "decriminalized framework" is used in Boston, Massachusetts, where public drunkenness was decriminalized on July 1, 1973. Pursuant to the Comprehensive Alcoholism Treatment and Rehabilitation Act, the police officer has four options: take the inebriate home, to a hospital, to a detoxification center, or to jail in protective custody. A public inebriate taken to jail is classified as an "incapacitated person"; he may not be held for more than 12 hours and no record of arrest is maintained. Admission to the detoxification center is voluntary and a street drunkard can be transferred from jail to the detox center. This approach provides formal options both for clearing the streets and for providing therapeutic services. In the fiscal year prior to decriminalization, there were 12,627 arrests for public drunkenness in Boston. In the year after decriminalization, there were 8,755 protective custody pickups. This suggests that protective custody is viewed by police officers as a viable option for clearing the streets.[28]

b. Clearing the streets vs. rehabilitation or reintegration. If clearing the streets is emphasized, many individuals incapable of rehabilitation will be delivered to therapeutic facilities, flooding their capacity and limiting the room available for potentially curable cases. Here again, informal methods are often used to resolve the conflict. Police officers often move skid row inebriates into alleys or other unobtrusive places, channeling only those perceived as "curable" into the rehabilitation system. Such methods, however, often violate the letter and intent of the law.

Detoxification centers may adjust to the clash by encouraging voluntary, nonpolice sources of referral of inebriates. When law enforcement personnel find detox centers frequently filled to capacity, they turn increasingly to informal methods or to criminal charges such as disorderly conduct, drinking in public, urinating in public, and the like.

Another device used by detox centers is the exclusion list, containing the names of persons the center is unwilling to admit. We found indications of this practice in nearly every therapeutic jurisdiction we visited. In some areas, the existence of such a list is a guarded secret. In others, such as Kansas City, the lists are published in memorandum form, read at roll calls, and posted on bulletin boards. They are generally updated monthly and typically include from five to eight "troublesome" inebriates. The Detoxification Center in Sacramento, California, has a "Do Not Admit"

list of approximately 80 persons, whose exclusion is based on the following, somewhat vague, criteria: (1) persons who have been disruptive in previous stays at detox; (2) overt homosexuals; and (3) persons who have indicated no interest in alcoholic rehabilitation or who are openly hostile to rehabilitation referral.[29] In San Francisco, the Mobile Assistance Patrol, the civilian pickup agent, has developed a sense of which types of inebriates should be taken to each of the four detox centers. Since pickup is voluntary, potentially troublesome cases are avoided.

Selective exclusion by the detoxification center can lead to strained relations between police and public health workers, since beat officers learn that they cannot rely on the center to solve their problems with public inebriates. On the other hand, some detoxification centers design intake policies in order to accommodate law enforcement needs. For example, the Erie Detox accepts referrals only from police officers. Such a policy is designed to save criminal justice resources and provide short-term services to the emergency-case public inebriate. Where a jurisdiction has a high volume of arrests, the diversion of inebriates to detox and other facilities can reduce the time law enforcement officials spend in court and can free correctional resources.

2. Conflicts Among Decriminalization Goals.

a. Emergency case service vs. rehabilitation. A detoxification center which begins by providing emergency services is not likely to show much success in rehabilitating inebriates. Staff personnel and police see the same intoxicated persons again and again and become disenchanted with the program. Others, such as political leaders and the media, criticize the program because of lack of understanding of its limited-purpose emergency character. Public health workers generally prefer to work with the more motivated clients (i.e., middle class inebriates). When health officials seek permanent funding, bureaucratic pressure grows to show "rehabilitative success."

Under such pressures, a system may change its goals and attempt to become a rehabilitation facility. But if improved results are to be shown, a change of focus may be needed. This may require dealing less with emergency skid row type cases and more with non-skid row inebriates. Since the police, as pickup agents, usually emphasize the delivery of skid row type emergency cases, the center may find itself turning more and more to voluntary intake mechanisms. Thus the system in time becomes more specialized and more discriminating, defining success not in terms of emergency service, but on the basis of low recidivism rates and other measures of rehabilitation.

This pattern is illustrated by the St. Louis Detoxification and Diagnostic Evaluation Center. In the fall of 1966, the St. Louis Center opened a 30-bed unit at St. Mary's Infirmary, a hospital near the downtown business district. Originally, the Center limited its admissions to police cases from the Fourth Police District, which accounted for over 50 percent of all drunkenness arrests in 1966. Within a month, the Third District was added, and in March, 1967, the Ninth District as well. Together these Districts accounted for 82 percent of the city's 1,733 drunkenness arrests in 1966. The remaining six police districts did not formally participate until 1970.

At first, officials were content to provide emergency services and accepted the marginal success in rehabilitation. When federal funds were exhausted, the Center was moved to the grounds of the state hospital as a means of securing state funding. The new location was far removed from the primary areas of drunkenness arrests. As new officials took over and the Center became larger and more institutionalized, the original mission faded and concern began to mount over the high frequency of readmissions. It was perceived that recidivism might be reduced if the population served by the Center changed. In 1973, detox stopped reserving beds for police cases, and patients were taken on a first-come, first-served basis. There are indications that the Center increasingly accepted more volunteer admissions, and fewer skid row cases. The ratio of voluntary admissions to police deliveries shifted radically.[30] Police officers report that they frequently found the Center filled, and police referrals declined in 1974, after a steady 4-year increase.

b. Rehabilitation vs. conservation of criminal justice resources. Decriminalization is likely to result in saving criminal justice resources, so therapeutic goals of improved services to the emergency case inebriate and rehabilitation are basically compatible with conserving criminal justice resources. In cities where arresting for public drunkenness is no longer an option, substantial savings are likely to be realized,[31] as police tend to deemphasize the pickup of the non-skid row inebriate. Where detoxification centers focus on the emergency police case inebriate, providing emergency services and saving criminal justice resources are probably compatible. A minimal commitment of police resources is involved in seeing to the needs of the emergency cases. However, a goal conflict may arise when the objective of rehabilitation produces an increasing number of voluntary admissions. In that case, beds that could be used for police admissions are unavailable when detox is filled to capacity.

In jurisdictions that have decriminalized public drunkenness, emphasis on voluntary admissions may increase pressure on police to substitute other charges when the detox center is filled. In Minneapolis, the Alcohol Rehabilitation Center has encouraged self-admissions of problem drinkers through advertising and community contact. This approach may have contributed to--and perhaps partially compensated for--the reduction in police arrests for public inebriation, although disorderly conduct arrests have increased. In the period June-August 1974, the total number of admissions to the detoxification center increased 17 percent, from 2,299 to 2,689, while police referrals declined from 844 to 480. Disorderly conduct arrests, which averaged just under 700 during 1960-1966, jumped to a yearly average of nearly 2,000 during 1971-1975. The effective result has been a continuation of arrests for public drunkenness, although the charge is now disorderly conduct.

In jurisdictions that permit both arrests for public drunkenness and diversion to a detoxification program, emphasis on rehabilitation through voluntary admissions may actually have an adverse impact on criminal justice resources. In Sacramento, California, for example, a principal goal of the detoxification center was a reduction in public drunkenness arrests of 50 percent over a 12-month period. The actual decline from June 5, 1973 through December 1, 1974 was less than 30 percent; during that period, voluntary admissions accounted for 28.4 percent of all admissions.[32] When

police found the detoxification center constantly filled to capacity, they turned to public drunkenness arrests as the only viable option.

There is a real dilemma here. To refuse voluntary admissions is to deny treatment to those having the highest rehabilitation potential. On the other hand, unlimited voluntary admissions tend to overload treatment facilities, and put increasing strain on the criminal justice system. Programs in Kansas City, Erie, the Manhattan Bowery Project in New York City, and San José, prohibit or discourage nonpolice voluntary admissions, but this too seems arbitrary since persons in need of treatment may be turned away at the door. A reasonable compromise would seem to be a policy limiting, but not entirely precluding, voluntary admissions.[33]

The degree to which the public policy goals will conflict or be compatible depends on the particular circumstances in each jurisdiction. Jurisdictions that have fewer public inebriates--Kansas City and Erie as contrasted with Washington, D.C., Minneapolis, and San Francisco--are likely to have much less difficulty in reconciling traditional criminal justice and therapeutic goals. Detoxification programs that focus on emergency police case inebriates seem most compatible with the goal of reducing the processing of public inebriates through the criminal justice system. Jurisdictions which stress "quality" (noninebriate) arrests and the informal disposition of street inebriates will have much less conflict and tension in adjusting to a decriminalized approach.

One of the discouraging conclusions is that, although theoretically there should be a compatibility between the therapeutic goals of providing more humane care and emergency services and rehabilitation, in practice a conflict exists. It is supposed to be possible to channel the emergency case from the detoxification center into the rehabilitation system, but a goal conflict tends to emerge with a greater emphasis on rehabilitation of middle class voluntary admissions at the expense of emergency care for the skid row inebriate brought in by the police.

C. EXCLUSIVE RELIANCE UPON THE POLICE AS PICKUP AGENTS

Police may be used as the exclusive pickup agent in both criminal and decriminalized jurisdictions to meet this mix of goals. Such pickup may require the assent of the inebriate or may involve the more traditional involuntary approach. In criminal jurisdictions, police pickup of public inebriates is one of the tasks usually assigned to the patrol division, although traffic division police officers may also make public inebriate arrests. Variations of this model, used in both criminal and decriminalized jurisdictions which retain the police as the exclusive pickup agent, include: (1) increased use of specialized transport vehicles, especially the police wagon or van; (2) increased use of specialized foot patrol officers; (3) use of jails as a drop-off point for subsequent delivery to a therapeutic facility and for "protective custody" release when sober.

Many jurisdictions use a combination of the above police pickup approaches. For example, in Houston, Texas, a criminal jurisdiction, two-man patrol cars typically cover relatively large beats. The inebriate is transported by the patrol vehicle either to the central cellblock or one of the outlying district cellblocks. This results in the patrol vehicle being

unavailable for patrol for 15 to 40 minutes, depending upon where the public inebriate is picked up. In the central district where Houston skid row inebriates are concentrated, a police "wagon man" specializes in transporting public inebriates to the central cellblock. Officers in the traffic division, including walking-beat officers, officers using solos (motorcycles) and three-wheelers, as well as patrol division officers are also instructed to make public inebriate arrests. Upon deciding to arrest a public inebriate, these officers will call for the wagon to transport the public inebriate to jail.

1. Specialized Transport Vehicles--The Police Wagon. A primary advantage of using a police wagon is the ability to pick up and transport several inebriates on one trip. Inebriates remain in the back of the wagon until several other inebriates are picked up for delivery. In Kansas City, Missouri, wagon officers actively seek out inebriates in the course of their patrol and, especially in the central patrol division, the wagon is heavily relied upon to transport public inebriates. In a ride-a-long with a wagon officer, we observed the pickup and delivery of four inebriates to Sober House, the Kansas City therapeutic facility for the police diversion program. Upon arrival at Sober House, the officer filled out an admitting report and called police headquarters to get identification numbers for his report, a process which took about 30 minutes or an average of about 8 minutes per inebriate. Here, both the goals of keeping the streets clear of inebriates and improving treatment of the emergency case can be met through the use of an aggressive wagon patrol which can deliver inebriates to a therapeutic facility as well as to the jail.

In St. Louis, Missouri, the police in 1963 doubled arrest rates in a short time, in part by using the more efficient method of transporting skid row inebriates by wagon. The police-initiated pilot program was designed to facilitate the arresting officer's disposition of the public inebriate, to encourage increased pickup of those intoxicated in public, and to assure an initial medical screening of inebriates at a city hospital. The arresting officer only had to call for a two-man police wagon and could return to service upon its arrival. The Intoxicated Person Report was completed by the officers in the wagon; they were responsible for transporting the inebriate to a city hospital for medical diagnosis and then to the Central Police Headquarters for booking.

In Chicago, Illinois, special two-man "bum squads" have been efficiently used to clear the streets of skid row inebriates. In 1968 virtually all of the 21,839 arrests under the drunkenness subsection of the disorderly conduct ordinance were made by special two-man squads between 6:00 a.m. and 10:00 p.m. Arrest-complaint forms were filled prior to patrol, leaving blank only the name, address, and occupation of the arrestee. This process permitted a large number of arrests--60 to 100 per day--with a minimum commitment of manpower.[34]

Overall, we found no more efficient means of keeping the streets clear of public inebriates than through the use of police wagons as either the core or a vital part of the pick-up process.

2. Increased Use of Foot-Patrol Officers. Increased use of foot patrol or walking beat officers in areas where public inebriates are

concentrated can be very effective. In Minneapolis, Minnesota we observed that an inebriate was much more likely to be picked up by an officer walking a beat than by one in a scout car. The beat officer has a greater opportunity to notice the inebriate and, of course, the inebriate is much more difficult to ignore when there is a personal encounter.

The St. Louis Police Department places an emphasis on foot patrol officers in the downtown business area. The officers who remain on walking beats for a period of years get to know many of the public inebriates personally. They become familiar with the areas where public inebriates hang out. They know the bar owners and managers of cheap hotels and missions. Informal dispositions are facilitated. The presence of the police officer on the street provides visibility and a sense of protection not provided by scout car patrol. When a foot patrol officer decides that a formal disposition is needed, he can call for a wagon or patrol vehicle.

In Kansas City, Missouri, the central patrol division assigns one foot patrol officer to the market area during the day shift. The officer who walks this beat knows all of the "gandies" (skid row men who occasionally work in transient jobs in the market area) and discourages intoxicated persons from milling around the market stands. Foot patrol officers can also be effective in dealing with non-skid row inebriates, especially in suppressing disorders around honky-tonks or bars.

The combination of a van and foot patrol officers may be organized into a specialized squad to conduct "police sweeps" to clear the streets of public drunks. In San Francisco, California, we observed a police sweep. A patrol wagon was slowly driven down the street with five or six foot patrol officers led by a sergeant. The officers walked on both sides of the street. Each public drunk encountered was walked, carried, or pushed into the back of a poorly ventilated police van. The van could hold 10 or more inebriates. The sweeps were undertaken twice each day, which left the officer free to engage in general patrol during the rest of the shift.

3. Use of Jails as a Drop-Off Point for Subsequent Delivery to a Therapeutic Facility or for "Protective Custody" Release When Sober. Other tactical approaches involve the use of alternative drop-off points to ease police burdens. The jail may be used as a temporary drop-off point for subsequent delivery to a therapeutic facility. Alternatively, the jail in a criminal jurisdiction may serve as a short-term holding facility where the public inebriate is released when sober with no further criminal processing. The jail may also be used in lieu of therapeutic facilities in decriminalized jurisdictions for "civil protective custody."

a. The jail as a temporary drop-off point. In Boston, Massachusetts, both police officers and civilian street "rescue teams" pick up public inebriates under the Alcoholism Treatment and Rehabilitation Act which decriminalized public drunkenness. When a police officer picks up a street inebriate, the inebriate is usually transported by the police to the local stationhouse and held, for a maximum of 12 hours, under "civilian protective custody." The civilian street rescue team is responsible for transporting inebriates from the stationhouse to detox. When a person is taken into protective custody, police officers are then obligated to notify the detoxification center. Rescue team members also make regular, informal

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2 OF 3

visits to the police station to pick up intoxicated persons about whom the center has not yet been notified. In the year following decriminalization, approximately 20 percent of admissions to the detoxification center resulted from police use of this two-stage processing system.[35]

The availability of the two-stage processing system in Boston, Massachusetts, provides an incentive for the police to pick up inebriates. The use of the jail as a drop-off point saves transportation time for many police officers and assures that space is always available. In practice, inebriates who elect not to be transferred to the detox center are released on average after 6.54 hours.[36]

The drop-off center for a two-stage processing system can be the local jail, a detox screening center, or a combination, using both criminal and detox facilities. In Santa Clara County, California, 12 police organizations[37] as well as alcoholism outpatient clinics and other organizations make referrals to the detoxification center. Most police referrals are from the San Jose Police Department. The 137 bed detox facility involves a 15- to 20-minute ride each way for San Jose police officers. The county established an alcohol service center with 24-hour intake and screening services in downtown San Jose. San Jose police officers conveniently drop off street inebriates at this screening facility. The detox center provides the transportation between the screening facility and the detoxification center. Although relatively few inebriates are referred from the outlying police departments, public inebriates are transported from rural jails and alcohol outpatient clinics by personnel from the alcoholism outpatient clinics, by a taxi cab voucher system, and by the police.

b. The use of the jail for protective custody/release when sober. Police departments have traditionally used the jail as an informal, overnight facility for public inebriates and truants. This informal system has been formalized in some criminal jurisdictions. In Pittsburgh, we were informed that this practice saves substantial jail costs, including feeding public inebriates, as well as court and correctional expenses. In Philadelphia, some 26,000 inebriates are "arrested" annually without a court appearance.

In decriminalized jurisdictions, police pickup and delivery to the jail may be continued for many inebriates. In St. Louis, a jurisdiction retaining the arrest option, a charge of "protective custody" is theoretically available only for drunkenness in a private place. But this charge has been heavily used for processing public inebriates. In Oregon, the state statute decriminalizing public drunkenness provides for civil custody in a city or county jail when appropriate treatment facilities are lacking.[38] The inebriate can be held for up to 48 hours; the court having local probate jurisdiction must be informed of the admission within 24 hours. In Salem, Oregon, prior to the opening of the detoxification center, civil protective custody pickups were used extensively. Finally, in San Jose, California, the jail has been used as an over-flow facility when detox was filled to capacity. Although of questionable legality, this approach may be one of the few viable ways of keeping the streets clear of public inebriates when the detox facility has inadequate bed space.

D. APPLICATION OF THE INCENTIVE AND DISINCENTIVE APPROACH TO IMPROVE HANDLING OF PUBLIC INEBRIATES

The incentives and disincentives reviewed in Chapter 1 (i.e., economic information, communication, authority, and power incentives) can provide the basis for criminal justice and public health planners and administrators to formulate a strategy for more successfully implementing public policy goals. This section suggests components of such strategy.

1. Formulation of Goals at Upper Levels of Police Command Structure, Public Health Agencies, and Municipal Government. The police chief executive and upper levels of the police command structure should give personal attention to the task of explicitly formulating priorities in the handling of public inebriates.[39] The priorities should be based on a consideration of the number, types, and location of street inebriates, as well as available resources and desires of community members and local groups. If a question arises concerning authority to formulate and set forth priorities, they should consider whether legislative authorization, formal or informal, and municipal government approval is desirable. In order to obtain information relevant to fashioning these priorities and enhanced legitimacy and acceptance, they should use a process that includes communication with public health agencies, personnel at various levels of the police department, including patrol officers, and, perhaps, representatives of interested groups and the general public.[40]

2. Operationalizing Public Policy Goals: Policy Directives, Guidelines, and Rules. Upon establishing priorities among public policy goals, information should be communicated to police and other pickup agents to enable such persons to understand the purposes and practical meanings of these priorities. Given the dimensions of the problem of selective enforcement in handling public drunkenness, goal statements should be supplemented by police directives, guidelines, and rules to provide adequate guidance to pickup agents.[41]

The growing literature on approaches to "confine," "structure," and "check"[42] police discretionary power may be of assistance procedurally and substantively in the task of formulating directives. Models may be considered in other areas of police discretion, for example, the comprehensive and detailed guidelines and rules to regulate police discretion in the handling of juvenile curfew violations by the Dayton, Ohio Police Department.[43]

In our site visits, we found examples of efforts of police administrators to set boundaries and provide guidance to police officers in dealing with public drunkards in Washington, D.C.,[44] Minneapolis, Minnesota,[45] Kansas City, Missouri,[46] and Salem, Oregon.[47] Also we saw examples of more traditional police department regulations, such as field procedures to be used on making a public inebriate pickup, regulations on admitting intoxicated persons to a detoxification center, communicating with the police radio dispatcher, completing police reports, and so on.[48]

Controversy exists on how particular and detailed guidelines and rules should be made for handling public inebriates without being impractical and interfering with the needed leeway for individual interpretation. Understandable police department apprehension can be dealt with by using drafting

phrases such as "absent extraordinary circumstances" and "ordinarily" to leave room for necessary discretion to individuals in light of all the facts and circumstances of particular cases, yet clarify the overall policy and its implications. Whatever procedure is adopted for formulating policy directives, a process that at least involves lower level command and line officers in its design will probably increase the likelihood of successful implementation.

3. Reinforcement of Policy Directives, Guidelines, and Rules. A variety of reinforcement or change devices (incentives and disincentives) is needed to develop among police officers a sense of the importance of public policy priorities with respect to public inebriates and to ensure that the implementation of legal and public policy norms is not thwarted by conflicting self-interest and organizational goals. While many types of reinforcement devices may be successfully used, we have selected those that are most subject to the short-term control of the police chief (and higher level governmental officials); hence, they tend to emphasize the organizational variable in our police discretion model. We do not discuss some devices, such as review panels and various forms of discipline that are unlikely to be very helpful in implementing these policies.

a. Economic incentives: specialization. There are various kinds of specialization available to a police chief executive to increase the likelihood of attaining the various public policy objectives involved in handling public inebriates. The most common form of specialization used is the general patrol specialist who operates within the ordinary organization of the patrol division. Two examples of the general patrol specialist, discussed earlier, are patrol wagon drivers and foot patrol officers. They may be used for implementing order maintenance and/or therapeutic goals both in criminal and decriminalized jurisdictions. A combination of walking beat officers and a wagon has proved especially effective in achieving street clearing aims in the downtown areas of large cities.

One problem of the use of general patrol specialists is that they also deal with a variety of other police tasks which may militate against their developing a commitment to the notion that dealing with public inebriates is really a matter of high departmental or social importance. An alternative is to organize a specialized unit within the police department for handling public inebriates. A department could establish a relatively small unit, either within the patrol division, a special operations division, or some other division of the department, and assign that unit the responsibility for achieving all or part of the department's objectives within geographic areas of high incidence of street inebriates. Undistracted by the wide range matters, both mundane and emergency, which confront the generalist patrol officer, specialist units tend to develop pride in their function, even though it may be disdained by generalist patrol officers. A specialist unit would be given either primary or exclusive responsibility for controlling public drunkards within designated geographic areas and, in therapeutic jurisdictions, could function as the police department counterpart to the civilian van programs.

Although the benefits of a specialist unit seem to be great, such units are expensive, not only in terms of basic personnel to perform the function, but because the unit needs supervisory, administrative, and

support personnel to fulfill needs usually absorbed when a function is performed by patrol division generalists, rather than by specialists.

b. Power and authority relationships.

