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# IMPROVING POLICE DISCRETION RATIONALITY IN HANDLING PUBLIC INEBRIATES

*(Part I of a two-part article)*

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## INTRODUCTION

This two-part article reports on the findings of the "prescriptive" phase of the American University Law School's Project on Public Inebriation.<sup>1</sup> First, we provide a framework or model designed to contribute to efforts to improve the rationality of police discretion and the quality of discretionary justice. Second, we seek to increase understand-

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<sup>1</sup>We gratefully acknowledge the financial assistance of NILE-LEAA, Grant Number 74NI-99-0055. The two other phases of the project, the impact of decriminalization of public drunkenness and police discretion, appear in D. AARONSON, C. T. DIENES & M. MUSHENO, FINAL REPORT—PROJECT ON PUBLIC INEBRIATION (1977) (filed with the Law Enforcement Assistance Administration) and "Police Roadblocks to Decriminalization: A Multiple-Time-Series Analysis of Law Enforcement's Response to Changes in Public Drunkenness Statutes" (February, 1977) (unpublished paper presented to the Law Enforcement Assistance Administration's (LEAA) National Criminal Justice Evaluation Conference, Washington, D.C.).

ing of, and provide the basis for improving, the intake process whereby public inebriates are delivered to designated facilities—jails, detoxification centers, etc.—in criminal and decriminalized jurisdictions. While the article focuses on the discretionary power of police officers to remove street inebriates, it should increase awareness of problems of decriminalizing so-called victimless crimes and aid understanding of the public policy issues involved in responding to behavior involving both order maintenance and public health concerns.<sup>2</sup>

Public drunkenness involves an area of police activity characterized by a large amount of selective law enforcement both in criminal and decriminalized jurisdictions. Public drunkenness behavior involves millions of individuals who may or may not have a serious alcohol problem. In December, 1971, the Secretary of the Department of Health, Education and Welfare delivered the "First Special Report to Congress on Alcohol and Health" and observed 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 3–5 percent who are skid row inhabitants.<sup>3</sup> Limited police resources and the low police priority accorded to public drunkenness result in virtually unlimited discretion to decide whether to intervene upon encountering a public inebriate and, if so, whether to take one or more of the diverse formal and informal modes of disposition. Jurisdictions providing therapeutic modes of disposition for public

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<sup>2</sup>The decriminalization of public drunkenness is but one of numerous adjudicatory alternatives that have been advocated and introduced in recent decades affecting the quality of discretionary justice administered by police, prosecutors, etc. Many alternatives stress "diversion" from the criminal justice system; others involve the rise of "popular" and "administrative" models of the criminal process, such as the use of arbitration and mediation to resolve intra-family and intra-neighborhood disputes; still others stress various measures of formal or *de facto* decriminalization. Adjudicatory alternatives reflect a trend toward acceptance of the place of official discretion in criminal case processing and a potentially important new approach to the societal management of deviant conduct. A central thesis of the emerging "alternatives movement" is that our criminal courts, patterned on an adversary model for the resolution of social conflicts, are an imperfect—and often inappropriate—societal response to the processing of alleged offenders, especially those involved in minor criminal offenses. See D. AARONSON, B. HOFF, P. JASZI, N. KITTRIE & D. SAARI, *THE NEW JUSTICE: ALTERNATIVES TO CONVENTIONAL CRIMINAL ADJUDICATION*; D. AARONSON, N. KITTRIE & D. SAARI, *ALTERNATIVES TO CONVENTIONAL CRIMINAL ADJUDICATION: GUIDEBOOK FOR PLANNERS AND PRACTITIONERS* (1977) (filed with the Law Enforcement Assistance Administration, Grant Numbers 73-NI-99-0023-G and 75-NI-99-0050).