(1) Personal attention of police chief. The amount of personal time and attention devoted by the police chief and the commander of the patrol division--as well as by other high level governmental officials--to emphasizing policies regarding public inebriates will significantly influence how those policies are perceived by the line police pickup agents. The real tone of a policy change may be set by public speeches and media statements of the chief of police and other high governmental officials rather than through written directives, guidelines, and rules. In this way, patrol officers are much more likely to pay attention to the written directives. Additionally, the police chief discussing the topic at staff meetings, conferring on a regular basis with the departmental coordinators, and reviewing and commenting on statistical reports will pay large dividends in the response of patrol officers implementing the department's policy directives.

(2) Designation of part-time supervisor coordinators. A well tested technique to induce compliance with policy directives is the designation of a departmental coordinator or coordinators to give continuing attention to their implementation. For example, the police chief of the Kansas City Police Department designated a senior official of the department to be responsible on a part-time basis for monitoring the level of public drunkenness in various parts of the city and the extent to which there is compliance or noncompliance with department policies. The deputy police chief in charge of the patrol division of the Houston Police Department similarly designated a senior supervisory official to monitor police operations involving public inebriates in the downtown area. The importance this kind of part-time assignment is likely to have for the designated coordinator will depend on how significant he thinks the matter is to the chief of police. This will depend, in part, upon how often the chief of police discusses the matter with the senior official. In turn, the perception among field personnel of whether or not the chief of police views the matter as important may be inferred from whether the designated coordinator is an official who sees the chief of police very often and is someone in whom the chief of police is believed to have confidence.

Another approach which can be used to supplement the part-time supervisor is for the chief of police to require each patrol district or other similar subunit of the department to select a unit coordinator, perhaps of the rank of lieutenant or sergeant, to be delegated specific responsibility within that unit for monitoring the implementation of the revised policy. If problems of public inebriation are concentrated within one or two patrol districts, unit coordinators may be advisable only within those areas. The value of the unit coordinator method can be enhanced if the chief of police insists that they be selected from among the ambitious junior officers seeking promotion. Also, the unit coordinators should be brought together on a fairly regular basis by a departmental coordinator or other senior official and/or be required to submit regular written reports to some reviewing official.

Finally, the police chief and public health officials should ensure coordination with the detoxification units in jurisdictions using therapeutic alternatives. Good relations with all levels of the patrol division and the detoxification unit are important. In order to "institutionalize" such contacts, the police chief should designate a high level official with the specific responsibility for coordinating and monitoring the interaction between the police and the detoxification unit. The function can be performed by the same senior level official designated to oversee the implementation of the department's objectives for handling public inebriates. In Kansas City, the commander of special operations routinely monitors police performance regarding street inebriates and maintains regular informal contact with the director of the detoxification center. In the District of Columbia, the inspector assigned as night supervisor was given responsibility for monitoring relations between the patrol force and the detoxification center while the director of planning was assigned responsibility for maintaining administrative coordination with the detoxification center.

c. Communication and information incentives.

(1) Training and reminders. Training is an obvious and basic form of reinforcement of policy directives, guidelines, and rules. Most of formal police training is done in the recruit school, but much is also done through in-service training sessions and roll-call training by supervisors. Recruit school training can be a valuable opportunity for instilling an understanding of the department's policies and approaches relating to public inebriates, alcoholism, the operation of the detoxification center, etc. Nevertheless, if recruits are taught new approaches in recruit school and then are sent to the field where experienced officers are using different approaches, the "peer relationship" interaction will operate to nullify or significantly diminish the impact of the formal training. Hence, a major change in departmental processes requires specific training of all patrol officer pickup agents including first-line supervisors.

But training programs can be very expensive. While proponents of training programs often count the cost only in salaries of instructors, classroom facilities, and supplies, the largest cost of instruction for a police agency is in the time of the police officers attending classes. For example, Jerry Wilson, former chief of police, Washington Metropolitan Police Department, has estimated that just 1 hour of roll-call training for each patrol division officer (not counting supervisors) of a 3,000 complement police department would cost about $10,000 in police time (measured by direct salaries) if performed during regular tours of duty and about $15,000 if performed as overtime assignments. Since salaries are fixed costs, however, the true economic cost would be the opportunity cost of lost work productivity, assuming training occurs during regular working hours. This is very difficult to measure. The potential benefits, however, in terms of improved management of public inebriates should be substantial.

Less expensive than formal roll-call training is the use of roll call for brief informational purposes, as well as for oral reminders by supervisors. In Erie, Pennsylvania, detoxification center officials used roll calls as the primary vehicle for explaining the new detoxification diversion program to all of the patrol officers. If oral reminders are specifically required on a weekly basis, there is a danger that some supervisors will

engage in such routinized litany that the reminders become meaningless. At the executive levels of the department, oral reminders may consist of discussions by the chief of police with other senior officials at staff meetings.

In our site visits, little use of training programs and reminders for handling public inebriates was observed. When the St. Louis Detoxification Center opened in 1966, the personnel of the Social Science Institute of Washington University participated in designing and providing instruction at the police academy. Six hours were devoted to the subject of problems of alcoholism, including instruction by Dr. Joseph B. Kendis, one of the founders and the first Medical Director of the detoxification center. Today there are less than 2 hours of a 640-hour training program devoted to the subject. Even this figure is generous since detoxification procedures are taught in connection with the subject of Driving While Intoxicated and mixed in with numerous other subjects.

(2) Reporting requirements. The requirement of statistical reports is probably the most prevalent form of reinforcement of written directives. Police departments require that monthly or quarterly performance tabulations be made showing the activity of each officer within a given organization or unit for such items as offense reports taken, traffic accidents investigated, and felony and misdemeanor arrests, including public drunkenness. While these performance reports often are criticized as constituting "arrest quotas," in practice they are usually less than quotas, serving as measures by which supervisors can judge which officers are "producing" while on patrol and which are not. In order to provide the information for these reports, patrol officers are required to submit a daily or weekly activity report of formal actions taken.

An illustration dramatically reveals the incentive of reporting requirements to direct police activity in handling public inebriates. In Washington, D.C., decriminalization of public drunkenness resulted in a substantial reduction of police interest in the problem. At one point in 1971, the spectacle of derelict inebriates on the downtown streets resulted in action by the chief of police to stimulate the police to pick up and transport such persons to the detoxification center. The primary device for accomplishing this was the requirement of a monthly statistical report from the First District commander to the police chief on the number of individuals taken to the detoxification center each day. Consequently, the number of derelict inebriates on downtown streets was reduced. After a time, the First District ceased submitting the report (due to inattention and a lack of feedback on the reports), resulting in a recurrence of a noticeable problem. The police chief, in 1972, reinstituted the reporting requirement to ensure increased street level attention to the problem. More recently, in Houston, "Operation Sparkle," an effort to clean up the downtown area including removal of skid row inebriates from the streets, resulted in a requirement of daily reports showing the number of citizen complaints and of public inebriate arrests.

There are numerous hazards in using statistical reports for measuring performance toward objectives. Aside from the possibility that false statistics may be submitted, there is the potential that personnel at the operational level will simply revise their procedures to produce the

statistics demanded without achieving the objective. Applying statistical reinforcement to the goal of taking derelict inebriates to a detoxification center might stimulate patrol officers to take in public inebriates who could just as well be sent home or derelicts who are not intoxicated.

4. Interagency Communication and Information Patterns: Improving Police and Detoxification Center Cooperation. Attention must be given to improving the contacts between police department and detoxification center personnel. What can be done through the public health bureaucracy to improve the interaction between the detoxification center and the police department to increase the likelihood of attaining public policy goals? The following discussion, unless specified assumes that police officers have responsibility for delivering intoxicated persons directly to the detoxification center. Civilian van pickup systems, including police officer contacts with civilian agents, are discussed in the concluding section of this chapter.

a. Consult with the police department in the early planning stages. As indicated earlier, the police department should be consulted when the initial goals are being established to insure that order maintenance needs and pressures are taken into account. In St. Louis and Kansas City, consultation took place with significant initial beneficial results. In Washington, D.C., and Minneapolis, consultation to any significant degree did not take place, resulting in a failure to obtain a consensus of public policy goals and inadequate consideration of practical issues in designing an effective pickup process.

b. Conveniently locate the detox center or provide drop-off centers. In addition to the needs of the public health bureaucracy, adequate consideration should be given to the location of the public inebriation problem and the needs of police pickup agents. There is a direct relationship between the transportation time and police costs and attitudes in delivering individuals to detoxification centers. If detoxification centers cannot be conveniently located, several alternatives are available, including the location of a separate intake unit, such as in Santa Clara County, California, or the use of the jails as the first stage of a two-stage pickup and delivery system.

c. Provide adequate bed space or develop guidelines and coordinate detox admissions. Delivery to detox should be ingrained in police officers as ordinary operating procedure. If adequate bed space is not available, detox should consider setting aside bed space for police referrals if the objectives include encouraging police referrals. In St. Louis, bed space was reserved for police cases after the detoxification center moved to the state hospital, but eventually, as the number of beds increased and the objectives shifted, this practice was discontinued with the result that police referrals declined. When beds are simply not available, a procedure should be worked out for giving advance notice through the dispatcher so tnat a wasted trip will not be made.

A serious problem in the allocation of bed space may result when the work schedules of the police and the public health officials are in conflict, such as occurred in Boston. The detoxification center, which is understaffed, suffers its most severe staff shortages during the evening and

night shifts. Patients are discharged during the day making available new space which is quickly filled so that few empty beds are available during the evening and night shifts. Police pick up inebriates 24 hours a day and pickup is heavier during evening and night shifts. When conflicts occur in work schedules, joint efforts should be made to coordinate scheduling of admissions and, if necessary, adjust work schedules to better attain public policy objectives.

Another manifestation of conflict between the organizational and value orientations of police and public health personnel is informal, and often secret, "do not admit" lists of detoxification center personnel. These are lists of public inebriates who are deemed unacceptable. Indications of this practice were apparent in nearly every therapeutic jurisdiction encountered. Criteria for exclusion from detox services include: (1) persons who have been disruptive in previous stays; (2) persons who have indicated no interest in alcoholic rehabilitation or who are overtly hostile to rehabilitation referral; and, occasionally, (3) overt homosexuals. The Kansas City detoxification center has been the most open about their monthly updated "blackball" list which is distributed to police officers at roll calls.

The use of "do not admit" lists reinforces police perceptions that the detoxification center cannot be relied upon to respond to their need to promptly and efficiently make all public inebriate dispositions. An accommodation between conflicting therapeutic and order maintenance goals of this importance should be legally authorized or at least based on criteria arrived at through joint consultation of higher level police and public health policymakers. A unilateral determination of lower level detoxification center personnel is likely to be heavily influenced by pressures to achieve rehabilitative success at the expense of other administrative goals.

d. Efficient and pleasant intake procedures at the detoxification center. Intake procedures should be designed so as to minimize the paperwork and reporting requirements of the admitting officer, to give priority to servicing the police, to reduce their out of service time, and to make the atmosphere and reception pleasant for police officers. At one detoxification center police officer percentions of a warm and friendly detoxification center staff were reinforced by free coffee and cookies or doughnuts. Police officers were encouraged to get to know the detoxification center personnel and their operations.

e. Improve communication with all levels of the police department. Consideration should be given to inviting the chief of police, or his representative, to sit on the board of directors of the detoxification center. For example, in Kansas City, one police officer has always served as a member of the board of trustees of the detoxification center. Further, detoxification centers in cities where skid row inebriates are a major problem in the downtown area should consider inviting a representative of the local merchants' association to sit on the board of directors. Since business establishments are a major source of pressure for clearing streets of public inebriates, their improved understanding of what the detoxification center is attempting to accomplish and their active assistance should aid in accommodating conflicting order maintenance and therapeutic goals. In San Jose, California, such an invitation was extended to the merchants'

association after the downtown merchants, tired of unheeded complaints, took their complaints directly to the mayor and city council.

Detoxification center officials should communicate with patrol officers not only at the detox center, but in police training programs, roll calls, and through the preparation and dissemination of reports detailing such information as the number of inebriates handled and the numbers and types of referrals. Detoxification center officials rarely consider police personnel as important members of the audience to which evaluative and other information should be disseminated.

Public health officials should make a concerted effort to counteract false and unrealistic impressions of what detoxification centers can accomplish for street drunkards. In most of the cities that were site-visited, the detoxification center has been "sold" to police officers as a place where public inebriates can be "rehabilitated." When police officers see the same intoxicated persons on the street (especially where the revolving door is actually speeded up due to the absence of longer term therapeutic facilities) they become disillusioned. It is preferable to emphasize the improved humane handling and emergency services provided by a detoxification center and the saving of scarce criminal justice resources, especially court and correctional resources. Additionally, in most cities that we visited, police officers tend to perceive detox as a place that is not generally suitable for non-skid row public inebriates. If public policy priorities include the use of the detoxification center for non-skid row inebriates, education and other efforts should be undertaken to alter these police perceptions, unless nonpolice sources, including voluntary admissions, can provide adequate intake.

E. RECENT INNOVATIONS FOR IMPROVED HANDLING OF PUBLIC INEBRIATES

1. Use of Nonpolice Personnel in Pick-Up and Delivery Systems. Both criminal and decriminalized jurisdictions are experimenting with approaches in which nonpolice personnel are used to pick up and deliver public inebriates to therapeutic facilities and other destinations. The most prevalent form of nonpolice pickup is the civilian van program. In light of its growing use and importance, we present four fairly detailed case studies in trying to assess how the use of civilian vans might help attain public policy objectives. Two of the civilian transport systems are in criminal jurisdictions (San Francisco's Mobile Assistant Patrol and Erie's Crossroads Center Pick-Up Program); two are in decriminalized jurisdictions (Minneapolis' Civilian Pick-Up Service and Salem's Mobile Outreach Program).

Following discussion of these civilian van programs, consideration will be given to other approaches using nonpolice personnel: combined police/nonpolice rescue teams (Manhattan Bowery Project); the increased use of public transportation, i.e., taxicab transportation of public inebriates; greater emphasis on private agency referrals, and encouragement of walk-ins.

a. Civilian van pick-up service in criminal jurisdictions.

(1) San Francisco, California Mobile Assistance Patrol. The Mobile Assistance Patrol (MAP), sometimes referred to as the "Boozer

Cruiser," is a civilian-run transportation system for public inebriates who "voluntarily" elect or are persuaded to be transported to public health facilities.[49] The MAP supplements the activities of the San Francisco Police Department in a jurisdiction that treats public drunkenness as a crime; it acts simultaneously as a "pre-arrest" case finder and police diversion program.[50] MAP has two vans, although only one is generally used, and operates 24 hours per day, 7 days each week with the services of eight driver/counselors and a supervisor. The civilian pickup system responds primarily to telephone calls from the police, public health personnel, and private citizens through a central office located in the downtown skid row area.[51] MAP deemphasizes routine patrol. It operates in a narrow geographical area of downtown San Francisco and focuses on skid row and transient public inebriates.[52]

MAP determines which street inebriates are in need of services and which services should be made available. It deals with the problem of a large number of street inebriates in need of services and a severe shortage of bed spaces at detoxification centers. The four detoxification centers[53] have a total capacity of approximately 70 beds, each servicing a somewhat different clientele.[54] Typically, there may be few or no available beds after 5:00 p.m. and on weekends.

Many street inebriates do not desire the services of MAP, especially when the alternative is not an impending arrest. The type of encounter most likely to lead to a request for MAP's services occurs when a police officer is the source of the call for MAP and elects to remain with the inebriate until MAP's arrival.[55] The choice then confronting the inebriate is between MAP pickup or arrest. Some inebriates do not meet the criteria used by MAP for making pickups. Inebriates are ineligible for MAP pickups if they demonstrate: (1) combative or assaultive behavior which is dangerous to staff or other clients; (2) inability to walk; (3) indications of illness more severe than intoxication, or injury requiring medical care or observation; (4) need of detoxification from drugs other than alcohol; (5) need of physical restraints; and (6) refusal to accept services.[56] In addition, MAP driver/counselors are aware of the additional informal criteria of the various detoxification centers as well as the names of inebriates on formal or informal "do not admit" lists.[57] Thus, the population of public inebriates with which MAP is concerned is not the same population with which the San Francisco Police Department is concerned. The target population for MAP appears to be the upper band of skid row inebriates, which usually leaves the more unruly, messy, and difficult cases for police processing through the criminal justice system.

MAP provides services in addition to transporting street inebriates to detoxification centers. These include calling an ambulance for public inebriates needing medical attention; delivering an intoxicated person from a hospital to a detox center; removing an inebriate from an unsafe area to a safer, more scheduled park or other place; talking with inebriates and letting them know that they have a friend on the street if they desire services or want to control their drinking behavior; providing a ride to a drop-in center furnishing coffee, companionship and day-time shelter; and occasionally bringing inebriates coffee on a cold morning. Often, MAP may do nothing when encountering inebriates, except, perhaps, wake them up or engage them in brief conversation.[58]

The stimulus for the MAP program was the availability of federal funds, in this case, NIAAA funding[59] through the Mayor's Criminal Justice Council. Administratively, MAP is a program contracted out by the San Francisco Bureau of Alcoholism to a private nonprofit corporation, the San Francisco Alcoholism Consortium, Inc.[60] A major advantage of the subcontract approach is flexibility in program operations. It permits the hiring of para-professional employees, including former alcoholics, who might have difficulty meeting civil service requirements. Since the Consortium represents all providers of alcoholism services, MAP is not directly associated with any one detoxification center. This arrangement enhances MAP's role in matching client needs to alcoholism services.

The staff of MAP, in the summer of 1976, consisted of a supervisor, six male counselors/drivers (all white), and two female counselors/drivers (one of whom was black). They ranged in age from 22 to 54. All the counselors shared a common interest in helping alcoholics; four of them were recovered alcoholics.[61] Staff turnover has been relatively high with five of the original eight counselors who began service in January 1975, no longer with the project.[62]

The counselors work in teams of two, 4 days a week on a 2 days-on, 2 days-off basis. The two shifts per day are from 6:30 a.m. to 5:00 p.m. and from 5:00 p.m. to 6:30 a.m. There is little activity between 2:30 a.m. and 6:30 a.m. A regular van with no partition between the driver/counselors and the inebriate is used with typical passenger seats and with rear and side doors.[63] The van has two-way radio contact with the MAP office and the Central Emergency (the city public health switchboard service). To contact the van, police must call through the MAP office.[64]

After qualifying for a position of counselor/driver, staff members were originally given an intensive 2-week training program. The training program included orientation/training at San Francisco General Hospital Ward 52, a first aid course, 2 days in detoxification units, experience on the street among public inebriates, and a view of court procedures. Subsequent counselors received training primarily on the job.

A distinctive feature of MAP is the hiring of women as counselor/drivers. In Honest Politician's Guide to Crime Control, the authors hypothesized that women drivers of a civilian bus or van would have an ameliorative effect on inebriates.[65] Our interviews of van drivers and a ride-a-long with one of the women driver/counselors provide some confirmation of this hypothesis. Skid row inebriates appear to react more positively to the presence of a woman. Male inebriates were described as behaving more "gentlemenly" in the presence of women.[66] Out of concern for the safety of the women counselor/drivers, women were given only day-shift assignments.

The philosophy underlying MAP and its voluntary, nonpolice pickup is that, as an illness, alcoholism cannot be treated adequately or remedied through coercion. A street inebriate must choose the MAP pick-up and such voluntary choice is more likely to result in clients more likely to be psychologically prepared to change their drinking habits and alter their entire pattern of living. This philosophy of pickup is keyed to features of the mental health/treatment system. Detoxification referral and

rehabilitation services in San Francisco cannot require a client to remain at their facilities or to continue a program upon departure from their facility. The opposite is true, for example, of St. Louis, Missouri, where a warrant can be issued when a person leaves detox against medical advice before 7 days. The San Francisco philosophy may promote the goal of rehabilitation and may also be a realistic accommodation to the shortage of detoxification beds. On the other hand, this approach seems limited in terms of a major goal of the MAP program--having an impact on the criminal justice system by reducing the number of public drunkenness arrests. The contractual documents state that the primary objective of MAP is an absolute reduction of public drunkenness arrests by 25 percent. During the first year of operations, in 1975, public drunkenness arrests, in fact, were reduced by about 9 percent.[67] Even this impact may be, in part, a result of MAP's policy of giving top priority to police complaints and then to complaints from citizens and public health agencies. MAP foregoes finding clients who might be more motivated for treatment in order to have a greater impact on the criminal justice system.

Interviews with police officers confirmed that while MAP is providing a helpful service, it does not provide a reliable alternative to public drunkenness arrests. Police officers emphasized that MAP driver/counselors have no authority because of the voluntary nature of the pickup service. The views of one police officer, who was more critical of MAP than others, can be summarized as follows: MAP is a feeble attempt to handle a large problem on the street. Drunks who use MAP are often not the ones who take up police time. Another officer stated: "Detox can't hold them; it's not like jail--they just walk out. They have so few beds and they are often filled up." Another officer stated that it may take from 20 to 45 minutes for MAP to arrive after he has placed a call and he just could not wait around for MAP to respond.[68]

Independent evidence that MAP has had only limited success in solving the inebriate problem is the fact that, after about 6 months during which police "sweeps" were discontinued to give MAP opportunity for contact with street inebriates, the sweeps were reinstituted in June 1976.

In summary, the strengths of MAP are improved humanitarian handling of public inebriates, coordination of the several smaller detoxification centers and other public health facilities dealing with inebriates, and first-stage screening of inebriates into the rehabilitation system. Its weaknesses are that it has only a limited impact on conserving criminal justice resources, does not significantly contribute to keeping the streets clear of public inebriates, and probably does not substantially aid crime prevention.

(2) Erie, Pennsylvania Crossroads Center Public Inebriate Pick-up Program. The first civilian van pickup system began on July 17, 1971, in Erie, Pennsylvania, a criminal jurisdiction with a relatively small inebriate population.[69] Erie County's alcohol and drug authority has contracted out for alcoholism services to a nonprofit agency, Serenity Hall, Inc., which operates detoxification, pickup and transportation, intermediate care, inpatient care, outpatient care, outreach, industrial programs, and education and training services. The philosophy of Serenity Hall, Inc.,

has been to provide a "continuum of care" to cover all the needs of persons with alcohol problems.

Prior to the initiation of the van program, which began in 1967, Crossroads Center operated as a drop-in center with 20 beds. Four or five beds were reserved for detoxification for police pickup and informal diversion.[70] The Center now has 35 beds located in a storefront close to the skid row inebriate area.

The origin of the van system is traceable to a budget crisis at Crossroads Center coupled with the availability of funding through the Governor's Justice Commission.[71] A study had been completed earlier showing the need for improved services for public inebriates.[72] The civilian van project received the cooperation of the Erie Police Department in part because of an expected savings in manpower.

The arrangements for the van program were worked out informally. The police department agreed to call Crossroads Center through a specially installed "hotline" if a public drunk was willing and appeared to be an appropriate candidate for Crossroads Center. If an inebriate appeared unusually disruptive or violent, he was to be arrested on a public drunkenness or disorderly conduct charge.

It was expected that the police officer would wait with the public inebriate until the Crossroads van arrived to provide transportation to the center. If the inebriate needed medical attention, the van would provide transportation to the alcoholic unit at St. Vincent's Hospital.

Consistent with these arrangements, the civilian van does not engage in routine patrol. In contrast to San Francisco's Mobile Assistance Patrol, there are no regular van drivers and the van is an adjunct of the detoxification center; the counselors at the Crossroads Center take turns driving the van. One of the counselors stated that occasionally a sobered-up client at Crossroads Center is taken along as an assistant. The client can provide assistance if needed in transporting the inebriate and explain the advantages of Crossroads Center.

Unlike San Francisco's MAP, the van is not equipped with a radio. This means that it can usually respond to only one police request at a time and then must return to Crossroads Center for further calls. The counselors do not receive medical training that would enable them to make on-the-spot diagnoses of the condition of the inebriate.[73]

Police cooperation in calling Crossroads Center over the "hotline" is a key to the success of Erie's van project, even though the center will accept the inebriate who appears at the center. Crossroads Center is widely known throughout Erie and voluntary admissions occur on a regular basis.[74] However, the van responds only to police calls. When businesses or residents telephone Crossroads Center with a referral, they are instructed to call the police who, in turn, will call Crossroads Center.

Several factors account for what appears to be close and effective cooperation between the Erie Police Department and Crossroads Center. The

police were brought into the decision-making process on the civilian van program. Police were already making informal diversions to Crossroads Center before the van service. At the start of the project, training seminars were given to most of the patrol officers. The Executive Director of Serenity Hall, Inc. as well as the author of a study on problems of alcohol abuse in Erie joined the faculty of the Police Academy.[75] When officers did not follow the arrangement, their superiors would contact them and issue firmer directives.[76] Several empathetic officers, who were recovered alcoholics and active members of Alcoholics Anonymous, were of assistance in getting patrol officers to cooperate.

Cooperation is facilitated because officers retain the arrest option and make the intake decision. There are other incentives. Paperwork has been virtually eliminated. Although officers are supposed to wait for the arrival of the Crossroads van, they do not have to transport the inebriate in their own patrol vehicle. Police officers also perceive Crossroads Center as a facility that is providing assistance to many inebriates. While Erie police officers probably would continue to deliver inebriates to Crossroads Center without a civilian van service, the van service is generally seen as saving some time and relieving the police of an undesirable task.[77]

In contrast to other detoxification centers that we visited, Erie police officers generally find Crossroads Center to be an easily accessible and dependable agency. The wait for a Crossroads van does not usually exceed 10 minutes. One statistical study showed that approximately 65 percent of the pickups occurred within a close radius of Crossroads headquarters.[78] The Erie police are never told that Crossroads is filled and can accept no more referrals. Crossroads Center appears to have adequate bedspace to handle the police referrals and can make more room by adjustments in the discharge dates of other clients. Yet, as in other cities, Crossroads does not want to take clients who are likely to become violent or unduly abusive. Finally, Crossroads Center is perceived by police officers as having had a definite impact on the presence of public inebriates as well as on the number of inebriates processed through the criminal justice system. Within 5 months of the initiation of the van program, the large drunk tank in the Erie police department was closed and converted to a file room.[79] There is virtually unanimous agreement that there are fewer public inebriates on the streets in the downtown area.

These results appear to be different from those in other jurisdictions that we visited. A partial explanation may be that arrests in Erie for disorderly conduct have increased and undoubtedly include many individuals who were formerly processed only on a charge of public drunkenness. For example, while public drunkenness arrests declined from 1,479 in 1971 to 392 in 1975, disorderly conduct arrests increased from 442 to 1,003 during the same period.[80] The increase in processing for disorderly conduct may be partially explained by a change in the citation release requirements in June 1973. Prior to the change, if an officer booked a person for disorderly conduct, a court appearance by the arresting officer was required when the defendant did not appear; this was not true for a charge of public drunkenness. Under the expanded citation release system, it is just as easy to book a person for disorderly conduct as for public drunkenness.[81]

Another reason for the success in keeping the streets clear relates to what happens to persons processed through Crossroads Center. The length of stay at the center is flexible and some persons stay substantially longer than the 3- to 5-day detoxification period. Crossroads Center itself provides a variety of services. While the stay at Crossroads Center is "voluntary," immediately upon arrival the inebriates' clothes are taken and sent out for cleaning. Staff members indicate that this serves as a practical impediment to clients leaving immediately upon drying out.[82] Participation in Alcoholics Anonymous is encouraged and meetings are held on the premises. Every effort is made to find meaningful referrals for clients pursuant to Crossroads' "continuum of care" philosophy.

Moreover, the nature of the referrals may explain some of the success of Crossroads Center in clearing the streets of public inebriates. For example, during the first 6 months of the program, 113 men were listed as temporarily or permanently diverted from the system, including "Men Transported From Erie--21." For the period July 1, 1975 through April 15, 1976, the following item appears in the referral data: "Men helped out of town--40."[83] Transients are encouraged to leave Erie. Bus tickets or other transportation have been provided for persons who have some other place to go. More conventional counseling and referral have resulted in claims of rehabilitative success.[84]

One limitation of the Erie van pick-up system is that women are excluded. The detoxification facilities at Crossroads Center are for men only.[85] The failure to provide any detoxification services for women at Crossroads Center is explained by limited resources.[86]

Another concern is whether black residents of Erie are obtaining adequate service. While the proportion of black persons in Erie's population has been estimated at less than 10 percent, black persons account for a substantially higher proportion of arrests for public drunkenness and disorderly conduct. The director of Crossroads Center estimated that only about 4 of 35 persons served are black.[87] He observed that black persons do not generally seem to stay at Crossroads Center as long as white persons and are more reluctant to accept referrals. In an effort to respond to this concern Serenity Hall, Inc. established an Outreach Program and opened a center to serve primarily inner city black residents who were not being helped by Crossroads Center.

b. Civilian van pick-up service in decriminalized jurisdictions.

(1) Minneapolis, Minnesota Civilian Pick-up Service. Since decriminalization and the opening of detoxification facilities in July 1971, police officers have continued involuntary pickup of publicly intoxicated persons, but deliver them to a detox center for care and treatment not to exceed 72 hours, after which the person is released. Pursuant to the Hospitalization and Commitment Act, police officers are given formal discretion to take a public inebriate to his home if he is not endangering himself, other persons, or property. This Act also authorizes "health officers" to perform these functions.[88]

The Minneapolis Police Department retains primary responsibility for the pickup of public inebriates after decriminalization. But in 1973 a

civilian van program began serving the central downtown police district (the First District).[89] It was operated by the Hennepin County Alcohol Receiving Center (ARC), the major detoxification facility.[90] A variety of public inebriates live in the First District; the problem is very acute and arouses strong community, especially business, concern.[91]

The Civilian Pick-Up Service operates only in the First District during a single shift, 4 p.m. to midnight, 6 days a week. Two drives operate a van, loaned by the Minneapolis Police Department, which does not bear police markings. It has no seats in the back; a pad covers the van floor. A screen separates the front and rear compartments. It is fully equipped with a two-way radio that permits continuous contact with the police. The civilian drivers are selected and trained as detoxification center personnel for ARC. Thus, they are familiar with the day-to-day needs and formal as well as informal intake policies of the detoxification center. Their full-time concentration on public inebriates within a narrow geographical area results in detailed knowledge of most of the regular public inebriates.

The civilian team engages in regular active patrol and responds to police department radio calls. The active patrol and radio communication permit several persons to be picked up in a short time before returning to the detox center. The direct contact between the van drivers and the police department means that the police can usually respond within minutes on a request for assistance.

The civilian team, like police officers, exercises considerable discretion in making decisions concerning what disposition, if any, to make upon encountering an inebriate. The team focuses on persons who are quite intoxicated and often ragged in appearance. Team members are often seen waving to individuals that they recognize as part of their regular clientele.

The staff of ARC, unlike other public health facilities that rely almost totally on police departments for delivery, has aggressively sought other means of attracting clients. The civilian van pick-up service was designed to reduce pressure on the Minneapolis Police Department in the downtown section of the city. An effort has also been made to encourage self-admissions of problem drinkers from more stable socio-economic backgrounds, through advertising and by working closely with business and government agencies.[92]

Prior to the creation of the civilian pick-up service, the Minneapolis Police Department accounted for 40 percent of all detox admissions and 60 percent of admissions from 4:00 p.m. to 12:00 p.m. After the implementation of the civilian van program, the civilian team transported almost 50 percent of all admissions to the detox center and 80 percent of the combined police and civilian admissions for the same hours.[93] Statistics collected by ARC show that the use of the civilian pick-up service has increased total admissions to detox while further reducing police involvement.[94]

Nevertheless, questionnaires administered to patrol officers and interviews with them underscore significant limitations of the civilian van service in meeting certain public policy goals. The fact that only one van patrols one precinct during a single shift means that the police still must

spend considerable time with public inebriates. When the detoxification center is filled, the options available both to the police and the civilian team are restricted. As in other cities which lack adequate longer term therapeutic facilities, police officers see the same public inebriates back on the street after 72 hours. They note that detox and the civilian van program are severely limited in responding to their need to "solve a problem on their beat"--to get the public inebriate off the street.[95]

As in the District of Columbia, the Minneapolis Police Department was only marginally involved in the deliberations resulting in decriminalization of public drunkenness.[96] Thus, no member of the policy subsystem[97] in Minnesota had a concern for or a vested interest in a critical "community valued" goal of keeping the streets clear of transient inebriates.[98] With the 72 hours holding requirement and the crowding of the detoxification centers, the police no doubt find the mandated means of solving the intoxication problem under decriminalization inadequate.

An increased reliance on arrests for disorderly conduct has apparently become one escape hatch, although this route runs directly against the intent of decriminalization. At the higher levels of the police command structure, relatively little attention has been given to the problem of public drunkenness. This has led to street decisionmaking, including a heavy reliance on disorderly conduct charges to solve "street cleaning" problems in those precincts where there are many destitute and transient inebriates. From 1960 to 1966, the yearly average for disorderly conduct arrests was 697. During the transition period the average increased to 1,167. Since decriminalization, 1971-1975, the yearly average has jumped to 1,875.[99]

(2) Salem, Oregon Mobile Outreach Program. A new civilian van program, the Mobile Outreach Program, was initiated in February 1976 in Salem, Oregon. Operated by the Marion-Polk-Yamhill Council on Alcoholism, it serves a huge, three-county area that includes 28 different police organizations. It operates primarily in Salem, the major urban center.[100]

The Mobile Outreach Program began in 1972 when Ms. Sybil Bullock, newly appointed executive director of the Marion-Polk-Yamhill Council on Alcoholism (MPY Council), worked with others to develop a comprehensive scheme of services.[101] Ms. Bullock drew on the experiences of the San Francisco Mobile Assistance Patrol and the Josephine County Mobile Van Program in Grants Pass, Oregon.[102] The Outreach Program received 3-year funding.[103] The views of state, county, and Salem city police were solicited at the outset through a Community Coordinating Committee of the MYP Council. The availability of Federal funds from the National Institute on Alcohol Abuse and Alcoholism, however, was the real catalyst for action.[104]

Although the civilian van program had only been in operation a few months at the time of our site visit, decriminalization of public intoxication occurred statewide in Oregon in July 1972.[105] The legislation provided that where no treatment facilities are available, an intoxicated person may be taken by a police officer to a city or county jail. The detention is termed "detoxification custody." The person detained must be

released within 48 hours and the court must be notified of the detention within 24 hours.[106] This option was used in the three-county area.[107]

A nonjail detoxification center, White Oaks Center, opened June 22, 1974, in a former nightclub in the far northeast section of Salem. Also operated by the MPY Council, it has 8 or 9 beds for detox clients--including 2 beds for women--11 beds for 30-day long-term rehabilitation and 9 beds for those in rehabilitation for an additional 30 days. Only voluntary, ambulatory persons in need of detoxification are admitted. The normal stay is 3 to 5 days, although some clients stay longer. The Oregon State Hospital, located in Salem, had earlier provided some detoxification in its general wards and on October 1, 1975, began operation of a 1-week medical model detoxification ward with a 2-week rehabilitation program. The Oregon State Hospital, with extensive bed capacity, serves as a backup if the White Oaks Center is filled. If a patient refuses voluntary admission, Oregon State Hospital can accept a police hold for a 48-hour period although the local court must be informed. After the 48-hour period, court approval must be given. Upon concurrence of two doctors, persons can be held an additional 5 days. Thereafter, civil commitment is required but this is difficult since the person is normally sober. Thus, there are nonjail treatment services available for both voluntary and involuntary cases.

The civilian van program is perceived as one part of a full treatment program that begins with the initial contact with the inebriate. The grant proposal states that the primary function of the Emergency Service Patrol is "to improve the continuity of care for alcoholic people by forming links between services. The Emergency Service Patrol will perform this function at the 'front end,' helping to identify people in need of social or medical emergency assistance, transporting them to that assistance, and assuring that they receive it."[108]

The Mobile Outreach Program is directed by a Service Coordinator responsible to the MPY Council director.[109] A number of qualifications for the position are set forth but the primary consideration has been experience with alcoholism and treatment programs.[110] There are two Outreach Assistants or van drivers. The formal qualifications in the job description stress ability to handle and counsel inebriates.[111] Since both drivers were experienced, there was little need for a separate training program and training was primarily in-service similar to San Francisco's MAP.[112]

There is a single van equipped with a mobile telephone-radio system. Police contact White Oaks Center which relays the message if the van is out. It is like San Francisco's MAP van from which it was copied with the exception of the different radio system.

The van operates on Monday-Thursday from 7:00 p.m. to 3:30 a.m. and on Friday-Sunday from 1:00 p.m. to 3:30 a.m. Those seeking assistance are asked to identify themselves and the condition of the person to be helped. For transportation to be provided, the intoxicated person must indicate a willingness to accept detoxification, although we were informed that the condition of the person often makes a groan sufficient. Belligerent or violent persons will not be accepted, because of the danger inherent in the single-driver operation. Persons must be 18 years old. The primary

source of calls for transportation is the Salem City Police, who account for nearly one-half of the clients transported.[113]

When a van arrives on the scene, another screening takes place since telephone calls often will misrepresent the situation. Blood pressure is taken and the person's physical condition is assessed. The van driver must determine if the inebriate is "appropriate for detox" and the person is asked what he wants to do. If the person wants to go to White Oaks Center, meets its criteria for admission, and if White Oaks has space, he is transported there.[114] If he is unacceptable to White Oaks, if White Oaks is full, or if he needs more extensive long-term medical care, he can be transported to Oregon State Hospital. It appears that an "unacceptable persons" list is developing at White Oaks, which is concerned about recidivists, especially those who are using the Center as a short-term hotel.[115] The drivers often try to get some sort of commitment for a 5-day stay.

The clientele of the Mobile Outreach Program is predominantly white, male, poor, over 35, and resides in Marion County. As the police officers interviewed put it, most inebriates needing help have friends or taxi money or other means of assistance.

Although the Mobile Outreach Program is still in its infancy, a few comments can be made about the implementation of the civilian van program. We can look to indicators of potential success and problem areas. It is too early to assess the impact of the program on police behavior.[116] By the time the Program began operations in 1976, the police department already had cut its involvement with public inebriates to the minimum.[117] The possibility of any impact is further diminished by the fact that police can simply drop the inebriates off at White Oaks Center or Oregon State Hospital themselves. In fact, the police had ample opportunity to develop the practice of simply transporting the inebriate to detox themselves prior to the start of the civilian van program.[118]

Still another problem lies in the fact that there is only a single van to cover a very large territory spanning three counties. If the van is in one of the outlying counties, it is not readily available to respond quickly to a police call. Prompt response seems to be a key factor in police acceptance of a van program. White Oaks Center is fairly far removed from downtown Salem.[119] Further, the van is not in operation 24 hours a day, 7 days a week. When officers have to deal with an inebriate, calling the van should be viewed as regular operating procedure and should not depend on the hour of the day or day of the week. San Francisco's project is purposely limited to a small defined target area, providing 24-hour service. The officers interviewed were aware that White Oaks Center frequently fills up, requiring officers to find an alternative.[120] Finally, White Oaks and the van operation are perceived by police officers as a source of disposition for a particular class of public inebriate--the resourceless person who drinks at two or three of the cheaper downtown bars and sleeps under a bridge, in a mission, or a cheap room. It is not perceived as an alternative for handling other types of inebriates, even on the occasions when they pose a police problem.[121]

Probably the greatest potential impact from the Mobile Outreach Program or from any other van program is the potential of improved services to

the public inebriate. This has both a quantitative and a qualitative dimension. First, probably more inebriates are now being served in the Salem area. When van drop-offs are added to police drop-offs, it appears that the total number of public inebriates helped has increased. This is corroborated by the fact that both White Oaks and Oregon State Hospital have experienced some increase in applications and admissions. The large number of beds available at the Oregon State Hospital would seem to allow the Mobile Outreach Program to expand its services beyond handling primarily police calls. However, the size of the target area, the single van, the limited manpower (two drivers), and the fact that Oregon State Hospital may not continue its detoxification program (the State favors community-based detox centers) makes such a development doubtful.

The qualitative dimension is difficult to measure. As in other cities, the personnel of the Mobile Outreach Program are dedicated, understanding people who, unlike the police, sought and were hired to work on a full-time basis with public inebriates. It is alleged that there is less "acting out"--as is termed by treatment people--by inebriates when they are humanely and patiently handled.

One driver on a van is probably sufficient if only voluntary cases are handled. The critical job qualification seems to be an ability to understand the problems of the street inebriate and a capacity to handle people--these qualities tend to be individualized. If two drivers are to be used, the presence of a recovered alcoholic or of a volunteer from the detox itself, as in Erie, Pennsylvania, might provide greater understanding.

2. Conclusions on the Relationship of Civilian Van Programs to Public Policy Goals. If the objective is relieving the police of a burden and impacting on police behavior, the criminal-decriminalized character of a jurisdiction seems important in assessing the value of a new program. The cases the police are forced to handle are often not the cases a detox van system is designed to serve. The existence of a voluntary van system is not likely to produce a significant decrease in the police time spent coping with the public intoxication problem. Justification of a voluntary van program in terms of major impact on police behavior is less likely in decriminalized jurisdictions.

If the van system is to work in any system to further police objectives, close relations with all levels of the police department are essential. The contact must occur not only at the outset but on a continuing basis. While police involvement was solicited at the outset of the Salem, Oregon Mobile Outreach Program, it was limited largely to command levels. Involvement in training programs, occasional visits to roll calls, dissemination of program information to both the command structure and the patrol force, and police representation on boards of directors of consultative committees are vital ingredients. The most probable impact of a van program is likely to be the character of the services available to the inebriates. Greater sensitivity, increased ability to handle an inebriate's "acting out" without violence, earlier and more expert diagnosis of what the inebriate needs are all possible advantages of a van pick-up system. This, of course, demands great care in the selection of van drivers, perhaps greater training in the inebriates' special medical needs, and promptness and regularity of services.[122] Further, civilian van transport need

not be limited to delivery to detox and (perhaps consequently) need not be limited to skid row inebriates. It need not be confined to the street but might also serve bars and restaurants, physicians, drunken drivers--it could operate much as a crisis intervention unit. Of course, adequate detox beds, shelters, or drop-off places for just "sleeping it off" would be needed.

Improved on-the-street services may or may not further rehabilitation goals. For the resourceless, skid row inebriates, the problems of rehabilitation would seem as great as ever--if the detox does not further rehabilitation goals, it is unlikely a van system will make any difference. For the non-skid row inebriate, contact with treatment-oriented facilities would be possible. If there is a problem posed by the removal of contact with the public sector for non-skid row inebriates following decriminalization, a civilian van transportation system may close this gap.

3. Other Approaches Using Nonpolice Personnel.

a. Combined police/nonpolice teams--the Manhattan Bowery Project. A unique public/private partnership was formed to create the Manhattan Bowery Project in 1967.[123] Alcoholism experts, Bowery clergy, flophouse owners, police and corrections officials, city and State officials, physicians and recovered alcoholics cooperated with the Vera Institute of Justice and Mayor John Lindsay to establish a 48-bed center. The New York City Police Department assigned four patrolmen and two unmarked rescue vehicles to be used to pick up public inebriates and bring them to the Project. The police also prepared special report forms for those admitted.[124]

A New York City police officer works with a recovered alcoholic to patrol the Bowery. One shift works from eight to four during the day and the other shift from four to midnight. When the rescue team spots a debilitated inebriate, the team offers the man assistance. Pickup is voluntary. The man is asked if he would like to accompany the team back to the Project. He is free to choose whether to remain where he is, be moved to a safer place, be brought in for detoxification, or, if the situation is more serious, have an ambulance called.

Based on a ride-along with the rescue team, the rescue operations lasted approximately 15 minutes each. The police officer on patrol driving the car was in plainclothes and had very little contact with the inebriate. When the patrol passed an inebriate who was either lying on the street or sidewalk or teetering badly, the recovered alcoholic on the team would get out of the car and approach the inebriate. If the inebriate was known to the rescue squad he would be called by name and offered transportation to a safer area (such as a doorway) or back to the Project. Of the six men approached, four agreed to return to the Project and one was removed to a safer place.

The civilian team member's offer was put to the inebriate as: "Do you want some help?" If the inebriate said yes he was asked if he would like to go to the Project or to another area. The rescue team immediately left the man who refused help. The men all seemed in no condition to talk at length about what they preferred to do and answered in a simple "yes" or "no." All seemed familiar with the Project. The men were returned to

the Project, helped out of the car and into the Men's Shelter where they were brought into an examining room for admission. Upon observing the sign-in procedure, we discovered that they were all recidivists. If an inebriate approached by the rescue team is not familiar with the Project, the recovered alcoholic member of the team will explain the Project to the prospective participant.

In fiscal 1975, of 6,109 inebriates approached, 3,002 were transported to the Project, 41 were taken directly to a hospital for more serious medical problems, and 1,503 were given other assistance such as removal to a sheltered area. Thus, over 75 percent of those approached accepted some kind of assistance.