<sup>3</sup>DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, *FIRST SPECIAL REPORT TO THE U.S. CONGRESS ON ALCOHOL & HEALTH* viii (1971).

drunkards may actually increase the discretionary choices available to the police officer.<sup>4</sup>

The importance of police departments as administrative agencies dispensing informal discretionary justice has been recognized in the seminal work of Professor Kenneth Culp Davis and others.<sup>5</sup> Professor Davis argues that "one of the great needs of the 1970s is to transfer know-how from the advanced agencies to the backward ones, and the backward ones include police and prosecutors."<sup>6</sup> Although American administrative law in its present stage of development is devoted almost entirely to formal adjudication, rule-making and judicial review, Professor Davis observes that eighty or ninety percent of the impact of the administrative process comes from informal discretionary action that is not reviewed.<sup>7</sup>

We offer a perspective which differs from the valuable insights of Professor Davis and others on how to improve the rationality of police decisions and to enhance social and individual justice. We submit that improving the rationality of police decisions cannot be achieved merely through confining, structuring and checking police discretion through policy directives, guidelines, rules and review procedures. Our approach is that improving the rationality and reducing the injustice involved in the use and misuse of police discretion requires recognition of the existence of conflicting public policy, organizational (bureaucratic) and individual (self-interest) goals. The existence of these multiple goals and the conflicts among them places limits on rational decision-making

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<sup>4</sup>Approximately one-half of the states have enacted legislation providing for decriminalization of public drunkenness. Several states have delayed implementation of decriminalization due to the lack of funds for therapeutic facilities. Other states permit local units of government to retain the arrest option. Even where decriminalization has been fully implemented, police officers still exercise their discretion to make arrests for a variety of related charges such as disorderly conduct and drinking in public. Criminal jurisdictions increasingly provide informal options for police diversion to therapeutic programs in lieu of arresting for public drunkenness. The FBI Uniform Crime Reports indicated 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.

<sup>5</sup>K. DAVIS, *ADMINISTRATIVE LAW TEXT* 88-122 (3d ed. 1972); *POLICE DISCRETION* (1975); *DISCRETIONARY JUSTICE* (1969). Examples of other articles viewing police discretion from an administrative law perspective include McGowan, *Rule-Making and the Police*, 70 *MICH. L. REV.* 659 (1972); Wright, *Beyond Discretionary Justice*, 81 *YALE L. J.* 575-97 (1972); Wilson & Alprin, *Controlling Police Conduct: Alternatives to the Exclusionary Rule*, 36 *LAW & CONTEMP. PROB.* 488 (1971); Caplan, *The Case for Rulemaking by Law Enforcement Agencies*, 36 *LAW & CONTEMP. PROB.* 500 (1971).

<sup>6</sup>K. DAVIS, *ADMINISTRATIVE LAW TEXT* 3 (3d ed. 1972).

<sup>7</sup>*Id.* at 88.

which necessitates attention to incentives/disincentives to direct police discretion towards behavior supporting public policy goals.

In order for the exercise of police discretion to be rational, it must be sensibly related to public policy goals. Public policy analysis has long recognized the need to identify public policy goals and, after evaluating possible trade-offs involved, to explicitly set clear priorities. However, we found during our site-visits to police departments throughout the country that inadequate attention has been devoted to this threshold task. Moreover, insufficient consideration has been given to the identification of alternative ways to exercise police discretion—i.e., various forms and modes of formal and informal dispositions—and the evaluation of these choices in relation to the designated goal or goals.

A major impediment to the more rational and just application of police judgment is that the preferred ways of exercising that discretion—i.e., the exercise of discretion to achieve designated public policy ends—are often thwarted by conflicting organizational and self-interest goals. The existence of these conflicting levels of aims explains why the most thoughtful police directives, guidelines, and rules, even when arrived at through an open, formal, administrative process, alone probably cannot result in significantly improved rationality in discretionary decision-making and discretionary justice.

Of greater importance than guidelines and rules, and as a supplement thereto, a variety of reinforcement devices—i.e., incentives/disincentives—is needed to insure that police exercise their discretion along preferred lines. The growing literature of the behavioral sciences, especially organization theory and attitudinal studies, provides guidance in identifying and evaluating these reinforcement devices. In order to devise appropriate incentives/disincentives a greater understanding of the determinants of police judgment is required. Hence, advancements in improving the rationality of police decision-making and the quality of discretionary justice may be aided significantly through the development of better explanations of police discretion.

Our framework or model is premised on four principal elements: (1) the goals that a jurisdiction may wish to achieve through its statutes, policy directives, guidelines, and rules for handling public inebriates; (2) the degree of conflict and compatibility of these goals; (3) alternative delivery mechanisms that are available for achievement of the goals; (4) techniques of administration—defined in terms of goal-related incentives and disincentives—to overcome the impediments of conflicting organizational and self-interest goals. Part I of this article focuses on the first two elements of the model; the third and fourth elements are discussed in Part II.