The 48 beds at the Project are almost always full since the rescue squad makes a run through the Bowery whenever a bed becomes empty. Although inebriates occasionally appear at the Project by themselves, they are refused admission. A rescue pick-up operation is dependent upon the number of vacant beds at the Project and the number of men in distress on the street. Some of the inebriates actually ask the squad to take them back to the Project. When an inebriate is taken off the street and admitted to the Project, he is encouraged to stay for at least 5 to 7 days. This time enables the staff to provide both emergency care services and offer a chance at rehabilitation. Counselors make the inebriate aware of the after-care facilities that are available upon release from the Project.[125] There are several recovered alcoholics working in the Project who at one time were themselves homeless derelicts in the Bowery. One of the men who now works as a counselor had gone through detoxification at the Project seven times before he finally decided to continue in the Project's follow-up care program. Women are not admitted to the Project.

The Project has instituted another civilian-police officer rescue squad on the West side. It offers inebriates transportation to a cooperating facility (e.g., French and Logan Memorial Hospitals) or, occasionally, to the Project itself. Of 1,678 men approached in fiscal 1975, 1,238 accepted an offer of assistance.

As a full-time staffer at the Project, the police officer is able to develop a commitment to what he is doing and a real desire to help the men he comes to know. When the officer is involved in the entire process of detoxification, through intake and time spent with the inebriates during their stay at the Project, he gets a better perspective of the problem and how to handle it. Relations between the police officers and civilian members of the rescue team appear to be good. The two police officers interviewed at the Project had a total of almost 30 years service on the police force. They recalled the predecriminalization practice of police arrests by quota in the Bowery, which they regarded as futile.[126]

What are the advantages and problems of using a combination police/civilian rescue team? Unlike other civilian pick-up services we visited, the Manhattan Bowery Project rescue team focuses on the most debilitated of skid row inebriates. This may increase the need for a two-person team and the occasional authoritative presence of a police officer. Moreover, in the Bowery, a high crime area, the police officers provide protection to detoxification center personnel by their full-time presence at the Project.

But a question may be raised whether the presence of a police officer, even one in plainclothes, may impinge upon the "voluntary" character of the pickup. It is possible that the combined police/civilian team may be most beneficial in a decriminalized jurisdiction which authorizes involuntary pickup and delivery to a detoxification center. The concept of a police/civilian team could be used whether the team was housed in the detoxification center, like the Manhattan Bowery Project, or in a police department. For example, in Washington, D.C., a jurisdiction where involuntary police pickup and delivery to detox occurs, detox center employees or volunteers could be teamed with police officers operating either from detox or regular police vehicles.

The rescue team concept at the Manhattan Bowery Project was formulated at a time when the only other planned programs were the Washington, D.C. and St. Louis Detoxification Centers, both of which used police pickup. Hence, it predated the civilian van programs. The use of the police officers supplements the resources of the Project since the police officers are paid by the New York City Police Department. In addition, the use of full-time police officers housed within the Project virtually ensures effective lines of communication on a day-to-day basis between the Project and the police department. Moreover, the specialized use of the police officers permits officers who are genuinely interested in working with public inebriates to do so. From the police standpoint, the loan of police officers to the Project may save the time of other officers in dealing with public inebriates and contribute to improved community and public relations.

The Manhattan Bowery Project rescue team concept raises some problems. The police officers have access to confidential Project data while they maintain professional obligations to the New York City Police Department as well as to the Project. Public inebriates are valuable sources of information on illegal drug traffic and other criminal intelligence information. It would be possible for police to use their contacts and access within the detoxification center for purposes that might be at variance with the objectives of the detoxification center. Perhaps safeguards can be devised to minimize the likelihood of such abuses.

b. Increased use of public transportation: e.g., taxicabs. The Santa Clara, California Bureau of Alcoholism Services relies on two supplemental forms of transportation in addition to police and civilian in-house services. In San Jose, the location of most intakes, the San Jose Police pick up public inebriates and deliver them to a conveniently located screening center at the Park Alameda Health Facility. The Bureau of Alcoholism Services then transports the inebriates to the Agnew State Hospital, located some distance from the downtown San Jose area, by in-house civilian transportation.[127] In other parts of the County during daytime hours, the police take inebriates to the nearest of seven Mental Health Centers which then assume responsibility for the civilian transportation to the Park Alameda Health Facility or to a hospital. If it is more convenient in the outlying areas and at night, the police may bring public inebriates to local jail facilities (such as the North County Jail facility in Palo Alto or to the Gilroy Jail--South County) where they will be picked up by civilian transportation.

When in-house transportation is not available, "medicar" and taxicabs are used to transport inebriates. Medicar is a service provided by contract from the county to transport inebriates to and from mental health centers. The cost is based on the distance, with an $8.50 minimum charge. If there is a doubt about the physical or mental health of the inebriate, medicar, rather than public taxicabs, is used, although taxicab service is usually cheaper. Detox personnel have found that the arrival time of medicar may be lengthy and that taxicab service is usually quicker.

The Bureau of Alcoholism Services pays from $600 to $1,000 per month in taxicab fares. The San Jose Yellow Cab Company supplies "charge-a-cab" voucher forms which are used by the cab drivers to obtain payment for the trip. The inebriate may not contract for use of a taxicab without authorization from Bureau of Alcoholism Personnel. The regular taxicab fare is charged. The county has been negotiating with other taxicab companies for an arrangement that would involve a "flat rate" for certain regular runs.[128] Taxicab charges from outlying areas, involving trips of approximately 20 to 30 miles, may cost from $17 to $24 per trip.

A program similar to this "medicar" service, operated by Maryland's Montgomery County Health Department, involves use of county cars to provide transportation to and from detoxification centers and from treatment centers to the courts. Montgomery County enacted legislation to permit the appointment of "special duty sheriffs" (Health Department counselors and other alcoholism program staff) to hold office at the pleasure of the sheriff. Montgomery County also contracts for local taxicab service to provide transportation to detoxification centers when Health Department cars are not available.[129]

The voucher programs could be expanded to permit taxicabs to pick up inebriated persons on their own initiative by obtaining authorization on a case-by-case basis or under general guidelines. A voucher could be issued upon arrival at the detox center or other authorized destination. While taxicabs have traditionally been used by non-skid row inebriates, these programs provide for the use of taxicabs and other public service vehicles for the transportation of skid row inebriates.

c. Increased emphasis on private agency referrals and transportation and self-admissions. Several of the detoxification centers that we visited have placed greater emphasis on private agency referrals and transportation and self-admissions. For example, in Minneapolis, Minnesota, the Hennepin County Alcoholism Receiving Center's staff have encouraged self-admissions of problem drinkers from more stable socio-economic backgrounds through advertising and by working with businesses and government agencies. In St. Louis, Missouri, there has been a dramatic increase in self-admissions since 1974 and a corresponding decrease in police admissions. The question arises whether these self-admissions represent public inebriate cases, especially skid row, chronic cases, or whether there is an increased number of middle class drinkers who probably would not have been criminally processed by the police. Whether the decline in police admissions has been replaced by informal police drop-offs,[130] self-transportation by the inebriates, increased delivery by interested groups such as AA and the Salvation Army, or an increase in police nonaction and informal disposition remains an open question. The public drunkenness arrest rate did

increase in 1974 but did not equal the decline in police admissions to the Detoxification Center.

In San Francisco, California, one of the four detoxification centers, the Guerrero Street Detox, obtains most of its clients from hospital and other agency referrals and accepts relatively few persons from the Mobile Assistance Patrol. The St. Vincent De Paul Society's Howard Street Detox is now getting more self-referrals.[131]

Increased emphasis on private agency referrals and transportation and encouraging walk-ins or self-referral may be at least a partial substitute for a pick-up service. Given limited budgets, it may be desirable to locate the detoxification facility near the clients and spend the money on increasing the number of detox beds and improving services. If there has to be a tradeoff, it can be argued that it is better to have poor pickup and very good housing and services for public inebriates than to have a very good pick-up service and very poor detoxification and other services.

However, if the public policy priority is to provide services for emergency case skid row inebriates, an increased emphasis on private agency referrals and transportation and walk-ins may be counterproductive. This is the reason why the Manhattan Bowery Project refuses to accept walk-ins and relies on its rescue teams to focus on the most destitute of inebriates. The physical condition or location of many public inebriates may require that pick-up procedures and bed space be oriented toward these persons in order to attain public policy goals.

4. Conclusions. A variety of police and nonpolice pickup approaches are available in jurisdictions seeking to better orient their pick-up mechanisms to the attainment of public policy goals. If the emphasis is on traditional order maintenance goals--i.e., street clearing and crime prevention--then continued police involvement in pickup and delivery is justified. We disagree with the view that police should not be used as the primary intake mechanism in therapeutic jurisdictions.[132] On the other hand, if the emphasis is on therapeutic objectives (providing improved emergency services, more humane handling, and increasing the likelihood of rehabilitation or resocialization), the use of nonpolice pick-up procedures as a supplement to police involvement is a valuable policy option.

Based on our site visits, we conclude that the involvement of the police is likely to continue to be substantial in criminal and decriminalized jurisdictions, especially larger cities. The question is not whether the police should continue to have a role in decriminalized approaches to public drunkenness, but how the role should be fashioned--e.g., which police officers should be selected, how police services should be delivered, what training should be provided, how communication between police and public health personnel can be improved, how police and nonpolice services may be combined in a viable mix, etc. In every jurisdiction we visited, the police were the only public service personnel on the streets 24 hours a day, 7 days a week, available to deal with large numbers of widely dispersed skid row and non-skid row public inebriates.

We do not agree that continuation of the police role in therapeutic jurisdictions, especially in conjunction with a civilian program, is

inherently undesirable. The police have a history of providing community service in addition to crime fighting and law enforcement functions. It is simplistic to assume that police, ipso facto, are inhumane and that civilian workers are humane. The critical issue may be what type of individual--whether police or nonpolice--is selected to perform the intake functions, what type of training is provided, and how the incentive-disincentive structure is used to reconcile conflicting public policy, organizational, and self-interest goals.

Nevertheless, we do feel that civilian intake can provide a valuable addition to a full-care program. The merits of such a program, however, cannot be based primarily on saving police time. Rather, the humanitarian and service benefits of such an undertaking seem to us of considerable importance. The extent of the project--the number of vans and counselors, the size of the area serviced, the hours of operation, the numbers of inebriates served, active patroling rather than merely responding to calls--must necessarily vary within budgetary constraints and competing policy goals. The availability of Federal funding has been a key factor in the initiation of civilian van programs. Whether local jurisdictions will determine that they can afford permanent funding from State and local sources remains to be seen. A civilian project designed to extend service beyond the detoxification center is an intake mechanism worth serious consideration.

NOTES--CHAPTER 4

1. Eugene Ehrlich, Fundamental Principles of the Sociology of Law, W. Moll (trans.), 1936, p. ixv.

2. For a general discussion of the interaction of goals in evaluating criminal justice policy, see T. Dye, Understanding Public Policy, ch. 13 (1972); Musheno, Palumbo, & Levine, Evaluating Alternatives in Criminal Justice: A Policy-Impact Model, 22 Crime and Delinquency, 265-83 (1976).

3. The criminal charges included: urinating in public, throwing bottles, drinking in public, panhandling, profanity, disturbing the peace, and malicious mischief. Interview with Robert B. Murphy, Chief of Police, City of San Jose, California (Summer 1976).

4. Interview with Captain George Sully, Secretary, Police Administration, San Francisco Police Department (Summer 1976).

5. National Conference of Commissioners on Uniform State Laws, Uniform Alcoholism and Intoxication Treatment Act (1971), [hereinafter cited as Uniform Act], set forth in Dept. of HEW, First Special Report to the U.S. Congress on Alcohol & Health 105-18 (1971).

6. The Uniform Act provides: Section 1. (Declaration of Policy). It is the policy of this state that alcoholics and intoxicated persons may not be subjected to criminal prosecution because of their consumption of alcoholic beverages but rather should be afforded a continuum of treatment in order that they may lead normal lives as productive members of society.

   A number of States have adopted this section in its entirety. See, e.g., Alaska Stat. §47.37.010 (1973); Kan. Gen. Stat. Ann. §65-4002 (Supp. 1973); Me. Rev. Stat. Ann. tit. 22, §1361 (Supp. 1974); Mont. Rev. Codes Ann. §69-6211 (Supp. 1972); S.D. Compiled Laws Ann. §34-20A-1 (Supp. 1974).

7. Powell v. Texas, 392 U.S. 514 (1968). See Robinson v. California, 370 U.S. 660 (1962). In Powell, the Court quoted from the President's Commission on Law Enforcement and Administration of Justice, stating: "[T]he 'strongest barrier' to the abandonment of the current use of the criminal process to deal with public intoxication 'is that there presently are no clear alternatives for taking into custody and treating those who are now arrested as drunks.'" The Court added that "[i]t would be tragic to return large numbers of helpless, sometimes dangerous and frequently unsanitary inebriates to the streets of our cities without even the opportunity to sober up adequately which a brief jail term provides." Id. at 528. It followed that "before we condemn the present practice across-the-board, perhaps we ought to be able to point to some clear promise of a better world for these unfortunate people. Unfortunately, no such promise has yet been forthcoming." Id. at 530. See Goodman & Idell, The Public Inebriate and

the Police in California: The Perils of Piece Meal Reform, 5 Golden Gate L. Rev. 259 (1975); Stern, Handling Public Drunkenness; Reforms Despite Powell, 55 A.B.A.J. 656 (1969).

8. C. Winslow, Public Inebriate Diversion System: Mobile Assistance Patrol--Evaluation Report 45 (1976) (paper submitted by Mayor's Criminal Justice Council, San Francisco, Calif.) [hereinafter cited as C. Winslow].

9. Therapeutic public inebriation programs in California have been subjected to intensive evaluation, including cost evaluation. In an interview by one of the co-principal investigators with Mr. Loren Archer, Director, Office of Alcohol Program Management, State of California (June 14, 1976), Mr. Archer stated that his review of cost information of California public inebriate programs indicates that generally the costs of a noncriminal justice system approach are greater than the costs of a criminal justice system approach.

   See also A. Young, Final Report--Evaluation of the Santa Clara County Alcohol Detoxification Facility (Aug. 1975) (prepared for the Bureau of Alcoholism Services, County of Santa Clara, Calif.) [hereinafter cited as A. Young]; A. Gilpatrick, Final Report: Santa Clara County Detoxification and Rehabilitation Planning Center: The Evaluation and Referral Unit (Sept. 1975) (prepared for Region J, County of Santa Clara, Regional Criminal Justice Planning Board).

   See also Office of Alcohol Program Management, Sacramento, California, The Detoxification Center Evaluation Report: Santa Clara County 83-84 (June 1973-March 1974); The Detoxification Center Evaluation Report: San Mateo County 73 (October 1973-March 1974); The Detoxification Center Evaluation Report: Monterey County 78 (June 1973-March 1974); The Detoxification Center Evaluation Report: Sacramento County 119-20 (June 1973-March 1974).

10. The primary approach involved in projecting criminal justice cost savings is to observe activities, record the time required for each activity and the personnel involved, and assign costs based on direct salary, administrative, and other overhead expenses for arrest, retention in jail, court, prison, farm, and other social agency costs. This approach assumes, for example, that police officers are presently operating at capacity with no down time for other activities and that time released from public inebriate arrests will be used in higher productivity law enforcement tasks or that fewer patrol officers will be needed. Public inebriate arrests, however, are low priority arrests in every criminal jurisdiction visited and such arrests are often postponed or ignored in order to respond to more urgent tasks. Also, former police chiefs in Washington, D.C., and Houston, Texas, cited the value of public drunkenness arrests as a crime prevention tool, arguing that public inebriates are frequently involved as offenders or victims in other, more serious crimes. They conclude, therefore, that the savings from the failure to make public drunkenness arrests may be offset by more serious law enforcement problems.

Most cost studies do not distinguish between fixed and variable costs. The jail system is a fixed cost system to a large degree and variations in the jail population do not impact significantly upon the overhead costs. Only if the correctional population growth would require new facilities in the long run would the savings equal the amounts assumed in cost projections. See M. Bohnstedt, Criminal Justice System Savings and Costs Associated With Alcohol Detoxification (Feb. 1974) (paper presented to American Justice Institute). Also, public inebriates provide valuable manpower to operate correctional facilities as well as stability for the jail population. For example, in Atlanta, Georgia, it was estimated that, in 1972, inmates supplied nearly 65,000 days of labor or the equivalent of 259 full-time personnel. Assuming a low annual salary of $4,000, this is equivalent to $1 04 million. R. Cook, Costs for Alternative Public Inebriate Services 27 (1973). See S. Thompson, supra note 18, at 19; J. Wilson, Executive Control of Policies for Police Handling of Public Inebriates 10-11 (1975) (unpublished paper); Arthur Young & Company, Final Report--Evaluation of the Santa Clara County Alcohol Detoxification Facility 46 (1975) (prepared for Bureau of Alcoholism Services, County of Santa Clara, California).

Moreover, a major assumption underlying cost projections is that rehabilitation of public inebriates will slow down the revolving door, ultimately reducing societal costs. Costs to society include losses of potential productivity and taxable income through work absences and unemployment, family disruptions, and the frequent need for public assistance, and health deterioration and the need for medical care are much greater. See Majors & Sample, Cost of Jailing vs. Psychiatric Care for Chronic Alcoholics, World Wide Med. Press 3 (Mar. 1, 1973); D. Coffler & R. Hadley, The Residential Rehabilitation Center as an Alternative to Jail for Chronic Drunkenness Offenders (1971) (unpublished manuscript). Additional income is projected as former public inebriates are integrated into the job market. This assumption remains untested. Savings resulting from rehabilitation and thus reduced arrests, improved employability, and less family and community disruption are not immediately apparent. Few, if any, jurisdictions have provided the essential components of a comprehensive community nonlegal services network. Also, we interviewed public health workers in several cities who have extensive experience in treating the skid row drunkards and they questioned the premise that a large proportion of skid row public inebriates can be rehabilitated. Many advocated various long-term civil commitment strategies that appear equivalent to incarceration or warehousing.

11. The sources of funding for detoxification programs are diverse. For example, funding for California detoxification programs may include county general funds, California Council on Criminal Justice funds (matching), NIAAA special project funds (100 percent Federal), Short-Doyle (90 percent State, 10 percent county), revenue-sharing funds (100 percent Federal), and Hughes Alcoholism funds (100 percent Federal). In the 1974-75 Budget for the Sacramento County Detoxification Center, $620,000 is funded from county funds ($320,000) and Federal funds ($300,000). The source of Federal funding (Hughes Alcoholism

grant funds) is "one-time" funding and is not likely to be available for subsequent years. S. Thompson, supra note 18, at 40.

12. In most therapeutic jurisdictions visited, persons admitted to detox centers are given some sort of physical examination following clean-up and showering. Following the admission process, nearly all patients are immediately given a bed with clean sheets "to sleep it off."

    Surroundings, although often crowded, are usually comfortable. Nutritious food is provided. Often drugs are provided, including tranquilizers, to aid in the detoxification process. After an initial period, counseling is provided, exposing the patient to available alcoholic rehabilitation programs, places to stay such as alcoholic recovery homes, job counseling, assistance in collecting pensions or welfare checks, etc. Some detoxification centers encourage attendance in Alcoholics Anonymous meetings which are sometimes conducted in space provided by the detoxification center.

13. Interview with Ms. Dee Druckenmiller, Head Psychiatric Nurse, Evaluation & Referral Unit, Dept. of Public Health, Santa Clara County, Calif. (June 1976).

14. A reduction in the average treatment stay from 2.8 to 2.0 days in the Sacramento County Detoxification Center has been recommended. Staff observations of persons in the detox center indicated that many persons in the facility were "sober, ambulatory and appeared physically healthy a few hours or a day after being admitted" and "many persons requested, but very few received, release prior to the 72-hour period." Also, this recommendation would increase bed capacity by 28.6 percent, allowing approximately 3,650 additional treatment stays per annum. S. Thompson, supra note 18, at 37-39.

15. Another perspective on humaneness is provided by Mr. Loren Archer, Director, Office of Alcohol Program Management, Sacramento, California. He argues that the size of institutions may have much to do with their humaneness. A basic principle may be that as institutions become too large, or when the numbers one deals with become too large, the treatment tends to be inhumane. The real basis for inhumanity may be the large number of public inebriates dealt with in any system. The same phenomenon has been observed in mental institutions that used to hold drunkards. One solution may be the 20-bed social setting of detoxification centers now being tested in such cities as San Francisco. Interview with Loren Archer, Director, Office of Alcohol Program Management, in Sacramento, California (June 14, 1977).

16. The National Institute on Alcohol Abuse and Alcoholism has outlined the essential components of a comprehensive rehabilitative approach:

    1. Emergency medical services--medical care for acute physical conditions (acute intoxication, delirium tremens, severe injuries, etc.).

    2. Nonmedical emergency services--24-hour social services to provide assessment and referral for immediate personal and family needs.

3. Screening, diagnostic, and referral services--definitive diagnosis with respect to the social, emotional, and medical aspects of the alcoholic's program.

4. Inpatient services--long-term hospital care for medical and psychiatric conditions.

5. Outpatient services--coordinated medical, emotional, and social support include a wide range of services and groups.

6. Intermediate or transitional services--a flow of contiguous services through which the patient moves, perhaps including partial hospitalization, halfway houses, or special boarding homes.

7. Rehabilitative services--a variety of vocational, education, and social service programs to restore the alcoholic's capacity to function.

8. Services for skid row alcoholics--special custodial community shelters to provide a structured living environment.

9. Consultation and community education services--development of knowledge and skills of agencies and citizens related to alcoholism and its treatment.

10. Training services--a variety of training opportunities for all agency staffs as a part of continuing education.

11. Research and evaluation services--basic programs of operations research and the evaluation of community needs, of services provided, and of the adequacy and cost-effectiveness of services.

National Institute on Alcohol Abuse and Alcoholism, Developing Community Services for Alcoholics: Some Beginning Principles (1971).

17. The average number of detox admissions, which total about 1,000 clients each month prior to the creation of the Arrested Drinking Program, has been approximately 130 less each month. As of July 31, 1975, 95 clients admitted to the program had a total of 2,886 previous admissions to the detoxification center, averaging 29 admissions each.

18. The Arrested Drinking Program is located on the second floor, above the detoxification center, in a State hospital which has locked doors. A client wishing to leave the program must make a specific advance request; the client understands that it is expected that he remain in the program for the full period. Other voluntary detoxification programs use various devices to provide disincentives to leaving. In St. Louis, a client "voluntarily" chooses detox over an arrest. A summons is left to provide a means to assure continued cooperation. In fact, "elopers" are seldom prosecuted. In Erie, Pennsylvania, the client's clothes are removed and sent out to the cleaners; clients are unlikely to elect to leave without their clothes.

19. One police officer explained why he usually would not deliver a non-skid row person to a detox center. He stated that unlike the earlier criminal period when such a person could forfeit collateral and be released within 4 hours, the 72-hour hold period of the detox center would result in family disruption, loss of income from unemployment, and communication to his or her employer of his detention in detox could result in loss of his or her job.

20. In our impact phase of the study, an effort was made to compute annual recidivism rates in the pre-change (criminal) and post-change (therapeutic) periods, based on a sampling of arrest and detox histories for selected years. In Minneapolis, Minnesota, for the pre-change years of 1967 and 1970, the estimated recidivism rates were 3.79 and 3.94, respectively. In the post-change years of 1972 and 1974, the recidivism rates were 4.71 and 5.03, respectively. Hence, if "recidivism" is an indicator of rehabilitation, which is doubtful, no indications of improved rehabilitation have been found in Minneapolis.

    Likewise, our estimation of recidivism rates in Washington, D.C., in the pre- and post-change periods also resulted in higher recidivism rates in the post-change periods. In the pre-change years of 1964 and 1966, the estimated average recidivism rates are 1.58 and 2.59, respectively. In the post-change period, the estimated recidivism rates are: 1969--2.03; 1970--3.32; 1971--3.15; 1972--2.87; 1973--2.68. These data are consistent with other findings that in Washington, D.C., in the therapeutic period, a smaller group of persons, mainly emergency case skid row inebriates, are being cycled through the detox center at a faster rate; in other words, the revolving door for this smaller population group has sped up. A 72-hour facility cannot be expected to solve the revolving door syndrome.

21. A few examples follow of responses of police officers to open-ended question number 15 which asked: "Please add whatever comments about police work or policy regarding the handling of persons intoxicated in public, on this questionnaire, that you wish." St. Louis respondent #067: "The habitual return of subject taken previously to detox by this officer makes me hesitant to take winos there"; respondent #061: "I have yet to see a regular intoxicated person quit drinking. I have yet to see an effective program for winos"; respondent #130: "Detox is a waste of money due to the fact most winos use it only to dry out for a couple days and get cleaned up."

22. It can be argued that every public inebriate is a potential offender or victim and, consequently, the goal of crime prevention can be maximized by the pickup of all public drunkards. Such a broad formulation makes this aim coterminous with the objective of clearing the streets.

23. As one St. Louis patrol officer stated: "The drunk who does his drinking at a bar or at home and then wanders out into public areas is a much more unpredictable and aggression-prone person as a rule. This sort often winds up being locked up for a nonalcohol city ordinance charge or criminal charge (peace disturbance, assault, etc.)."

Respondent #172 to Question 15, supra note 21, of St. Louis Questionnaire distributed to patrol officers.

24. In Minneapolis, the use of disorderly conduct arrests significantly increased since decriminalization. From 1960 to 1966 the yearly average for disorderly conduct arrests was 697. Since decriminalization (1971-1975), the yearly average has jumped to 1,975. These arrests are probably in response to the goal of keeping the streets clear of public inebriates as well as the objective of crime prevention. Those formulating the reform legislation neither anticipated nor desired the continuation of criminal arrests for public drunkenness.

25. Although detoxification centers may be filled to capacity, especially during peak periods, police perceptions that detox is filled may result from problems in communication with public health officials. In the District of Columbia, former Chief of Police Jerry V. Wilson observed:

> "In the fall of 1969 . . . it was reported to me that inebriates were not being taken to the Detoxification Center because the Center was usually filled to capacity. I had the Field Inspections Division follow through on this report, intending to press the Department of Human Resources for more capacity, and learned that the report was not factual, that the Detoxification Center had never been filled and would welcome additional clients. This information was relayed through staff meetings to the patrol force with general directions that intoxicated individuals be taken to the Detoxification Center. Staff Minutes, Field Operations, September 25, 1969, emphasized that the Detoxification Center is open 24-hours daily and there is no record of its ever being full." J. Wilson, supra note 50, at 16-17.

On the other hand, bureaucratic practices of detoxification centers as well as self-interest goals of detox staff members can result in detox beds filling up quickly especially on certain shifts, to avoid having to process additional inebriates, or retaining existing clients for longer than necessary to avoid the additional work of discharges and admittances.

26. According to Captain Donald T. Tamm, the police officer in charge of the San Jose, California, central jail, these persons are released when sober. No formal records are kept of these persons.

27. In St. Louis, although in theory, a charge of protective custody is available only for drunkenness in a private place, in fact this offense has been heavily used for processing public inebriates. In the early and mid-1960's, pickups for this charge exceeded drunk-on-street arrests by a 2 to 1 ratio, although this has been subsequently reversed. Under the protective custody charge, an individual is retained in custody for up to 20 hours, and then released. The police do not seek any information. Since there is a police Intoxicated Person Report, the charge is added to the person's police

record. There are indications that this device is being phased out after the city attorney expressed reservations over its legality.

28. E. Rubington & R. Geddes, Detoxification, Decriminalization and the Criminal Justice System in the City of Boston: A Preliminary Report 10, 21 (1976) (unpublished preliminary report submitted to the National Institute of Law Enforcement and Criminal Justice, LEAA).

29. If the primary goal of a detoxification center is the provision of more humane short-term sobering up services, the criterion of "persons who have indicated no interest in alcoholic rehabilitation or who are overtly hostile to rehabilitation referral" seems inappropriate. It is based on the assumption of the importance of the goal of rehabilitation. Also, the criterion of "persons who have been disruptive on previous stays at Detox" denies admittance based on past behavior. In contrast, the only statutory exemptions of the Penal Code, §647-F, relate to presently observable behavior to be determined by the police officer: (a) where a person has also used other drugs; (b) committed another misdemeanor; or (c) presents a security or medical problem. See S. Thompson, supra note 18, at 35-36, 60-61.

30. Detoxification Center officials maintain that increased voluntary admissions at least partially reflect the fact that more skid row inebriates are finding their way to the Center on their own and becoming voluntary admissions. Further, there are reports that police often drop drunkards off at the Center and let them self-admit.

The following table indicates St. Louis arrest rates and detox admissions for a 14-year period from 1960 to 1974. Relevant administrative and detox changes are noted.

Year	Arrest	Detox		Total
		Police	Voluntary	
1960	2,853			2,853
1961	2,768			2,768
1962	2,978			2,978
1963	7,847			7,847
1964	3,786			3,786
1965	2,488			2,488
1966[a]	1,719	60	--	1,779
1967	796	1,120	--	1,916
1968[b]	551	1,174	--	1,725
1969	333	946	--	1,279
1970[c]	540	1,251	215	2,006
1971	463	1,317	203	1,983
1972	300	1,301	217	1,818
1973[d]	168	1,449	533	2,150
1974	301	801	1,698	2,800

Footnotes from table on preceding page:

[a]First admission to Detox Center (St. Mary's Infirmary), November 1966.

[b]Detox moved to St. Louis State Hospital in Nov. 1968. Twenty-eight bed capacity.

[c]All police districts included. Detox begins setting aside four beds for walk-in, nonpolice cases.

[d]Bed capacity increased to 40, 8/13/73. All patients accepted on first come, first served basis--no beds reserved exclusively for patients brought in by the police.

31. A savings of criminal justice resources, however, does not mean there will be an overall resource savings. See note 9, supra.

32. Increased "recycling" of the public inebriate on the street and thus increased police contacts with the public inebriate resulting in more involuntary admissions also contributed to the fact that the decline in arrests was less than anticipated.

33. For example, an evaluation of the Sacramento County Detoxification Center recommended that voluntary admissions be limited to 10 percent of the available bed capacity in order to emphasize the goal of providing an alternative to arrest and jail.

34. R. Ninner, Two Million Unnecessary Arrests: Removing a Social Service Concern from the Criminal Justice 41-42 (1971) [hereinafter cited as R. Nimmer]. In chapter 4, "Criminal Justice Systems: New York City," Nimmer describes the use of New York City foot patrol officers and a special squad to police the Bowery for public drunkenness in the late 1960's:

> "Police operations on the Bowery involve two methods of patrol. The first is the assignment of foot patrolmen to specific posts within the area. The orientation of these foot patrols is strongly directed toward the goal of maintaining order in the area, and arrests are not a primary department evaluation index for this kind of assignment. Officers assigned to foot patrols seldom arrest nondisorderly derelict men; rather, they ignore them or move them off the street and into an inconspicuous, and, safer location." Id. at 62.
>
> "Arrest of nondisorderly derelicts on the Bowery, as on Madison Street in Chicago, is the function of a special squad of officers. In New York this squad is labeled the 'condition men,' the reference being to the preoccupation with the on-the-street condition of the Bowery. These squads perform roundups of derelict men . . . . The two-man teams of condition men go out onto the Bowery streets

> in a police van operated by a third officer. Unlike Chicago, however, the condition men make no effort to remove all derelicts who come within any operational arrest criterion. Rather, they approach their patrol efforts with a predetermined number of arrests in mind and return to the station house once they have reached this number of arrests." Id. at 62-63.
>
> "Since there are always many more men on the streets than are arrested by the condition men, arrests are selective. However, no affirmative criteria are employed; and given the pressure of time and the numerical orientation of their task, condition men make arrests on a first come, first served basis subject only to the negative criterion that men most in need of help are not arrested. Arrestees must appear in court a short time after arrest, and there is no time for the severely intoxicated man to sober up or for the debilitated man to regain his strength." Id. at 64.

35. E. Rubington and R. Geddes, The Organizational Record of Decriminalization: Police and Detox Contact with Inebriates (unpublished draft report to LEAA, 1976) [hereinafter cited as E. Rubington and R. Geddes]; Exemplary Project Validation Report: The Boston Alcohol Detoxification Project (1974) [hereinafter cited as ABT Associates].

36. E. Rubington and R. Geddes, supra note 35 at 6. In Boston, Massachusetts, however, certain problems exist in the two-stage delivery system which should be considered by other jurisdictions contemplating such an approach. In the year following decriminalization, while 34.3 percent of all inebriates taken into "civil protective custody" between 8:00 a.m. and 4:00 p.m. were released to detox, only 5.4 percent of those taken into protective custody between midnight and 8:00 a.m. and 2.1 percent of those taken in between midnight and 8:00 a.m. were released to detox. The movement of inebriates between protective custody and detox may be a function of significant differences in work schedules of police and detox personnel. Beds in detox become available during the day as patients are discharged. The pressure to fill empty beds that are in demand by persons on the street and in protective custody during this period results in few beds being available during the evening and night. On the other hand, police pick up public inebriates 24 hours a day and pick up fewer during the day than during either the evening or night. Also rescue team members work four 10-hour shifts per week. The detoxification center, which is understaffed, suffers its most severe staff shortages during the evening and at night, when rescue teams are on-call only. E. Rubington and R. Geddes, supra note 35 at 11-16; ABT Associates, supra note 35, at 10-11.

37. The following police agencies utilize the services of the Santa Clara detoxification center: San Jose Police Department, Palo Alto Police Department, Los Altos Police Department, Mountain View Police Department, Campbell Police Department, Los Gatos Police Department, Gilroy Police Department, Morgan Hill Police Department, Santa Clara Police

Department, Sunnyvale Public Safety Department, Santa Clara County Sheriff's Department, and the California Highway Patrol.

38. "In the absence of any appropriate treatment facility, an intoxicated person . . . who would otherwise be taken by the police to a treatment facility may be taken to the city or county jail where he may be held until he is no longer intoxicated." Or. Rev. Stat. §426.460 (3).

39. National Advisory Commission on Criminal Justice Standards & Goals, Police Chief Executive: Report of the Police Chief Executive Committee of the International Association of Chiefs of Police 87 (1975) in Standard 11, "Establish and Communicate Objectives and Priorities," includes the following commentary: "Setting objectives occurs in every police agency--sometimes with no conscious effort to set objectives. The difference between a mediocre and an outstanding policy agency may depend upon whether a conscious effort is made to set, measure, and accomplish objectives."

40. National Advisory Commission, supra note 44, at 87, provides in part: Every police chief and executive should encourage employees at every level of the agency and members of the community to provide input for the establishment of agency objectives. Individuals at all levels of the policy agency should recommend, determine, or agree upon unit objectives and priorities that are consistent with agency objectives and priorities . . . . Every immediate superior of a police chief executive should review and approve the objectives and priorities determined by the policy chief executive . . . .

41. Four national organizations and commissions have endorsed the need for police administrators to follow up setting public policy priorities with specific explanations of their meaning and implications to guide patrol officers: (1) The President's Commission on Law Enforcement; (2) American Bar Association's Project on Standards for Criminal Justice, The Urban Police Function 116-44 (1972); (3) National Advisory Commission on Criminal Justice Standards and Goals, 21-28 (1973); and (4) International Association of Chiefs of Police. The International Association of Chiefs of Police has approved the ABA Standards on the Urban Police Function and sponsored the preparation of a set of Model Rules for Law Enforcement Officers.

42. K. Davis defines these terms as follows:

> "A rule that confines discretion says to the officer: 'Here are the boundaries of your discretion. You are free to make your own choices within this area, but don't go outside the boundaries.' A rule that structures discretion says to the officer: 'Within the area in which you have discretionary power, let your discretion be guided by these goals, policies, and principles, and follow these procedures that are designed to minimize arbitrariness.' Discretion of an officer is 'checked' when it is reviewed by a supervisor, by a prosecutor, by a judge, by a private party, by the

> press, by legislators, or by someone else; discretion that is checked is obviously less likely to be arbitrary than discretion that is unchecked."

In addition see D. Aaronson, B. Hoff, P. Jaszi, N. Kittrie, & D. Saari, The New Justice: Alternatives to Conventional Criminal Adjudication (1977); D. Aaronson, N. Kittrie, & D. Saari, Alternatives to Conventional Criminal Adjudication: Guidebook for Planners and Practitioners (1977); K. Davis, Discretionary Justice (1969); Caplan, The Case for Rulemaking by Law Enforcement Agencies, 36 L. & Contemp. Prob. 500 (1971); McGowan, Rule-Making and the Police, 70 Mich. L. Rev. 659 (1972); Wilson & Alprin, Controlling Police Conduct: Alternatives to the Exclusionary Rule, 36 L. & Contemp. Prob. 488 (1971); Wright, Beyond Discretionary Justice, 81 Yale L. J. 575 (1972); Project on Law Enforcement (1973).

43. Dayton, Ohio Police Department, Office of Public Information, Police Brief (Jan. 24, 1974).

44. The police chief in Washington, D.C., issued a special order following the congressional enactment of the District of Columbia Alcoholic Rehabilitation Act of 1967 which eliminated intoxication as a criminal offense except when public intoxication endangers the safety of the individual or other persons or property. In Section II of the regulations, the general policy of the police department was set forth:

> "II. Policy, Intoxication shall be handled on a public health rather than on a criminal basis. No intoxicated person shall be taken into custody except where his conduct clearly and immediately endangers the safety of himself or of any other person or of property. An intoxicated person shall be accorded the same consideration as any individual suffering from an illness."

The chief of police also provided an interpretation of the phrase "clearly and immediately endangers . . ." to provide clearer guidance to police pick-up agents:

> "III.C.1. Intoxication is a criminal offense only when it results in a substantial and immediate danger to the safety of the intoxicated individual or other persons or property. A hazard that is theoretical or potential does not constitute a substantial danger. The normal manifestations of intoxication, such as, staggering, falling down, sleeping on a park bench, lying unconscious in the gutter, begging, singing, although perhaps disagreeable and disturbing to the senses, do not under this statute constitute a substantial or immediate danger and do not justify placing the criminal charge of intoxication." John B. Layton, Chief of Police, Washington, D.C. Metropolitan Police Department General Order No. 11 (Oct. 24, 1968).

45. In Minneapolis, Minnesota, the chief of police issued guidelines in July 1971, explaining to police officers that under the revised Hospitalization and Commitment Act decriminalizing public drunkenness, the decision to pick up and transport an intoxicated person to the detoxification center is discretionary. The officer was informed of several criteria he might use in making his decision, including: speech, clothing, odor of breath, manner of walking or position, hazard to inebriate or others, physical condition, appearance of eyes and face, ability to understand and answer questions, ability to identify self, surrounding conditions and circumstances, and what was said or admitted. Interpretation of the criteria and consideration of other factors were left to the officer's "own experience and judgment." Once the officer has made his decision to transport the inebriate, no consent is necessary and "such force as is reasonably necessary" may be used. Minneapolis, Minnesota, Chief of Police, Memorandum (June 29, 1971). While at first glance the above criteria may appear to be unbiased, a closer look suggests a bias in some of the criteria (e.g., surrounding condition, clothing) that increases the likelihood that police would pick up destitute and transient inebriates.

46. Clarence M. Kelley, Chief of Police, Department Memorandum no. 27 (May 14, 1971).

47. After Oregon formally decriminalized public intoxication in 1972, providing for detoxification custody in lieu of other detoxification facilities, the Salem, Oregon, Police Department issued a Training Bulletin. Commenting on the general discretion vested in the police officer to take or send an inebriate home or detain him, the Bulletin stated:

> "Our department policy prohibits transporting an intoxicated person to his home or other place except a treatment facility. It is also department policy to allow an intoxicated ('sick') person to continue on their way whenever possible. Place the intoxicated person in the same category as the 'sick' person and you should have little trouble deciding when assistance is required. Determine if immediate health or life is at stake."

In instructing the police officers on the mandatory delivery requirement for incapacitated persons, the Bulletin stated: "(t)his becomes necessary when the situation is serious and there is no violation requiring an arrest." It noted that while this left "considerable leeway for detoxification custody," it was departmental policy that "the situation must be serious with no other solution available before using detoxification custody." Salem, Ore. Police Training Bulletin, SPD-TB 72-2, vol. 6, no. 2.

After detoxification facilities were established, the Salem Police Department issued the following regulations, effective May 24, 1976:

I. Use of Detoxification Custody

A. Detoxification custody should only be exercised when all other reasonable efforts to take care of the individual have failed (for example, if the subject has no friend or relative to transport him home, or no funds for a taxi).

B. Police officers will not transport the subjects unless they have been taken into detoxification custody.

II. Guidelines

A. Unconscious or Seriously Injured Subject.

1. DO NOT take into detoxification custody.

2. Call for an ambulance and have the subject transported to Salem Memorial Hospital. Do not transport the subject in the patrol unit.

3. Complete an Incident Report (sick or injured person).

B. Subject is Antagonistic, Mildly Abusive, or has Minor Injury Not Needing Emergency Treatment.

1. Attempt to get the subject to commit himself to the Oregon State Hospital.

2. The State Hospital does not have the emergency facilities to take the seriously injured, but can accept patients that do not need lab work or emergency care.

3. If the subject refuses to commit himself, the officer has the alternative of making an emergency commitment.

4. The State Hospital has the necessary staff to handle the combative subject, and have advised they will accept emergency commitments in most detoxification cases.

C. Intoxicated Person.

1. If the subject is noncombative and is unable to care for himself, take the subject to the Detoxification Center.

2. The Command Center supervisor should call ahead to ascertain if there is room at the Center.

3. The Detoxification Center usually has only one female staff member on duty and is not equipped to handle the violent or combative subject.

Salem, Ore. Police Department Training Bulletin, SPD-TB 3.12.

48. We acknowledge our indebtedness to Jerry V. Wilson, former Chief of Police, Washington, D.C. Metropolitan Police Department, for improving our understanding of how police chief executives can successfully implement policy changes in a large urban police department. In addition to numerous conversations, we drew upon his unpublished paper, Executive Control of Policies for Police Handling of Public Inebriates (1975) (filed with The American University Law School's Project on Public Inebriation).

49. During the first 15 months of MAP's operation, January 20, 1975 through March 16, 1976. MAP's statistics show 9,857 clients assisted. Most of the people assisted were males: 9,218 (93.5 percent) male as compared with 639 (6.5 percent) female. MAP client assists were approximately 80 percent white (7,910--80.2 percent), 11 percent black (1,039--11.1 percent), 9 percent American Indian and Oriental (835 American Indians--8.5 percent--and 23 Oriental--0.2 percent). Mobile Assistance Patrol, Statistical Summary, January 20, 1975-March 16, 1976 (mimeograph on file at the San Francisco Alcoholism Consortium, Inc.).

50. Two statutes have been enacted in California which provide for diversion of public inebriates. Cal. Penal Code §§849(b)(2), §647(ff) (West 1972). Enacted in 1957, §849(b) gives police officers statutory authority to release persons arrested only for public intoxication prior to arraignment when further proceedings are not "desirable." Section 647(ff), enacted in 1971, requires police to take all public inebriates to civil detoxification facilities if they are "reasonably able to do so," provided the inebriate is not disorderly, has not committed other crimes, and is not intoxicated by a combination of alcohol and other drugs. Neither law sets forth the factors to be considered in deciding which inebriates are to be delivered and which are to be criminally processed.

51. Almost all of the public inebriates in the area patrolled by MAP are skid row inebriates. The sources of information for pickup are calls through the radio communication system and observation while on patrol. Most of the contacts are from the former. The police frequently call directly or through Central Emergency, a central city emergency assistance telephone service. Friends and relatives of inebriates place calls. Ambulance drivers place calls. Agencies call for transfer to other facilities--e.g., a hospital will call for a public inebriate to be transported to detox. There seems to be relatively little patrol. The limited bed space available in detoxification centers provides little incentive for MAP to engage in active patrol.

52. The primary areas patrolled by MAP are south of Market and Mission Streets. South of Market is the Southern Police District. This encompasses the original skid row area that now has been affected by urban renewal. Most of the flop houses have been torn down and replaced by massive areas of parking lots with drunks living in former basements (foundation left exposed) and under sidewalks. There are numerous cheap hotels. MAP occasionally will pick up outsiders in the area--i.e., transients and blue-collar public inebriates.

The Mission area is in the Mission Police District. Its residents are primarily from minority groups--blacks, Indian Americans, and Mexican Americans. This area is becoming the new skid row as residents of the old skid row are forced to move out because of urban renewal.

53. The social setting detoxification centers in San Francisco are as follows:

1. Howard Street Detox Center, 1175 Howard Street, operated by the St. Vincent De Paul Society. It is a 20-bed unit (16 male, 4 female), 72-hour social setting detoxification program. It receives Federal funds from the National Institute on Alcohol Abuse and Alcoholism.

2. Mission Unity Group Center, 695 South Van Ness Avenue, a 15-male bed, 72-hour social setting detoxification program. Clients needing medical detoxification are admitted to the St. Joseph Hospital Detox Ward. St. Joseph Hospital, 155 Buena Vista Avenue, operates a medical detox facility of 20 beds (16 male, 4 female) and accepts Medi-Cal and medical insurance. It receives Short-Doyle funds (State--90 percent, local--10 percent).