In our model, the objectives may be conceptualized as the dependent variable and the delivery mechanisms as the independent variable. Techniques of administration may be perceived as the intervening variables. The techniques of administration consist of economic, information, communication, authority, power, and environmental incentives and disincentives that administrators might use to assure that police discretion is exercised to meet specified ends. In analyzing the relationships between various elements of the model, we can ask what types of pickup dispositions and what delivery mechanisms best fit a certain goal or set of goals.

In operationalizing this model, we engaged in a literature review and site visits requiring record data gathering and elite interviewing. The site visits were undertaken to jurisdictions that have adopted innovative approaches to the pickup and delivery of public inebriates to therapeutic facilities. The objective was to select cities which, when added to those jurisdictions visited for the impact and discretion phases of the study,<sup>8</sup> would provide a viable sampling of the options presently available.<sup>9</sup> During the site visits, we sought to identify the policy objectives that the planners and administrators were seeking to effectuate; the extent of conflict and compatibility between them; the delivery mechanisms and techniques of administration used; some rough measures of the degree of success in realizing the objectives and the prob-

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<sup>8</sup>During the 1975-1976 academic year, we intensively studied Washington, D.C. During the summer, 1976, site visits were made to two other therapeutic jurisdictions, Minneapolis, Minnesota, and St. Louis, Missouri, and to two criminal jurisdictions, Richmond, Virginia, and Houston, Texas.

<sup>9</sup>Five additional cities were selected for site visits: Erie, Pennsylvania; Kansas City, Missouri; Salem, Oregon; San Francisco, California; and San Jose (Santa Clara County), California. We visited these cities during the summer of 1976. Also, we briefly visited Sacramento, California, primarily to interview state public health officials.

The selection of cities for site visits during this phase of the study was a difficult task. Most writing that exists on treatment of public inebriates has been done on a statewide basis (*e.g.*, the state plans) and does not contain the specific information needed about pickup and delivery programs in individual cities. We reviewed the state plans for all states seeking to identify pickup and delivery programs that furthered delineation of the prescriptive model. Letters were sent to the appropriate alcoholism agency of the state Department of Health, requesting that a short questionnaire be completed identifying innovative programs within the state. We conducted personal interviews with experts in the handling of public inebriates in Washington, D.C. and other cities. Often these interviews yielded valuable information, particularly on smaller cities that we might otherwise not have found. Additionally, we consulted with the U.S. Conference of Mayors and the International Association of Chiefs of Police which have recently conducted national surveys related to handling of public intoxication.

lems encountered,<sup>10</sup> and lessons that might be helpful to other jurisdictions facing similar problems.<sup>11</sup>

The first element of our model focuses on public policy goals and their implications for public service bureaucracies—i.e., the police and public health in-take personnel—in implementing legislative, judicial or administrative mandates to pick up public inebriates.

## I. 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 were identified.<sup>12</sup> Public interest aims and priorities may differ among persons who comprise the criminal justice-public health policy subsystem in a particular jurisdiction (e.g., legislators, planners, administrators, police

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<sup>10</sup>Our ability to measure the extent to which jurisdictions are achieving goals varied from one aim to another. For example, if a major objective for jurisdictions decriminalizing public drunkenness laws is the saving of criminal justice resources, a rigorous analysis requires fairly sophisticated cost-benefit analysis, which is well beyond the capabilities of this project (even assuming the dubious premise that appropriate methodological techniques are available). If the goal is providing emergency services to public inebriates, the critical question becomes measuring the extent to which drunkards in need of emergency services are getting them. A very rough qualitative measure of this was achieved by interviewing knowledgeable persons in the police department and public health departments, and other sources, such as limited contacts with skid row persons, reviewing newspaper reports to determine if there are reports of persons dying because of lack of services, and determining if there has been any litigation involving the inadequate provision of services to publicly intoxicated persons. Where the goal involves increasing or maintaining a high rate of intake to meet "order maintenance" and "street cleaning" expectations, we were generally able to gather a sufficient amount of intake data over time to make a determination of the extent to which such an objective is being met.

<sup>11</sup>We express our appreciation for the assistance of Mr. Terrell Tannen, formerly on the staff of the National Clearinghouse for Alcohol Information, National Institute on Alcohol Abuse and Alcoholism, for consultant services, including a site visit to the Manhattan Bowery Project. We are also indebted to Steven S. Manos, Esq., formerly Administrative Director, Manhattan Bowery Project, for making available unpublished materials relating to this program and to Professor Rubington and Mr. Gettes for making available materials relating to their study of the Boston Alcohol Detoxification Project.

<sup>12</sup>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).

officers, public health workers, and others). Building a broad consensus of the aims and priorities in the pickup and delivery of public inebriates is a prerequisite to fashioning a pickup and delivery system that will be fully responsive to those goals. As will be discussed below, 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 upon which ends are emphasized.

Table No. I on page 454 depicts the diversity of public policy, organizational and individual or self-interest objectives. Consideration of the objectives set forth in the table on page 454 suggests that conflicts exist both within and between each of the three goal categories. Public policy objectives cannot usually be implemented without incentives and effective administration to reconcile conflicting organization and self-interest goals.

At the outset we observe that the public policy goals for handling public inebriates are likely to be emphasized differently within different parts of any city and in the same location at different times. This results not only from differences in circumstances but also because of failure to think through and formalize the objectives of the system.<sup>13</sup> 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 rehabilitative programs, or to diminish or prevent disorders arising out of drunkenness. To help insure that pickup agents are responsive to public policy goals, these pursuits should be made explicit and related to the types of public inebriates likely to be encountered and the location of the "public inebriate" problem. Since public policy goals do not necessarily apply to all persons intoxicated

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<sup>13</sup>Due process and equal protection issues, beyond the scope of this article, arise where public drunkenness laws typically include language incorporating vague standards. For example, the California State Penal Code provides two standards for arrest: danger to self and others or nuisance. CAL. PENAL CODE § 647(f) (Supp. 1977) states:

Every person . . . is guilty of a misdemeanor . . . who is found in any public place under the influence of intoxicating liquor . . . in such a condition that he is unable to exercise care for his own safety or the safety of others, or by reason of his being under the influence of intoxicating liquor . . . interferes with or obstructs or prevents the free use of any street, sidewalk, or other public way.

In San Francisco and other California cities, legal complaints have been filed or threatened alleging that police have used the foregoing statute to improperly discriminate against certain classes of public inebriates and also, in response to business and other pressure, to arrest non-inebriated skid row persons as well as others (street people, young persons, drifters), who do not fit community norms.

Table No. I

*Diversity Among Public Inebriate Objectives*

Goal Categories	Alternative Goals
Public Policy Goals	<ol style="list-style-type: none"> <li>1. Deal with a public nuisance by clearing the streets (maintaining intake levels)</li> <li>2. Minimize the expenditure of scarce criminal justice resources</li> <li>3. More humane handling of public inebriates, especially emergency cases</li> <li>4. Improve longer term rehabilitation or resocialization of public inebriates</li> <li>5. Prevent crime by and against public inebriates</li> </ol>
Organizational Goals (Illustrative)	<ol style="list-style-type: none"> <li>1. Increase in size, status, budget and authority of police and public health officials</li> <li>2. Improve relations with significant public and private community groups</li> <li>3. Reduce time and resources devoted to administration and overhead</li> <li>4. Increase the quality of arrests and quantity of designated arrests</li> <li>5. Improve response to certain requests for assistance and citizen complaints</li> <li>6. Improve recruitment, training, and retraining of police officers and improve communications within the Department</li> <li>7. Maintain a proper image with the media</li> </ol>
Individual or Self-Interest Goals (Illustrative)	<ol style="list-style-type: none"> <li>1. Increase income and fringe benefits</li> <li>2. Obtain promotion or transfer to new assignment</li> <li>3. More flexibility and freedom in use of time</li> <li>4. Minimize paperwork and unpleasant bureaucratic procedures</li> <li>5. Improve job performance and more efficient use of time</li> <li>6. Minimize time spent on unpleasant and unimportant police tasks</li> <li>7. Enhance education and knowledge</li> </ol>



in public, efforts need to be made to distinguish between the types of public inebriates to which they do apply. Each of the five public policy goals listed in Table No. I will now be discussed.