3. Salvation Army, 1255 Harrison Street, is a 15-male bed, 72-hour social setting detoxification program. In addition, there are 3 post-detox "holding" beds. It receives Short-Doyle funding (State--90 percent, local--10 percent).

4. Thirteen Thirty-five Guerrero Detox, 1335 Guerrero Street, is a 20-bed social setting detoxification center for both males and females. It is affiliated with Garden-Sullivan Hospital. Referrals are accepted from the total community. It is funded by the National Institute on Alcohol Abuse and Alcoholism and is the only social setting detoxification center that is not funded or supervised by the San Francisco Bureau of Alcoholism.

In addition, San Francisco General Hospital Ward 52 operates a 20-bed detoxification unit (16 male, 4 female) but admits only cases with hospital admissible medical problems in addition to detox need. It will treat all persons regardless of ability to pay. San Francisco, Cal. Bureau of Alcoholism, Overview: San Francisco Alcohol-Related Services 1-3 (Jan. 1976).

54. Each of the detox centers caters to a somewhat different clientele. The agreement with the city provides that MAP "will make every effort to insure that clients who belong to a specific ethnic group will be transported to the drying out facility most syntonic to the individual's needs." At the same time MAP will make every effort to apportion clients equitably among drying out facilities, but client's choice of a specific drying out facility will be respected when feasible. (Exhibit A, Public Inebriate Program Diversion Systems Services Agreement 3 (Oct. 1975)) [hereinafter cited as Exhibit A].

Interviews with counselor/drivers reveal that Howard Street Detox, located just south of Market, is perceived as a place to deliver younger inebriates and women. It is perceived as emphasizing counseling and using volunteer workers from the community. Howard Street Detox is often filled after the first week of a month and the middle of a month. They often close on Friday for the weekend because they are filled. According to Mr. Eugene B. Smith, Director, Howard Street Detox, the sources of clients are as follows: referrals--46 percent; MAP--43 percent; family/friends--3 percent; agency referrals--8 percent. Letter from E. B. Smith to D. E. Aaronson (June 24, 1976).

In contrast, the Salvation Army ("Sally") is perceived as a place to deliver older and more middle-aged persons, white and black, as well as persons who have relatively low motivation to change their lifestyle. "Sally" is perceived as being less rehabilitation oriented than the Howard Street Detox.

The Mission Unity Group Center is perceived as a place to deliver minorities, especially "Latinos," and younger street persons. The Guerrero Detox accepts relatively few referrals from MAP. They are located further away from the skid row area. They emphasize a middle class clientele and take a large number of hospital referrals.

The counselor/drivers noted that the Howard Street Detox fills up the fastest of the detox centers because they get more walk-ins. Also, the personnel may keep clients longer than the 3- to 5-day period, often emphasizing rehabilitation over short-term sobering up services.

55. When the police call and are present at the time of pickup the public inebriate is more likely to "voluntarily" accept pickup if offered a choice of jail or detox. When an inebriate is approached directly or when the police officer does not wait for the counselor/driver before leaving the scene, there is less likelihood that the inebriate will "choose" to go to detox.

56. Exhibit A, supra note 51, supra at pt. C. Counselor/drivers are instructed to notify a medical facility and request ambulance transfer for those clients not physically eligible for MAP transportation. If a client develops medical symptoms which would make him ineligible for entry into a drying out facility while enroute to that facility, the client is to be taken directly to the nearest appropriate medical facility. If a client, while being transported, displays behavior which would make him ineligible for entry into a detoxification facility, or if he decides that he no longer wishes to participate in the program, counselors are instructed to release the client at the nearest safe point of exit.

    If an inebriate is unconscious, the counselor/driver attempts to wake him and get him to talk. This is done by shaking him or using ammonia capsules. The inebriate must be mobile or the MAP must call an ambulance. The public inebriate usually must agree to stay in detox for 72 hours. Inebriates are asked what is wrong with them and checked for medical injuries. If serious medical injuries are apparent, an

ambulance is called. If inebriates show hostility, they are left alone or on rare occasions the police are called. If they are borderline drunk, they will usually be taken to detox. If they are obviously not very intoxicated they are referred to a half-way house. The "poly-drunk" presents a problem for MAP. Unlike Minneapolis, Minnesota, MAP pick-up agents will not take a person to detox who is intoxicated both by alcohol and other drugs. Women will be picked up, unlike other cities such as Erie, Pennsylvania, which has no facilities for women, and taken to the Howard Street Detox where four beds are set aside for women.

57. MAP has the names of approximately 15 to 20 persons who either do not want to go to detox or who are unacceptable to the detox centers, or both. The counselor/drivers feel pressured by detox personnel and wish to accommodate them. Counselor/drivers stated that if they send too many inebriates to detox centers who are unwilling to accept referrals from detox to other facilities, a common criteria by which the efforts of detox centers are evaluated, personnel at the detox center will complain. Known "trouble makers" are left on the street and not taken to detox.

58. Counselor/drivers are not supposed to go into homes or hotel rooms, although police officers or health outreach teams can bring a person outside to the van. Under guidelines, counselor/drivers are not supposed to transport persons to a home, apartment, recovery home, etc.

59. Through direct funding of community treatment programs and formula grants to the States, the National Institute on Alcohol Abuse and Alcoholism has funded approximately 700 alcoholism service programs across the country. NIAAA is one of three Institutes of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), the newest of six health agencies in the Public Health Service, U.S. Department of Health, Education, and Welfare. Alcohol, Drug Abuse, and Mental Health Administration, Meeting America's Needs 1, 11 (1975).

60. MAP began operations in January 1975, with initial funds originating from the Mayor's Criminal Justice Council, through the Bureau of Alcoholism, to the San Francisco Alcoholism Consortium, Inc. The Consortium does not directly operate any of the four social setting detoxification centers or other facilities to which public inebriates are taken or which provide services to public inebriates. Rather, it serves as a clearinghouse for its members, providers of alcoholism services, seeks to eliminate overlapping of services, and seeks funds for expansion of services.

61. The criteria used in hiring counselor/drivers are as follows: (1) at least 3 months' experience in alcoholism treatment; (2) completion of a minimum of one training course in alcoholism; (3) possession of a valid California motor vehicle operator's license (clean for the past 2 years); (4) possession of a standard first aid card (within 2 weeks of employment); (5) 1 year of sobriety if a recovered problem drinker. Exhibit A. supra note 51, at III A.2.

62. Several factors account for the relatively high turnover rates. Two counselor/drivers who were recovered alcoholics suffered relapses. One staff member left the project in order to go back to school. One staff member left because of personal problems having nothing to do with the work of the counselor/drivers. Relatively low pay with little opportunity for advancement undoubtedly contributed to the turnover. Also, one staff member indicated that the work can be frustrating because of the lack of much follow-up contact with inebriates and expressed a desire eventually to work on an alcohol program where there is more intensive contact with a smaller number of inebriates.

63. Three of the eight counselors interviewed for an evaluation study of the Mayor's Criminal Justice Council recommended the following changes in the MAP van:

> "The van was too big, too high off the ground and it lacked seat belts and hand bars for passengers. The size of the van is unnecessary as only a few passengers should be transported at one time because the clients tend to be bothered by the other passengers. The size also limits maneuvering in heavy traffic. The height of the van makes it difficult for clients to get in, and they ought to have bars to hold onto and seat belts to keep them secure."

64. The communication system consists of a radio in the van with direct input from the central office and from Central Emergency (Public Health). In turn, the MAP office and Central Emergency can contact or be contacted by the public by telephone, the police by a direct line (no dialing), or each other by a direct line. Also, Central Emergency can contact an ambulance by radio, and can monitor the radio communications between the MAP office and the van at any time. There are no direct communications between the police and the MAP van. Under the present system, a policeman in a patrol car must radio his district station, which contacts police communications, which contacts Central Emergency or the MAP office, which then contacts the MAP van.

65. "For the police and the paddy wagons we would substitute minibuses, each with a woman driver and two men knowledgeable of the local community in which the minibus will move. A woman is preferred to a man as the driver-radio-operator because it is our experience that the presence of a woman has an ameliorative effect on the behavior of males, even drunken males." N. Morris and G. Hawkins, The Honest Politician's Guide to Crime Control 7 (1970).

66. Ms. Carol Robertson, one of the women counselor/drivers, stated that both of the women felt that their participation in the project demonstrated that women can satisfactorily perform the functions of counselor/drivers and can make a valuable contribution as public inebriate pick-up agents. Interview with Carol Robertson (June 2, 1976).

67. Total arrests for public intoxication in San Francisco from 1971 through 1975 are as follows: 1971--17,291; 1972--15,208; 1973--15,130; 1974--15,202; 1975--13,846. Explanations for the less than expected reduction in the arrest rate may be either that the

population of public inebriates is actually much larger than the police and MAP combined can handle, the population is increasing, or the population of public inebriates with which MAP is concerned is only in part the same population with which the San Francisco Police Department is concerned.

Also reductions that have occurred in arrests of public inebriates may be partly the result of a deemphasis within the San Francisco Police Department on such arrests rather than the direct result of MAP diversion. In addition to MAP several other changes occurred that reduced the incentives for police officers to arrest public inebriates.

1. Police sweeps were discontinued in order to give MAP fuller responsibility and opportunity to respond to the problem. This resulted from negotiations between criminal justice personnel and alcoholism personnel, especially through a city-wide Alcoholism Advisory Committee.

2. An increased emphasis on release when sober of public inebriate arrestees. As of February 2, 1976, a new general order, General Order No. 8, issued by a new police chief interested in deemphasizing public drunkenness arrests, mandated release when sober "whenever a person is arrested by a police officer for intoxication only and there are no further proceedings desirable." San Francisco Police Department General Order No. 8 (Feb. 2, 1976). This also coincided with a new city prosecutor who campaigned on a promise of increasing attention to serious crime and a deemphasis on victimless crimes. Persons released when sober are usually held at a station for up to 3 hours and then released.

3. A California State Supreme Court case, In Re Walters, 543 P.2d 607, 126 Cal. Rptr. 239 (1975), held that a person taken into custody and charged with a misdemeanor is entitled to a judicial determination of probable cause. Implementing this decision, General Order No. 8 provided that in all cases where the public inebriate is not released when sober, the incident report must contain all data relied upon by the officer in effecting the arrest and shall include the specific reason(s) for the arrest. The increased paperwork for a review by a magistrate is a disincentive to arrest.

4. COSMOS (Committee of Sober Members of Society), an unincorporated association of chronic alcoholics, filed suit through Gilbert T. Graham, Esq., San Francisco Neighborhood Legal Assistance Foundation. COSMOS, Civ. No. 644265 (Super. Ct. San Francisco, filed DEA: Rule 10:5(b)), alleging violations of due process and equal protection in the enforcement of the public drunkenness laws and sought injunctive relief. On March 31, 1976, Judge Lawrence S. Mana issued an opinion finding that the constitutional violations existed but stayed a proposed order, giving all interested parties an opportunity to remedy the problem.

5. Finally, unlike earlier periods when an activity sheet was used to tabulate all arrests, including those for public drunkenness, now officers receive no credit for making drunkenness arrests. Under

the "release when sober" option, the officers observe the speeding up of the revolving door and may feel, to a greater degree, that picking up public drunks is a waste of time. Interview with Captain George Sully, Secretary for Police Administration, San Francisco Police Department (June 3, 1976).

68. In the Southern Police District, police have relatively little contact with van drivers. Police place a call to MAP and will usually not wait for the van to arrive. This cuts down on the number of pick-ups from calls. Of approximately 50 calls to police, approximately 20 to 25 will be picked up. Occasionally, MAP has asked police whether they will take inebriates to jail and hold for MAP pickup if they cannot wait. At Central and Park Police Districts, police will do this. MAP is supposed to give the police, when they call MAP, an estimated time of arrival.

69. In the early and mid-1960's, a series of deaths and violent killings of chronic alcoholics resulted in efforts to establish more adequate alcoholism services with an emphasis on residential facilities. Under the leadership of a charismatic Catholic clergyman, who was also a member of Alcoholics Anonymous, a community movement ensued. C. W. Weis, Diversion of the Public Inebriate from the Criminal Justice System 13, n. 3 (1973).

70. Erie County, Pennsylvania, had a 1970 population of 263,674. The city of Erie, the county seat, had a 1970 population of 129,231. The city houses the major industry for the county.

71. Interviews with Edward Cuff, Director, Crossroads Center, and William Downey, the first Executive Director of Serenity Hall, Inc. (July 13, 1976). Crossroads Center received an initial discretionary LEAA grant of approximately $60,000 in 1971 to carry out its civilian van pick-up service. Subsequent funding has been received from the Pennsylvania Governor's Justice Commission and other sources.

72. Crossroads applied for and received through the Vocational Administration, Department of Health, Education, and Welfare, a small "workshop improvement grant" which was used to carry on a study of alcohol programs. See C. W. Weis, Alcoholism and Alcohol Abuse in Erie: A Study of the Problems in the Erie Area and Effectiveness of Existing Services with Recommendations for Improvement (1970). This study aided in obtaining initial funding.

73. The counselors interviewed noted the need for improved in-service training, especially medical training to better understand the symptoms of delirium tremens, epilepsy, etc. It was suggested that a general first aid course would be very helpful.

74. The co-principal investigators found that virtually everyone they met in Erie, Pennsylvania, had heard of Crossroads Center. This reflects the relatively small population, the relatively long existence of the project, its downtown location, the widespread publicity both locally and nationally accorded to the project, and the reputation

it enjoys as the principal place to provide detoxification and other services for public inebriates.

For the period July 1, 1975 to June 15, 1976, the sources of clients were as follows: self-referrals--314; staff referrals--9; St. Vincent's Hospital--5; Alcoholics Anonymous--10; police pickups--539; other sources--167. Data provided by Edward Cuff, Director, Crossroads Center (July 13, 1976) [hereinafter cited as Edward Cuff].

75. William Downey and Charles W. Weis participated in the training seminars. This participation in police training seminars parallels the participation of the St. Louis Detoxification Center personnel in in-service training programs and the close cooperation that existed during the initial phase of that program.

76. Erie Police Chief Samuel J. Gemelli noted that in the earlier stages of the Crossroads Center program, there was a first-name basis communication between Mr. William Downey and Mr. Edward Cuff and top police officials. They would get together, have lunch, and discuss problems. In recent years Crossroads has become more business-like, professional, and sophisticated with a loss of that informality in relations with the police department. He says Serenity Hall, Inc. has greatly expanded and they do not have the time for the contact they previously had. Interview with Samuel J. Gemelli, Police Chief, Erie, Pa. Police Department (July 12, 1976).

77. In cities where the civilian van has radio equipment and sufficient business to make more than one stop before returning to base, the time savings are likely to be greater.

78. Of the 213 pickups made by the Crossroads van during the period July 1 through October 31, 1972, 141 or 65 percent were made in the small central area between Lake Erie (1st Street and 26th Street) and the four-block area of French Street, State Street, Peach Street, and Sassafras Street. Serenity Hall, Inc. Project Crossroads: January 29, 1973 Report at 5 (unpublished mimeograph on file at Serenity Hall, Inc., Erie, Pa.).

79. Within 1 year of the inception of the van program, Crossroads Center declared: "Erie Police Chief Charles Bowers has indicated that most of the hard core, revolving door inebriates are no longer seen by officers on duty . . . . Also, the police department has had little use for the police wagon since the inception of the Police Pick-Up Program. The wagon is now used primarily for retrieving stolen bicycles, and the officers previously assigned as drivers can now be utilized for more important duty." Statement by W. G. Downey, Executive Director, Crossroads Center (1972 Grant Application to Pennsylvania Governor's Justice Commission).

80. Police Drunkenness and Disorderly Conduct Arrests in Erie, Pennsylvania

Year	Public drunkenness arrests			Disorderly conduct arrests		
	Male	Female	Total	Male	Female	Total
1975	359	33	392	884	119	1,003
1974	478	30	508	648	83	731
1973	331	49	380	632	78	710
1972	229	32	261	590	74	654
1971	1,479	91	1,570	381	61	442
1970	1,912	92	2,008	174	20	194
1969	1,339	87	1,426	250	29	279
1968	1,006	59	1,065	214	25	239
1967	1,013	40	1,053	209	18	227
1966	1,061	39	1,100	142	8	150
1965	865	44	909	257	21	278

Source: Erie, Pennsylvania Police Department, annual arrest data compiled for reports to the Federal Government.

81. Interviews with Lt. Jerry Kubeja and Officer Ballos, Erie, Pa. Police Department (July 14, 1976).

82. The use of antabuse is mandatory upon clearance by physicians who visit the project. Also, Project Crossroads has "isolation" rooms for inebriates who occasionally need to be restrained. After the patient is seen by a doctor, the patient will get back his clothes.

83. Crossroads Center, Six-Month Survey of the Center's Activities, July 1971-December 1971. This report also shows that seven men were placed at Warren State Hospital and three persons were admitted to foster care homes: Crossroads Center, Referrals, July 1, 1975-April 15, 1976.

84. Crossroads Center claims that is has had considerable success leading to the rehabilitation of some of its clients. For example, in its 1973-1974 refunding application, it stated:

> "In addition to the accomplishments of the program mentioned above, we find 225 of the total number of pick-ups we have had experience with who have remained in the program long enough for, what we feel is, complete rehabilitation. These are men relocated from a homeless situation; reunited with family; for whom jobs have been obtained, or men whose physical and emotional debilities were, in large measure, responsible for putting them into the Criminal Justice System in the first place, who have had these problems resolved so that they are no longer, what we might call, even a threat to themselves where inebriation is concerned."

Statement of William G. Downey, Executive Director, Crossroads Center 4b-4c (1973 Grant Application to Pennsylvania Governor's Justice Commission).

85. See note 77 supra, for data on the annual numbers of women arrested for public drunkenness and disorderly conduct, from 1965-1975.

86. We were informed that other organizations in Erie, Pennsylvania, such as Hospitality House, do provide services to women.

87. Edward Cuff, supra note 71.

88. The Minnesota Hospitalization and Commitment Act was enacted in 1967. Minn. Stat. §253A.01-.21 West Supp. 1977. No special treatment facilities for inebriates were authorized under the legislation and the health officer clause in the legislation was developed to recognize the use of ambulance service as a means of transporting intoxicated persons. While the ambulance mode of intake and delivery is available in many States, it is seldom used as a routine means of transporting public inebriates. Such has been the case in Minneapolis.

89. The First Precinct, the headquarters precinct, is relatively small but includes the major downtown business and thriving commercial areas as well as many bars, "adult" theatres, and flop houses that attract a variety of transient individuals.

90. Hennepin County's Alcoholism Receiving Center serves as the primary detoxification and referral facility for Minneapolis under the decriminalization mandates. A secondary facility is located in the Model Cities area (Police District Six), serving mostly the Native American population. The primary sources of intake for this facility, the Southside Detox, are police deliveries, self-admissions, and referrals from the Indian Neighborhood Club. Like the Alcoholism Receiving Center, this detox receives its funding from Hennepin County.

91. Four types of individuals principally comprise the public intoxication population in the First Precinct (downtown) and the Sixth Precinct (Model Cities area), where there is the highest concentration of problem drinkers: (1) Native Americans (recent arrivals from rural areas); (2) young whites (new residents from small towns and rural areas); (3) blacks (small population of primarily poverty level blacks); and (4) chronic "skid row" individuals ("old-timers" from the "hobo" era).

92. Interview with Mr. Paul Thorne, Director, Alcoholism Receiving Center, Hennepin County, Minneapolis, Minn. (June 5, 1975).

93. Hennepin County Alcoholism Receiving Center, the Public Inebriate: An Innovative Approach to the Transporting of Clients to a Detoxification Center 1-2 (paper presented to the North American Congress on Alcohol & Drug Programs, Dec. 16, 1974).

94. For example, in June through August of 1974, "the total number of admissions to the Center increased 17 percent (from 2,299 to 2,689) while police referrals were reduced from 855 to 480 admissions." Id. at 40.

Based on total admissions for the first 8 months of 1974, civilian van pick-up admissions increased from 19 percent to 27 percent while police admissions were reduced from 23 percent to 17 percent.

95. Some responses of patrol officers to the final, open-ended question of the questionnaire are as follows. Question 15 stated: "Please add whatever comments about police work or policy regarding the handling of persons intoxicated in public, or this questionnaire, that you wish."

Respondent Number 6: "The Police Department should have the detox van start at 12:00 in the afternoon instead of 4:00 p.m."

Respondent Number 50: "There should be more detox vans."

Respondent Number 5: "No place for those who are unacceptable for D-Tox [sic]. No place for those when D-Tox is full."

Respondent Number 81: "Detox will hold someone for treatment for 3 days. I feel this is not sufficient time for 'drying' a person out, and a better program is needed. We have far too many repeaters going to Detox."

Respondent Number 72: "Detox wagons should be city wide, not just coop area. Police Officers should not act as Taxi's to Detox."

Respondent Number 7: "Persons taken in more than 2-3 times should be given long-term treatment and not let back on the street as soon."

Respondent Number 23: "Detox requires and must use long term treatment facilities to ever hope to accomplish their goals."

Respondent Number 8: "Detox is fine for those who want help. The law against Public Drunk shouldn't have been eliminated. The police officer should have been given decressionary [sic] power to determine weather [sic] a person would go to jail or detox. We have to [sic] many return drunks on the street. Not only do they cause a problem with other citizens but they only get three day's care. Before we could give them a months care and a change to get their health back. We can't do that any more."

Respondent Number 35: "Needed is a long term (90 day) treatment center to take over where Detox leaves off. The 72 hours or less is nothing more than a means of removing the drunk from the street. It does nothing to help the hard core drunk who may end up in Detox at least once a week. As long as the drunk law was removed from the criminal code drunks should be handled by a health agency just as other sick people are handled. The Police should only be called upon to assist unruly drunks."

Respondent Number 29: "Detox seems to be uneffective [sic] to their purpose."

Respondent Number 27: "Detox is a failure."

Respondent Number 1: "Detox, as operated here, is a joke."

Respondent Number 10: "Return Public drunkenness as a criminal offense so person could be held against his will."

Respondent Number 17: "They should all be sent to the Workhouse for at least 10 days or more."

96. In contrast, St. Louis and Kansas City, Missouri, Police Departments played a central role in the formulation of a noncriminal alternative.