Remove Public Inebriates, Usually  
Skid Row Persons, From the Streets  
and Other Public Places

Although public intoxication in criminal jurisdictions is often said to be a victimless crime, most neighborhoods would prefer not to have their sidewalks and parks cluttered with persons in various stages of intoxication. 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 groups for the removal of drunken persons from the streets and other public places. This goal is more likely to be emphasized in downtown business districts where large numbers of skid row public inebriates often reside and where businesses are especially sensitive to panhandling of customers, begging, and the unsightly appearance and behavior of intoxicated persons.

The goal of clearing the streets of public drunkards implies a substantial commitment of personnel and transportation for the pickup and delivery of intoxicated persons, i.e., indiscriminate intervention to remove street inebriates from designated areas; and, therefore, this aim is usually emphasized only in particular areas of a city. To the extent that public inebriates are formally processed to other non-police facilities, this objective also implies substantial resource commitments for those facilities.

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-cleaning objective. Further, detoxification centers return chronic skid row drunkards to the streets more rapidly.<sup>14</sup> 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 so forth.

The goal of clearing the streets of drunkards was a dominant policy in Washington, D.C. during the criminalized era, producing from 40,000 to 50,000 arrests per year during the early 1960s. It is presently

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<sup>14</sup>See note 45 *infra*.

emphasized in Houston, Texas. During our site 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. The police used an assortment of technical criminal charges as the basis for arrest.<sup>15</sup> The effect was an immediate drop of about thirty percent in detoxification center admissions and an overflow of the jails. This special police activity was in response to pressure by downtown San Jose merchants on the City Council protesting that the continued presence of drunkards in their doorways, on the sidewalks, etc. was harmful to business. 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 site 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 of such persons resulted in a more difficult problem for police to handle. It was concluded that a controlled response may be more effective than a very high level of enforcement and that it was preferable to contain drunks in a particular area.<sup>16</sup> Finding an appropriate location and level of acceptability of street inebriates requires a fine-tuning of public policy where priority is given to order maintenance.

#### Save Overburdened Criminal Justice Resources

Removing inappropriate subject matter jurisdiction 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. These ideas were emphasized repeatedly in every therapeutic jurisdiction visited and, in-

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<sup>15</sup>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).

<sup>16</sup>Interview with Captain George Sully, Secretary, Police Administration, San Francisco Police Department (Summer, 1976).

deed, form an essential part of the rationale for the decriminalization movement.

The illness rationale is inadequate since the decriminalization approach is extended to the pickup of publicly intoxicated persons irrespective of the presence of an underlying illness. A broader form of the illness rationale is that publicly intoxicated persons are incapacitated and that it is, therefore, desirable to help in every episode of public—though not private—alcoholism, even if that help is given to persons not desiring it.<sup>17</sup> It is established that many, if not most, publicly intoxicated persons are not chronic alcoholics, including both skid row and non-skid row public inebriates, as depicted in the diagram on the following page.

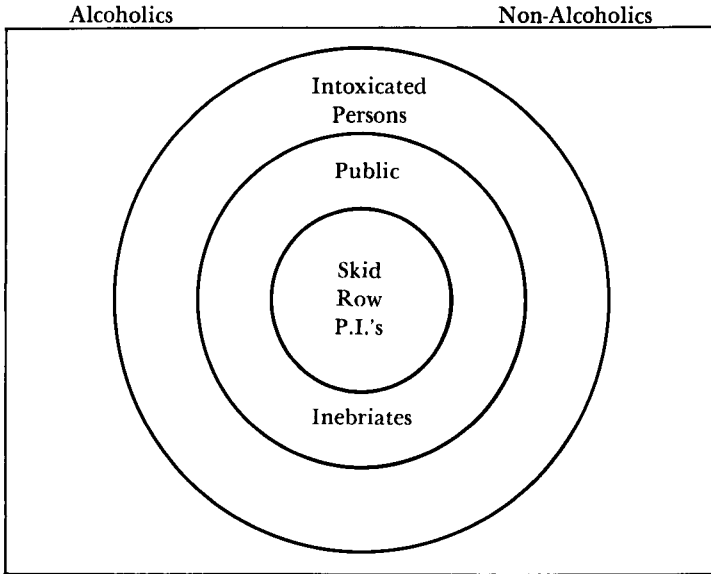
Many skid row derelicts are not chronic alcoholics.<sup>18</sup> Further, most intoxicated persons are not public inebriates: i.e., they are intoxicated at home or, at least, not intoxicated in “public.”