97. In Minnesota the policy subsystem included the following forces: the traditional alcohol reform lobby (e.g., clergy, Alcoholics Anonymous); State commissions and associations (e.g., Minnesota Commission on Alcohol Programs, Governor's Commission on Crime); civil groups (e.g., the League of Women Voters); legal professionals; and mental health professionals. Interviews with Jim Pearson, Chemical Dependency Program Specialist, Hennepin County Alcohol and Inebriate Program, Minneapolis, Minn. (June 9, 1975), and with Dale Simonson, Attorney at Law, Minneapolis, Minn. (June 17, 1975).

98. Minneapolis police officers are quite sensitive to cues from the business community, governmental officials, and general public. This pressure is especially felt by officers in the First and Sixth Districts where the proliferation of street inebriates and the concentration of other citizens often converge and interact. The importance of keeping the streets clear of intoxicated persons in the downtown business and governmental areas remains a primary preoccupation of the Minneapolis Police Department in the reform era.

99. Figures are based on annual statistics, Official Statistics of the Minneapolis Police Department, Annual Reports, 1960-1975. Statistical tests of the time series data show that increases in disorderly conduct arrests since decriminalization were statistically significant. $T = 2.61$; $df = 14$; $P - .02$.

Also interviews with mental health officials provide corroborating evidence. These officials feel that since decriminalization the police have been picking up a considerable number of public inebriates and arresting them for disorderly conduct. Interview with Mr. Leonard Boche, Director of Hennepin County Alcohol and Drug Program, Minneapolis, Minn. (June 3, 1975).

100. Marion County alone covers 1,175 square miles. The 1975 population for Marion, Polk, and Yamhill counties combined was 252,400. Salem, the State capitol and the Marion County seat, has a city population of 76,300 and a greater Salem area population of 127,900. This is a predominantly agricultural region, serving as one of the largest food processing centers in the nation. The largest employer in Salem is the government followed by wholesale and retail trades and manufacturing industries.

It has been estimated that 13,093 persons in the three-county area have alcohol-related problems. P. G. Marden, A Procedure for Estimating the Potential Clientele of Alcoholism Service Programs (an unpublished paper on file at The American University College of Law).

101. Unless otherwise indicated, the discussion of the Salem, Oregon, Mobile Outreach Program is based on interviews with Sybil Bullock, Executive Director, Marion-Polk Yamhill Council on Alcoholism, Salem, Ore. (June 7, 1976); Jeffrey Harper, Service Coordinator, Salem, Ore. (June 7, 1976); and Edward Shaw, Mental Health Division, Salem, Ore. (June 9, 1976).

102. The Josephine County Council on Alcoholism has a civilian outreach person, an Alcohol Control Officer, who answers calls from anyone who needs help with public intoxicants, drunken drivers, and alcoholics. He uses the communications and referral services of the Grants Pass Police Department to offer an alternative to jail. An Alcohol Emergency Care Unit is run by the Council on Alcoholism. The Alcohol Control Officer patrols bars and streets and answers calls from private homes. The police note that they turned more than 220 persons over to the Alcohol Control Officer in 1973. They claim a reduction of shop-lifting of wine, beer, etc., by winos, assaults by and upon drunks, and less public inebriates acting as a nuisance on the streets. The Alcohol Control Officer assisted 128 persons during the last half of 1973, as follows: 31 taken to detox, 10 to jail, 6 to the hospital, 46 taken home, and 35 other dispositions (secured a room, called a relative, taken to a bus station). Alcohol Control Officer, Josephine County Council on Alcoholism, Year End Report (1973).

103. See note 56 supra.

104. The grant proposal to NIAA was drawn up by Melinda Woodward, Coordinator, Alcoholism Programs, Mental Health Division, Oregon State Department of Human Resources. Region II of the Mental Health Division subcontracted for the program to the Marion-Polk Yamhill Council on Alcoholism. $49,910 was provided for the first year funding; $52,768 was provided for the second year of operation. Oregon Mental Health Division, Application for Continuation of Special Grant for Implementation of Uniform Alcoholism and Intoxification Treatment Act (Apr. 19, 1976).

105. Or. Rev. Stat. §§430.306-430.375. The legislation is based on the Model Alcoholism and Intoxicated Treatment Act.

The State law allowed local jurisdictions to retain certain criminal ordinances. Salem, for example, had a public intoxication ordinance which the city argued was permissible even after decriminalization. It provided: "It shall be unlawful for any person to create, while in a state of intoxification, any disturbance of the public in any public or private business or place." Salem, Ore. Rev. Code §95.122 (Dec. 28, 1971). A police training bulletin indicated that this local ordinance would conform the state and local law: "It is no longer unlawful for a person to be drunk in public. Unless an intoxicated

person is actively creating a disturbance he has committed no crime." Salem, Ore. Police Training Bulletin, SPD-TB 71-13, Vol. 5, no. 13. This appears to be an effort to conform to the new State law while retaining a criminal back-up sanction. The Salem police officers were told that this ordinance survived the decriminalizing State law. Salem, Ore. Police Training Bulletin, SPD-TB 72-2, Vol. 6, no. 2. Nevertheless, it does not appear that the local ordinance was actively used in Salem. A State law signed by the Governor July 8, 1975, apparently closed this gap by amending the decriminalization law to remove the caveat allowing local ordinances. 1975 Ore. Laws, ch. 715 (amending Or. Rev. Stat. §430.325 and repealing Ore. Rev. Stat. §166.035). Salem arrest statistics showed no public intoxication arrests from October 1975 to the present.

106. Or. Rev. Stat. §426.460(3) & (4).

107. In a memorandum on standard operating procedures, the Salem police chief stated that adult intoxicated males would be taken to the Salem City Jail, adult intoxicated females to the Marion County Jail, and intoxicated juveniles to the Marion County Juvenile Home. Ben H. Meyers, Chief of Police, Memorandum to All Police Department Personnel Regarding Detoxification Custody (July 13, 1972).

A Training Bulletin issued in 1972 elaborated on the use of the new "Detoxification Custody." Commenting on the general discretion vested in the officer to take or send an inebriate home or to detain him, the Bulletin stated:

> "Our department policy prohibits transporting an intoxicated person to his home or other place except a treatment facility. It is also department policy to allow an intoxicated ("sick") person to continue on their way whenever possible. Place the intoxicated person in the same category as the "sick" person and you should have little trouble deciding when assistance is required. Determine if immediate health or life is at stake."

In instructing police officers on the mandatory delivery requirement for incapacitated persons, the Bulletin stated: "[t]his becomes necessary when the situation is serious and there is no violation requiring an arrest." It noted while this left "considerable leeway for Detoxification Custody, it was 'departmental policy'" that "the situation must be serious with no other solution available before using Detoxification Custody." Salem, Ore. Police Training Bulletin, SPD-TB 72-2, Vol. 6, no. 2.

While the Bulletin clearly envisions minimal use of the jail detox, it was used as a vehicle for removing the inebriate from the street. From July to December, 1972, 233 protective custody deliveries were made to the Salem City Jail. This device was also used in the three-county area generally: Marion County held 45 persons in jail detox, Yamhill County Jail held 9 males and 2 females, and Polk County Jail had 3 males and 3 females for the same 6-month period. Mid Willamette

Valley Co[illegible]il of Governments, Alcohol Plan, District III 17 (Sept. 1973).

108. Oregon Mental Health Division, Application for Special Grant for Implementation of Uniform Alcoholism and Intoxication Treatment Act (1973). The responsibilities of the Outreach Assistants are defined as follows:

1. Provide outreach, screening, and transportation services for intoxicated persons in the tri-county area;

2. Establish effective working relationships with law enforcement personnel in the tri-county area;

3. Develop and implement alcohol education for special groups, as identified and approved by Director, such as bartenders, tavern owners, etc.;

4. Participate in monthly White Oaks Community Coordinating Committee meetings;

5. Submit daily, monthly, and quarterly reports as required;

6. Work within confidentiality rules of Council, Mental Health Division, State of Oregon, and Federal (HEW) rules relating to confidentiality of Alcohol and Drug Abuse Patient Records.

109. The Service Coordinator is paid $782 to $1,145 monthly (after 5 years) for a 40-hour work week, 8 hours per day, 5 days a week, Monday through Friday.

110. The qualifications set forth in the job description are:

1. Show specialized training, experience, and knowledge of alcohol and other drug abuse that would indicate ability to successfully carry out the responsibilities of this position;

2. Know community resources available to the alcohol dependent person, and know how to procure these services;

3. Be able to evaluate needs of alcohol dependent persons for community services and secure those services for client;

4. Evidence empathy and understanding of the alcohol dependent person;

5. Relate in a positive manner to people with alcohol problems, law enforcement personnel, community agencies;

6. Be able to contribute to milieu therapy by providing a staff atmosphere of harmony, empathy, and competence;

7. Have an interest in continuing personal education and training related to effective job performance;

8. Drinking behavior;

   a. Minimum of 2 years of documentable sobriety and stability if alcoholic;

   b. Responsible drinking behavior if nonalcoholic.

111. The qualifications of Outreach Assistants set forth on the MPY Council's job description are:

1. Show specialized training, experience, and knowledge of alcohol and other drug abuse that would indicate ability to successfully carry out the responsibilities of this position, including the judgment factor;

2. Relate in a positive way to people with alcohol problems, law enforcement personnel, and community services;

3. Evidence empathy and understanding of the public intoxicant, yet be able to assess needs of the person, as to whether they should be taken to White Oaks, the State hospital, or home;

4. Relate effectively to the families of intoxicated persons;

5. Establish rapport with bartenders and tavern owners in the community;

6. Be able to remain calm and handle crisis situations in cool and effective manner;

7. Have skills in first aid with a Red Cross first aid card;

8. Evidence a good driving record;

9. Possess excellent physical and psychological health;

10. Be available for swing/graveyard and weekend shifts;

11. Have an interest in continuing personal education and training as related to effective job performance;

12. Be able to contribute to milieu therapy by providing a staff atmosphere of harmony, empathy, and competence;

13. Drinking behavior:

   a. Minimum of 2 years of documentable sobriety and stability if alcoholic;

   b. Responsible drinking behavior if nonalcoholic.

112. The formal statement of the training received by the Outreach Assistants includes consultation and observation at White Oaks Center and Oregon State Hospital, program orientation at the MPY Council office,

briefings on admission criteria and procedures used by Oregon State Hospital, assignment of responsibilities by the Service Coordinator, assisting the Coordinator, brief police and sheriff's departments on the program and procedures, meeting with the Council Board of Directors, briefing on the history of the Council and Mental Health Division funding and evaluation role, first aid training, and chauffeur's licensing. In fact, since both drivers had experience there was little need for a separate training program and training was primarily in-service training as at San Francisco Mobile Assistance Patrol.

Since the Outreach Assistants are expected to identify only gross medical symptoms and handle only minor problems, first aid was deemed adequate. The Service Coordinator did feel that increased diagnostic training would be valuable. However, the drivers are not expected to have the qualifications of ambulance drivers. There is no insurance coverage for more diagnostic work and it is believed there would be potential conflict with ambulance services if more than rudimentary first aid were provided.

113. The sources of calls to the mobile outreach telephone service from February 25, 1976 through May 3, 1976 are as follows:

Source of referrals	Number of calls
Salem Police	63
McMinnville Police Dept.	4
Marion County Sheriff	9
Polk County Sheriff	1
Woodburn City Police	1
Oregon State Police	3
Self	24
Family	2
Friend	5
Oregon State Hospital	11
Memorial Hospital (Emergency Room)	10
Cry of Love Free Clinic	2
Salvation Army Mission	1
Physician	1
Business owners	10
Oregon College of Education	1
White Oaks (in-house)	11
In person request	1
McMinnville office	1
Other	1
TOTAL	162

Some 38 calls were not referred to Outreach Assistants during the first quarter of operations for the following reasons: calls were made during unscheduled hours--12; the van was unavailable--4; the

people were inappropriate for admissions--20; or other transportation was provided--2.

114. Reasons listed by the Mobile Outreach Program for persons failing to meet White Oaks Center's admissions criteria, during the period February 25, 1976 through May 31, 1976, are as follows:

No need for detox	19
Not voluntary	21
Unconscious	4
Not ambulatory	6
Psychotic/violent	11
Requires hospital treatment	11

The above categories are not mutually exclusive; the total number of persons who failed to meet the admission criteria during this period is 45.

115. White Oaks Center has been keeping separate data on recidivists. One individual was admitted 48 times, often for 1 or 2 hours, not counting the number of occasions he dropped in without advance admission. He was turned away on four occasions with referral to Oregon State Hospital twice, once apparently rejected as "inappropriate" and once turned over to the Salem City Police.

116. While there was a notable decrease in the use of Detoxification Custody during the first full months of the program's operation, it returned to pre-change levels in April and then it fell off again.

117. The earlier decriminalization of public inebriation and the delay in providing nonjail detox and implementing the civil van program meant that police officers were already handling very few cases of public drunkenness. When the Mobile Outreach Program began, the Salem police were formally processing only a handful of inebriates and the number of inebriates formally handled by other police organizations in the three-county area was even smaller. Police directives in Salem clearly call for nonintervention in most cases, informal disposition of most cases requiring intervention, and delivery to a treatment center only for incapacitated public inebriates. As the police officers interviewed indicated, today the public inebriate is usually ignored. The police view problems in Salem as being a small number of resourceless persons who simply cannot be left on the street without danger. Police intervention and handling occur primarily in emergency cases often involving an unconscious person. Given this reality, the opportunity for the Mobile Outreach Program to achieve an observable, statistically verifiable impact on police pickups--unlike other cities we visited--is limited.

118. The officers interviewed indicated that it is often just as easy for them to transport an inebriate and the statistics indicate that this disposition continues even with the van program. The following statistics show that there was an immediate fall-off in police drop-offs to White Oaks Center after the Mobile Outreach Program began operations February 25, 1976, only to return to pre-change levels:

	Police drop-offs to White Oaks Center	Total admissions to White Oaks Center	Police drop-offs as a % of total admissions
Dec. 25, 1974-Jan. 25, 1975	19	64	29.7
Jan. 25, 1975-Feb. 28, 1975	34	63	54.0
Mar. 1975	21	50	42.0
Apr. 1975	29	55	52.7
May 1975	24	64	37.5
June 1975	20	68	29.4
July 1975	17	66	25.8
Aug. 1975	6	60	10.0
Sept. 1975	15	55	27.3
Oct. 1975	18	68	26.5
Nov. 1975	13	51	25.5
Dec. 1975	22	62	35.5
Dec. 25, 1975-Jan. 25, 1976	19	51	37.3
Jan. 25, 1976-Feb. 28, 1976	19	51	37.3
-----Mobile van in operation-----			
Mar. 1976	9	70	12.9
Apr. 1976	22	89	24.7
May 1976	20	60	33.0

However, the same police officers interviewed express support for the civilian van as taking a messy, unpleasant job off their hands in some cases and note that it can take about 15 or 20 minutes each way to White Oaks Center. At the Oregon State Hospital the police officers may have to wait for a doctor. In one case we observed, over 1 hour was used from the time an officer left the street and returned, much

of it lost time waiting for the doctor to come and determine admissibility.

119. While this may seem a minor matter in a town the size of Salem--the van can get to the prime areas in about 10-15 minutes--even this delay provides a negative impetus.

120. It is interesting to note that in August 1975, when White Oaks refused 35 cases because they were filled, police drop-offs as a source of referral dropped from an average of about 20 per month to 6. See note 116 supra. While in Salem the Oregon State Hospital handles the overflow, the van is perceived primarily as a White Oaks operation and, in any event, any complication merely offers an inducement to nonaction.

121. The Director of the Marion-Polk-Yamhill Council on Alcoholism expressed concern whether the van program could be cost-justified after its 3-year life and questioned whether local funds would be available to permanently fund the program. If cost-effectiveness is to be measured in terms of saving police resources in a decriminalized system like Oregon's, it may not be cost-justified--at least if the program is voluntary and refuses to serve certain inebriates with complications or those who have abused the program. Police simply do not have these options if the person is dangerous to himself or others. On the other hand, if cost-effectiveness can be assessed using the more intangible factor of improved services offered the public inebriate, the Mobile Outreach Program, with proper resources, alleviating some of its present constraints, might well prove to be justifiable on a cost-benefit basis.

122. See text discussion at notes 116-118 supra, for more specific observations concerning the preconditions for a successful civilian van program.

123. The Bowery is one of the oldest, largest, and best known concentrations of skid row persons in the United States. The northern half of the Bowery has many cheap lodging houses, bars, and other facilities for derelicts. The southern portion is predominantly commercial. Over the years the Bowery has become a tourist attraction with the primary feature being the numerous skid row men lying on the sidewalks and streets. Due to the nature of the area, police are under less pressure from merchants and residents to remove public inebriates from the streets. In the Bowery a sense of camaraderie and, perhaps, contentment exists among the skid row population to a greater degree than in other skid row areas. The men know and rely on each other. Patients interviewed at the Manhattan Bowery Project indicated that the streets of the Bowery are their home and that fellow inebriates are their family. This attitude may tend to reduce the desire of chronic alcoholics for rehabilitation because it makes them more secure in being homeless. The men consider themselves to be a community of outcasts rather than outcasts in a community.

Since the inception of the Project in 1967, the homeless population of the Bowery has decreased in number and changed in makeup. Whereas

the population in 1967 was mostly white and over 60 years of age, in 1976 the Bowery population is younger with a higher proportion of black persons. The skid row population appears to be continuing to spread onto the West side of the city. Speculation as to the cause of this migration includes: (1) increased tolerance of the derelict in other areas of the city; (2) reduced fear of the inebriate of arrest; and (3) a lower crime rate in the West side where the inebriate could feel secure. Skid row men are often beaten and robbed of their welfare checks by youngsters who come in from out of the area for an easy touch.

Nimmer states that at the end of the decade of the 1960's there were an estimated 4,000 to 5,000 derelict population of the Bowery, representing a steady decline over a 10-year period from 10,000 to 12,000. R. T. Nimmer, supra note 34 at 60. New York Times Jan. 27, 1969, at 21, col. 4. Nimmer suggests two factors that contributed to this decline. In anticipation of an impending urban renewal program, many lodging houses closed their doors. Also, the City Department of Social Services attempted to disperse its skid row welfare recipients to other parts of the city, a policy partially responsible for the development of small skid rows in other areas of the city, notably the upper West Side of Manhattan. R. T. Nimmer, supra note 34, at 60-61.

124. Planning for the project was done by the Vera Foundation at the request of Mayor Lindsay with funding from the Ford Foundation. Initial funding for the project operation was provided by the Bureau of Alcohol of the New York State Department of Mental Hygiene, the New York City Community Mental Health Board, and LEAA. In-kind (personnel and equipment) support was granted by a half-dozen city and State agencies, in addition to the New York City Police Department, including the following:

    1. The New York City Department of Social Services provided a floor of its Men's Shelter at 8 East 3rd Street as the detox unit, provided food and housekeeping services, clothing for patients, assigned four caseworkers, and helped institute an outpatient program for rehabilitation;

    2. The New York City Department of Corrections assigned four officers to aid in bookkeeping and security as well as donating recreational materials and beds for the patients;

    3. The New York City Department of Hospitals provided medical equipment;

    4. St. Vincent's Hospital agreed to serve and serves as the supporting hospital for referrals. The hospital performs laboratory work for the Project and donates the time of its resident physicians to serve as the Project's night shift in order to ensure a physician's presence 24 hours a day.

125. The Manhattan Bowery Project operates several programs in addition to the detoxification center. At the same location of the Men's Shelter

at 8 East 3rd Street, an outpatient medical clinic offers diagnosis and medicine for skid row persons. It receives walk-ins as well as patients brought by the rescue teams. The Project also operates a halfway house, Project Renewal, a work-oriented program geared to reinstate self-respect in the chronic inebriate by providing an opportunity to hold onto a job with steady earnings. The program lasts 1 year with the residents of the house working as a cleanup crew for playgrounds. In 1974-75, seven men graduated from the program and held jobs as health aides and alcoholism counselors. The Project's Supportive Therapeutic Environment Program (STEP) is situated on the sixth floor of a single room occupancy hotel in lower Manhattan. The program's 14 residents may remain in the work-oriented program up to 6 months. During fiscal 1975, 15 men completed the 6-month stay and were graduated from the program while another 17 left while sober in search of a job elsewhere.

126. See note 34, supra for a description of earlier arrest practices in the Bowery.

127. See text discussion at note 37, supra for a discussion of Santa Clara County's two-stage processing system.

128. Interview with Frank Sarsfield, Administrative Assistance, Santa Clara County Bureau of Alcoholism Services (June 10, 1976).

129. C. W. Weis, Diversion of the Public Inebriate From the Criminal Justice System 21 note 4 (Sept. 1973).

130. To avoid the waiting and processing time, St. Louis police officers have engaged in the practice of dropping the public inebriates off at the front door of the detoxification center at St. Agnes Hospital, Since the police officer does not sign the inebriate in or fill out a police report form, the inebriate is counted as a "self-admission."

131. Mr. Eugene B. Smith, Director, Howard Street Detox, stated: "The following breakdown shows where the Detox clients are coming from. It is interesting that we are now getting more self referrals as clients have learned about the availability of the program. Self Referrals--46 percent; Mobile Assistance Patrol--43 percent; Family/Friends--3 percent; Agency Referrals--8 percent. Letter from Eugene B. Smith to David E. Aaronson, June 24, 1976.

132. See R. Nimmer, supra note 34, at 152-53.

APPENDIX A

SAMPLE QUESTIONNAIRE

The American University Law School is currently studying the way various police departments, including that of the District of Columbia, deal with persons intoxicated in public. I especially want your opinions as officers who are knowledgeable in the day-to-day work of enforcing the law. I would like to know what your experiences with persons intoxicated in public have been and how you feel about these experiences.

Your answers are, of course, strictly confidential. The information will be presented in summary form only. So do not sign your name. I am only interested in what you think, not who are you. It will only take you about 20 minutes to help us out. Thank you very much.

IN ANSWERING THIS QUESTIONNAIRE, CONSIDER ALL PERSONS INTOXICATED IN PUBLIC WHETHER THEY ARE VAGRANTS, SKID ROW, BLUE COLLAR, OR MIDDLE OR UPPER CLASS PERSONS. DO NOT CONSIDER DRUNK DRIVERS.

1. Indicate how long you have been working on the street in this district--

_____ Less than 1 year _____ 1-2 years _____ 2-3 years
_____ 3-5 years _____ 5-7 years _____ 7 or more years

2. Describe your present assignment:

_____ scooter _____ one man scout _____ one man transport
_____ foot patrol _____ two man scout _____ two man transport
_____ one man wagon _____ two man wagon

3. How much time have you had as a police officer:
Please check the appropriate space--

	In MPDC	Other (e.g., military police)
Less than 1 year	_____	_____
1-2 years	_____	_____
2-3 years	_____	_____
3-5 years	_____	_____
5-7 years	_____	_____
7 or more years	_____	_____

4. If you are presently working with a partner indicate how long your partner has been on the force.

_____ Less than 1 year _____ 1-2 years _____ 2-3 years
_____ 3-5 years _____ 5-7 years _____ 7 or more years

5. Indicate how old you are--

___ 19-25 ___ 26-30 ___ 31-35 ___ 36-40 ___ 41 or older

6. Check the appropriate line for the last grade of schooling completed--

_____ some high school _____ college graduate
_____ high school graduate _____ some graduate training
_____ some college

7. Please check the appropriate space to indicate your race--

___ White ___ Black ___ Chicano ___ Puerto Rican ___ Other

8. Please check the appropriate space to indicate your sex.

_____ Male _____ Female

9. If relevant please indicate your sector number. _____

10. We would like to find out what kinds of action you have taken with persons intoxicated in public whom you have observed while on duty. Please make an X in the space below that represents your best estimate of the number of actions you took during the given period.

A publicly intoxicated person who is seen on two or more different days is to be counted two or more times.

In the LAST FOUR ON-DUTY PERIODS about how many times did you do the following with persons intoxicated in public?	NONE	1-2 times	3-5 times	6-9 times	10-15 times	Over 15 times
Called for a wagon or took to Detox						
Arrested for criminal offense						
Called for an ambulance or took to a hospital						
Sent by cab or took home						

	NONE	1-2 times	3-4 times	5-19 times	20-49 times	50-99 times	Over 100 times
Saw a publicly intoxicated person and decided that no action was necessary							
Told the person to "move on"							
Sent home by friend or acquaintance							

	NONE	1-12 times	13-24 times	25-49 times	50-75 times	Over 75 times
In the LAST SIX MONTHS about how many times did you call for a wagon or take a publicly intoxicated person to Detox?						

11. How much do the following groups and individuals influence your decisions in handling persons intoxicated in public?

	A great deal	Some	Not very much	Not at all	Not applicable
Your fellow officers in your district					
Liquor store owners and managers					
Other store, hotel, restaurant and bar owners and managers					
Your sergeant, lieutenant, and higher police officials					
Citizens in your patrol area					
Personnel at A.A., Gospel Mission and groups that provide service to inebriates					
Public officials					
Detox personnel					
Government officials in charge of grounds and buildings					
Public inebriates					
Veteran police officers					
Your partner					

12. Below are a number of statements people have made about the problem of publicly intoxicated persons in the District of Columbia in recent years. Indicate your degree of agreement or disagreement according to the following scale and write the number that best represents your opinion in the space after each statement.

1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6

1	2	3	4	5	6
Agree a lot	Agree a little	Neutral but leaning toward agreeing	Neutral but leaning toward disagreeing	Disagree a little	Disagree a lot

FOR EXAMPLE: If you agree a lot with the following statement you would mark a "1" on the space following the statement.

--Filling out questionnaires like this is not the most exciting part of police work 1

--Removing intoxicated persons from public places makes the police officer too much of a social worker ____

--Detox returns persons intoxicated in public to the street without helping them ____

--Police are an appropriate agency to remove intoxicated persons from public places ____

--A good police officer's conduct closely conforms to departmental general orders ____

--The MPDC gives a high priority to the problem of removing intoxicated persons from public places ____

--Because this is the Nation's Capital, it is especially important that intoxicated persons be removed from public places ____

--Removing intoxicated persons from public places should be given a lot priority in comparison to other police tasks ____

--Detox returns persons intoxicated in public to the street too quickly ____

--The failure of the MPDC to give credit for picking up persons intoxicated in public is important to me ____

--Detox is so far away from my patrol area that it is impractical to send many publicly intoxicated persons to Detox ____

--If the police department were divided into a "community services branch" and a "criminal activities branch," I'd choose to be in the community services branch ____

1	2	3	4	5	6
Agree a lot	Agree a little	Neutral but leaning toward agreeing	Neutral but leaning toward disagreeing	Disagree a little	Disagree a lot

--Private groups providing services to intoxicated persons want the police to increase their efforts in removing intoxicated persons from public places ____

--The MPDC makes an effort to train police officers in problems of removing intoxicated persons from public places ____

--Businessmen in your sector want the police to increase their efforts in removing intoxicated persons from public places ____

--The Alcoholic Rehabilitation Center at Occoquan doesn't rehabilitate intoxicated persons ____

--Compared with other public health problems in the U.S., public intoxication is a very serious one ____

--Liquor store owners in your sector want the police to increase their efforts in removing intoxicated persons from public places ____

--The general public in your sector wants the police to increase their efforts to remove intoxicated persons from public places ____

--Political leaders in your sector want the police to increase their efforts to remove intoxicated persons from public places ____

--Detox personnel want the police to increase their efforts in removing intoxicated persons from public places ____

--Few persons intoxicated in public are a physical threat to police officers ____

--Persons intoxicated in public in your sector want police to increase their efforts in removing them from public places ____

--Veteran police officers think it is a waste of time to remove intoxicated persons from public places ____

--Persons intoxicated in public who are well-dressed usually do not require police intervention ____

--Most persons intoxicated in public are not belligerent toward the police ____

1	2	3	4	5	6
Agree a lot	Agree a little	Neutral but leaning toward agreeing	Neutral but leaning toward disagreeing	Disagree a little	Disagree a lot

--Groups like Gospel Million, A.A., etc., in your sector want the police to increase their efforts in removing intoxicated persons from public places ____

--Most persons intoxicated in public bother other citizens ____

--Most persons intoxicated in public who are poorly dressed usually require police intervention ____

--Your fellow patrol officers in your district do not mind removing intoxicated persons from public places ____

--Most persons intoxicated in public need protection from inclement weather ____

--Most persons intoxicated in public are potential victims of a robbery or mugging ____

--It's impossible to remain idealistic after being a police officer for a while ____

--Few persons intoxicated in public are in need of medical assistance ____

--Most persons intoxicated in public are unable to get around on the street without assistance ____

--Removing intoxicated persons from public places is a messy and unpleasant task ____

--My partner thinks it is important to remove intoxicated persons from public places ____

--It is important to me that publicly intoxicated persons are properly cared for ____

--It is important to me that Detox and RCA are effective ____

13. Please add whatever comments about police work or policy regarding the handling of persons intoxicated in public, or this questionnaire, that you wish.

THANK YOU

WE ARE GRATEFUL FOR YOUR COOPERATION IN COMPLETING THIS QUESTIONNAIRE.

APPENDIX B

INDICATORS OF INDEPENDENT VARIABLES

Organizational variable

CONFORMS	A good police officer's conduct closely conforms to the MPD's General Orders.
PRIORITY	The MPD gives a high priority to the problem of removing intoxicated persons from public places.
TRAINING	The MPD makes an effort to train officers in problems of removing intoxicated persons from public places.
CREDIT	The failure of the MPD to give credit for taking persons intoxicated in public to Detox is important to me.

Role variable

SOCWORK	Removing intoxicated persons from public places makes the police officer too much of a social worker.
APPROP	Police are an appropriate agency to remove intoxicated persons from public places.
SERVICES	If the police department were divided into a "community services branch" and a "criminal activities branch," I'd choose to be in the community services branch.
IDEAL	It's impossible to remain idealistic after being a police officer for a while.

Peer variable

VETOFF	Veteran police officers think it is a waste of time to remove intoxicated persons from public places.
BUDDIES	Your fellow patrol officers in your district do not mind removing intoxicated persons from public places.
PARTNER	My partner thinks it is important to remove intoxicated persons from public places.

Strategic environment variable

TOURIST	Because this is (the nation's capital, a tourist area) it is especially important that intoxicated persons be removed from public places.
SERIOUS	Compared with other public health problems in the U.S., public intoxication is a very serious one.
NOHELP	Detox returns persons intoxicated in public to the street without helping them.
EFFECTIVE	It is important to me that Detox is effective.
FARAWAY	Detox is so far away from my patrol area that it is impractical to send many publicly intoxicated persons to Detox.
THREAT	Few persons intoxicated in public are a physical threat to police officers.
BELLIGERENT	Most persons intoxicated in public are not belligerent toward the police.
MESSY	Removing intoxicated persons from public places is a messy and unpleasant task.
WELLDRESS	Persons intoxicated in public who are well-dressed usually do not require police intervention.
POORDRESS	Most persons intoxicated in public who are poorly dressed usually require police intervention.
BOTHER	Most persons intoxicated in public bother other citizens.
MUGGING	Most persons intoxicated in public are potential victims of a robbery or mugging.
WEATHER	Most persons intoxicated in public need protection from inclement weather.
IMMOBILE	Most persons intoxicated in public are unable to get around on the street without assistance.
MEDICAL	Few persons intoxicated in public are in need of medical assistance.
PROPCARE	It is important to me that publicly intoxicated persons are properly cared for.

Strategic interaction variable

BUSINESS	Businessmen in your sector want the police to increase their efforts in removing intoxicated persons from public places.
GENPUB	The general public in your sector wants the police to increase their efforts in removing intoxicated persons from public places.
POLITICO	Political leaders in your sector want the police to increase their efforts in removing intoxicated persons from public places.
AAETC	Groups like Gospel Mission, A.A., etc., in your sector want the police to increase their efforts in removing intoxicated persons from public places.
DETOXII	Detox personnel want the police to increase their efforts in removing intoxicated persons from public places.
LIQUOR	Liquor store owners in your sector want the police to increase their efforts in removing intoxicated persons from public places.
CRTPRSNL	Court personnel want the police to increase their efforts in removing intoxicated persons from public places.
DRUNKS	Persons intoxicated in public want the police to increase their efforts in removing intoxicated persons from public places.
CORROFF	Corrections officials want the police to increase their efforts in removing intoxicated persons from public places.
PUBPROS	Public prosecutors want the police to increase their efforts in removing intoxicated persons from public places.

APPENDIX C

INTERVIEW SCHEDULE FOR PATROL OFFICERS

A. Discretion

1. Can you tell me something about what your beat is like?

   (NOTE: Check one or more of the following.)

   -- neighborhood retail business _____
   -- major business district _____
   -- industrial _____
   -- residential _____
      high income _____
      middle income _____
      low income _____

2. Are there many public drunks in this area?

   NOTE: When I use the terms "public drunk" or "person intoxicated in public," I mean all persons intoxicated in public, whether they are winos, blue collar, middle class, or upper class persons. But, I don't include drunk drivers.

   _____ many
   _____ some
   _____ very few
   _____ none

3. Can you tell me something about the type of public drunks on your beat? For example, about how many _____ (insert type) do you have?

	Many	Some	Very few	None
Wino				
Blue collar				
Middle class				
Upper class				

4. When you come into contact with public drunks, what do you generally do?

5. In terms of _____ (insert disposition using list from #6) these public

what types would you _____ (repeat disposition) ?

6. About how many _____ (insert type of drunk) would you _____ (insert disposition)

over an average month's period?

(NOTE: Write in each square one of the following: MANY, SOME, VERY FEW, NONE.)

Dispositions:	Winos	Blue collar	Middle class	Upper class
Send to Detox				
Send home				
Send to hospital				
Tell to move on or get off the beat				
Do nothing				

7. Suppose you saw a guy staggering down the street, obviously drunk. What would you do?

Send to Detox _____
Send home _____
Send to hospital _____
Tell to move on or get off beat _____
Do nothing _____

-- would it matter if he were a wino or not? Yes ___ No ___
-- would it matter if you knew him? Yes ___ No ___
-- would it matter what the weather was like? Yes ___ No ___

8. Suppose the drunk was sitting on some steps, or hanging around a hotel, a business or some government building. What would you do?

Send to Detox _____
Send home _____
Send to hospital _____
Tell to move on or get off beat _____
Do nothing _____

-- would it matter if there was a radio call or complaint?

Yes ___ No ___

9. Suppose the drunk was lying on the sidewalk or on the grass or in the park. What would you do?

Send to Detox _____
Send home _____
Send to hospital _____
Tell to move on or get off beat _____
Do nothing _____

-- would it matter if he is mobile (able to move on his own) or is unconscious?

Yes ___ No ___

10. In addition to the particular situation, what other factors influence your decision on what to do, if anything, with persons intoxicated in public?

_____ number of public drunks on the streets
_____ availability of a transport vehicle
_____ presence of another call
_____ extent of other activity
_____ whether Detox is filled
_____ distance to Detox
_____ other (indicate)

11. Does the Department want intoxicated persons removed from public places?

11. Continued

-- how do you know?

_____ general orders
_____ superior officers
_____ credit given
_____ training
_____ quotas
_____ fellow officers (word of mouth)
_____ other (indicate)

-- how important to you is the Departmental policy on picking up public drunks?

_____ very important
_____ of some importance
_____ not important

12. Do you feel that arresting public drunks is a proper job for police officers?

Yes ___ No ___

-- how would you compare it with other tasks in _____ (insert each of the _____ categories below)?

	Much more important	More important	Less important	Much less important
Maintaining public order				
Enforcing the law				
Serving the community				

-- which of these police jobs is most important to you?

_____ maintaining public order
_____ enforcing the law
_____ serving the community

12. Continued

-- in which of these categories would you place picking up public drunks?

_____ maintaining public order
_____ enforcing the law
_____ serving the community

13. How do your fellow officers view the importance of picking up public drunks?

_____ very important
_____ of some importance
_____ not important

-- how about _____ (insert each item below)?

	Very important	Of some importance	Not important
Rookies			
Veterans			
Your partner			

14. Is there much outside pressure to get drunks off the street?

Yes ___ No ___

--is there much from _____ (insert sources)?

	Very much	Some	None
The general public			
Neighborhood residents			
Liquor store owners			
Other businesses, like hotels			
Private groups serving drunks			
Government officials			
Government officials in charge of grounds and buildings			

-- how important to you is this pressure in deciding whether to pick up public drunks?

	Very important	Of some importance	Not important
The general public			
Neighborhood residents			
Liquor store owners			
Other businesses, like hotels			
Private groups serving drunks			
Government officials			
Government officials in charge of grounds and buildings			

15. How do you feel about persons intoxicated in public and the problem of alcoholism?

16. Does Detox do a good job?

Why do you say that?

17. Now I'd like to ask you a couple of final questions about your understanding of what the law on public drunks is:

Under what conditions can you legally remove a publicly intoxicated person from a public place?

Probe: Consent required?

Dangerous to self and others?

Offensive to others?

Can you ever do nothing?

According to the law, what options are open to you?

B. Background

Now, I'd like to ask you some questions about yourself.

1. How long have you been _____ ?
(insert)

	With the department
Less than 1 year	
1-3 years	
3-5 years	
5-7 years	
7-10 years	
10-15 years	
15-20 years	
Over 20 years	

2. How old are you?

___ 19-25 ___ 26-30 ___ 31-35 ___ 36-40 ___ 41-50 ___ Over 50

3. What was your last grade of schooling completed?

_____ some high school
_____ high school graduate
_____ some college
_____ college graduate
_____ some graduate training

(NOTE: Interviewer Fill-In)

4. Describe assignment:

_____ scooter
_____ foot patrol
_____ one man wagon
_____ two man wagon
_____ one man scout
_____ two man scout
_____ horse patrol
_____ motorcycle
_____ one man transport
_____ two man transport

5. Race:

_____ White _____ Black _____ Chicano _____ Puerto Rican

_____ Indian _____ Other

6. Sex: _____ Male _____ Female

7. District _____

Sector _____

APPENDIX D

INTERVIEW SCHEDULE FOR SUPERVISORY POLICE OFFICIALS

Discretion Questions

1. As a police official, how do you feel toward the problem of picking up police drunks? By the way, by the terms "public drunk" or person intoxicated in public, I mean all persons intoxicated in public, whether they are winos, blue collar, middle or upper class persons. But, I don't include drunk drivers.

2. Are most public drunks being picked up today?

-- how about the wino types?

-- how about nonwinos (blue collar, middle class, upper class)?

-- would you say that all public drunks needing assistance are getting assistance?

3. What do you see as being the present Department policy toward picking up public drunks?

4. What is your role as a _____ (insert rank), if any, in implementing this policy?

5. How do you evaluate patrol officers' conduct in picking up persons intoxicated in public?

PROBE:
-- do you maintain any records on the extent of pickups by your officers of persons intoxicated in public?

6. Are there any economic advantages or disadvantages for the patrol officer in picking up or not picking up public drunks (e.g., overtime pay, promotion)?

7. Are there any advantages or disadvantages to the patrol officer in the amount of time or flexibility in the use of his time from picking up or not picking up public drunks?

-- as a supervisor, how good a use of an officer's time is it to pick up and deliver drunks to detox?

8. How is the Department's policy in this area communicated to the patrol officers?

-- police orders

-- roll call communications

-- academy or in-service training

-- informal communications

-- credit and promotion policies

9. How does the Department know if the policy is being implemented?

-- records

-- time sheets

-- informal communication

10. What are these contacts or communications that exist between public health personnel (like Detox personnel) and the Department?

11. How do these communications take place?

-- liaison officer

-- word of mouth between high level personnel

-- informal communication between police officers and public health staff

-- cooperation on policies and procedures

-- in budgets

-- written communication

-- joint records

-- public health training or briefing of police officers

12. Back in the Pre-Easter days about 40,000 drunks were being arrested. Today, few drunks are at Detox. What about those not sent to Detox?

-- where are they?

-- who are they?

(i.e., if Detox is handling the emergency (man down) wino cases, what about the nonwino and nonemergency wino types?)

13. What's the reason for the changes?

-- is there much outside pressure for picking up drunks?

-- public

-- gov't officials

-- liquor store businesses

-- other businesses

-- neighborhood residents

-- service agencies for drunks

-- Detox or RCA personnel

-- are there less public drunks?

-- are the public drunks less visible?

-- have changes in the city affected this?

14. Should the police be picking up the P.I.'s? Is this the job for them?

Are patrolmen equipped to handle the job?

Who should handle it if not police?

15. Are Detox, RCA doing an adequate job? (probe strengths and weaknesses)

16. Are drunks today better or worse off than back then?

17. Now I'd like to ask you a couple of final questions about your understanding of what the law on public drunks is:

-- under what conditions can you legally remove a publicly intoxicated person from a public place?

-- consent required?

-- dangerous to self or others?

17. Continued

-- offensive to others?

-- can you ever do nothing?

-- according to the law, what options are open to you?

Now I'd like to ask you some questions about yourself--

1. How long were you with the Department at various command levels?

	With department	List command levels and indicate
Less than 1 year		
1-3 years		
3-5 years		
5-7 years		
7-10 years		
10-15 years		
15-20 years		
Over 20 years		

2. How old are you?

___ 19-25 ___ 26-30 ___ 31-35 ___ 36-40

___ 41-50 ___ 51-60 ___ Over 60

3. What grade level in school have you completed?

_____ some high school
_____ high school graduate
_____ some college
_____ college graduate
_____ some graduate training

4. Present position and duties (interviewer: fill in yourself).

5. Sex: _____ Male _____ Female

6. Race:

_____ Black
_____ White
_____ Chicano
_____ Puerto Rican
_____ Indian
_____ Other--indicate

APPENDIX E

INTERVIEW SCHEDULE FOR PUBLIC INEBRIATES

We are interested in finding out how the police deal with people who sometimes get drunk in public. We really won't be able to understand the process until we know what happens from your point of view and how you feel about your contacts with the police and other public agencies. We appreciate your talking to us and sharing your experiences and insights. We want to assure you that whatever you tell us will be considered confidential and we will not tell anyone what you say or use your name in any way.

First of all, we would like to know something about you and your background.

For example, what do you think about your own drinking habits?

Do you think of yourself as a light drinker, a moderate drinker, a heavy drinker, or a very heavy drinker?

In your own terms, how would you describe any problems you have with drinking?

In what ways is drinking a problem for you? (Probe for health, employment, relations with family/friends)

About what percentage of the times you drink do you get drunk?

Where is your home?

Compared with (a year ago/five years ago) do you drink more, less, or about the same as you did then?

In the past month how many nights have you spent here or in other places that are set up to help people who have been drinking? Harbor Light, Gospel Mission--Other mission, Occoquan.

In the past month about how many meals have you eaten here or in other places set up to help people who have been drinking?

Do you have a job at the present time?

What other jobs have you had in the past year?

What is your marital status? (Probe for lack of or broken family relationships)

Do you have a regular income? Approximately how much is it per year, including any pension or social security benefits?

Now, about your regular home? Do you rent a room, or an apartment? Do you live with a friend or relative? If you rent, do you rent by the day, month, week? Do you mind telling me how much you pay in rent? How many different places have you lived in the past year?

How old are you?

Are you a veteran?

Do you belong to any groups or organizations? AA, Church, Veterans.

Now we would like to know some things about your relationship with the police.

About how often in the past year have you come into contact with a police officer in the following types of situations while you have been drinking?

You were drinking with a friend

You were drinking alone

You were just walking along

You were injured or sick in any way

You had passed out on the sidewalk

You were panhandling

You were arguing with another person who had not been drinking

You were fighting on the street with another person who had been drinking.

Could you describe for us in some detail the last time you were picked up by the police? Why do you think you were picked up this time?

Thinking back on the times you were picked up in the last year for being drunk, about how many times were you--

taken or sent to Detox

taken or sent to a hospital because of injuries or your general physical condition

taken or sent home

simply asked by the officer to "move on"

Do you ever try to avoid the police when you have been drinking?

How often do you notice that a police officer sees you in a situation in which you have been drinking and he seems to deliberately ignore you?

In what part of town do you spend most of your time when you are drinking?

liquor stores?

Of course police officers do many other things besides make sure you go where they want you to. For example, has a police officer ever:

asked you to stop drinking?	How often?
made you angry? How?	How often?
made you feel sorry for yourself? How?	How often?
hit or kicked you?	How often?
insulted you? How?	How often?
given you a drink or the price of a drink in exchange for information about criminal activities in the neighborhood?	How often?

Have you ever been arrested? during the past year?

What was the charge? Had you been drinking at the time? Have you been in the Washington area long enough to remember the way it was when police arrested people for being drunk in public?

How many times were you arrested for public drunkenness?

How would you compare the efforts of the police department in picking up "drunks" as between the old arrest system and the present Detox system? Under which system were you most likely to be picked up for being drunk in public?

How many times have you been taken by the police to Detox?

Describe your general experiences there. How were you treated?

Does staying there for a short period of time help you? How?

Have you ever asked a police officer to take you to Detox? to a hospital? How often?

How do police officers usually respond to such a request? Have you ever admitted yourself to Detox or to a hospital for help after you have been drinking?

During the past year, have you ever dried yourself out without the help of Detox, a hospital, or any other agency?

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