<sup>17</sup>See ALCOHOLISM AND INTOXICATION TREATMENT ACT (the “Model Act”) prepared by the Legislative Drafting Research Fund of Columbia University. In substituting a civil procedure for the criminal law, the Model Act provides a sweeping power to detain against their will persons who are intoxicated and incapacitated in a public place: “A person shall be deemed incapacitated when he appears to be in immediate need of emergency medical attention, or when he appears to be unable to make a rational decision about his need for care.” § 10(a).

The Model Act defines an alcoholic as one who uses alcoholic beverages to the extent that they injure his health or substantially interfere with social or economic functioning. This definition bears no necessary relationship to the public inebriate, who may be picked up whenever incapacitated (determined on the basis of inability to make a rational decision about the need for care, or on the basis of medical need). S. Manos, *The Role of the Law in Improving the Quality of Life of the Public Alcoholic* (May 8, 1973) (unpublished paper prepared for seminar of the National Institute on Alcohol Abuse and Alcoholism) [hereinafter cited as S. Manos], observes:

This determination is made by a police officer or a civilian surrogate authorized by the statute. Thus, the *operational* definition of public alcoholic is one who is designated by government representatives acting pursuant to statutory authority. The truth is that, given this operational definition, *abulia* is in the eyes of the beholder. Likewise, the need for emergency medical attention. Categories which give the appearance of rational classification come to nothing more than the unbridled discretion on the part of the evaluating official. An honest reading of the statute suggests that one purpose, like that of its criminal law predecessor, is social control. This seems to be a striking example of the return of the repressed in disguised form. *Id.* at 15–16.

<sup>18</sup>The traditional view that skid row is a subculture composed almost entirely of chronic alcoholics has been seriously challenged by research findings. “Some of the chronic inebriate offenders are confirmed alcoholics; others are miscreants whose present use of alcohol is preliminary to confirmed alcoholism; and others are non-addicted excessive drinkers who will never become alcoholics.” D. PITTMAN & C. GORDON, *REVOLVING DOOR: A STUDY OF THE CHRONIC POLICE CASE INEBRIATE* 2–3 (1958). This view was confirmed by a recent study interviewing skid row persons in Sacra-



It would be virtually impossible to administer a program that required police or courts to discriminate on a case-by-case basis among chronic and non-chronic public inebriates. During the transition period after *Easter v. District of Columbia*<sup>19</sup> and before the District of Columbia Alcoholic Rehabilitation Act<sup>20</sup> went into effect in August, 1968, mass confusion and uncertainty prevailed, since the court decision was confined to chronic alcoholics. The Alcoholic Rehabilitation Act cured the chaotic situation by extending the new public policy to all publicly intoxicated persons. The Uniform Alcoholism and Intoxication Treat-

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mento, California. A street sample 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." S. Thompson, *Drunk on the Street: An Evaluation of Services to the Public Inebriate in Sacramento County* 8-11 (Mar., 1975) (paper prepared for the Sacramento County Dept. of Mental Health) [hereinafter cited as S. Thompson].

<sup>19</sup>In *Easter v. District of Columbia*, 361 F.2d 50 (D.C. Cir. 1966), 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 a local statute as well as common law principles, could not be convicted for his involuntary intoxication.

<sup>20</sup>District of Columbia Alcoholic Rehabilitation Act, Pub. L. No. 90-452, 82 Stat. 618 (1968).

ment Act,<sup>21</sup> 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.<sup>22</sup> In *Powell v. Texas*,<sup>23</sup> the United States Supreme Court in 1968, however, narrowly rejected the claim that the constitutional guarantee against cruel and unusual punishment requires chronic alcoholism be recognized as a defense to 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) emphasizing the goal of saving criminal justice resources requires that those public drunkards, who otherwise would probably have been criminally processed, be picked up and delivered to therapeutic facilities. Detoxification centers, such as at 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

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<sup>21</sup>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 H.E.W., FIRST SPECIAL REPORT TO THE U.S. CONGRESS ON ALCOHOL & HEALTH 105-18 (1971).

<sup>22</sup>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. 1974); S.D. COMPILED LAWS ANN. § 34-20A-1 (Supp. 1974).

<sup>23</sup>*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.'"

*Id.* at 528 n. 22.

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).

using civilian counselor/drivers, has as its primary objective an absolute reduction of public drunkenness arrests by twenty-five per cent and as its secondary objective, *inter alia*, diminished expenditure of police and court time. One evaluator perceives 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).<sup>24</sup>

Thus, jurisdictions emphasizing this goal must carefully analyze the target population to be serviced 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 drunk 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 savings. Whether an overall cost savings results depends on the cost of the services that are substituted for the criminal justice process and the results of those services. Preliminary indications are that the 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.<sup>25</sup>

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<sup>24</sup>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].

<sup>25</sup>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 non-criminal 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-

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 publicly intoxicated persons.

There are several problems involved in determining the degree to which the adoption of therapeutic approaches will save criminal justice resources that have not been adequately addressed in existing studies and program justifications.<sup>26</sup> Also, arguments for cost-effectiveness that

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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).

<sup>26</sup>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,

may influence local officials initially to adopt a therapeutic alternative for processing street inebriates are often based on a distinction between local costs and outside expenditures by other units of government. It is local costs that are sought to be minimized. Federal funding has been a major stimulus to designed innovation in the processing of public inebriates.<sup>27</sup> For example, Law Enforcement Assistance Administration funds provided the initial stimulus for the first detoxification center in St. Louis. While federal funding is excellent for initial project funding—i.e., for one to three years—other sources of financial support must be found to ensure the project's survival beyond the initial experimentation period. Changes in economic sources may result in substantial changes in the operation of a program. 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 funding. Transportation time, which can have a major influence on costs as well as the level of public drunkard pickups, was substantially increased. A lesson from the St. Louis experience is that for long-range support, street inebriation programs must depend on state and local sources for funding.

Funding for therapeutic handling of persons intoxicated in public must, in the long run, compete with sums available for other alcohol programs servicing more than 90 percent of the alcoholic population. Most therapeutic programs have not yet experienced sufficient operating time to feel the full effects of this competition.<sup>28</sup> David J. Hampton,

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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 non-legal 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.

<sup>27</sup>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% federal), Short-Doyle (90% state, 10% county, revenue-sharing funds (100% federal), and Hughes Alcoholism funds (100% 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.

<sup>28</sup>The cost-effectiveness of many public inebriation programs could undoubtedly



Director of the Santa Clara County, California Bureau of Alcohol Services, presented a financial statement that suggests a substantial proportion of the Bureau's \$5.621 million projected annual expenditures—\$2.027 million—will be spent on 650 chronic public drunkards, amounting to \$3,120 per individual.<sup>29</sup> Finally, financing to improve pickup and delivery of public inebriates to therapeutic facilities must compete with alternative ways to aid the same population, such as needed drop-in centers, improved housing and detoxification services.

Humanize the Handling of Public Inebriates,  
Especially Provide Prompt Care and Services  
to the Emergency Case Public Inebriate

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."<sup>30</sup> The stigmatizing effects of involvement with

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be substantially improved. An evaluation of the San Mateo County, California, Detoxification Center concluded:

While there has been a small decrease in the criminal justice costs, overall the detoxification program has increased county costs. If costs are the only factor to be considered in determining if the detoxification program should be continued several factors should be considered: (1) Placing detoxification facilities closer to the pickup areas would decrease police time in handling individuals and it would undoubtedly result in more individuals taken to the detoxification center. This would reduce considerably criminal justice costs, *i.e.* reduced handling time, transportation time, and less cases going to court and jail. (2) The decreased costs on the criminal justice side would have to be offset by the cost of operating detoxification programs. (The detoxification program costs could be lower if located closer to pickup areas and in low overhead facilities.) *Supra* note 25, at 73.

An evaluation of the Sacramento County Detoxification Center made recommendations in the areas of cutting food costs, building maintenance service costs, and charging patient fees on an ability-to-pay basis. S. Thompson, *supra* note 18, at 41-44.

In Santa Clara County, California, an experiment is being undertaken to bring chronic inebriates under probate conservatorships and qualify those individuals for supplemental social security income payments. The Public Guardians' Office has been generally successful in qualifying clients for eligibility on the premise of prolonged alcoholism, multiple alcohol arrests and/or admission to alcohol treatment facilities with repeated failures, evidencing severe disability from the social and occupational standpoint. The amount of social security income varies between \$283 and slightly more than \$300 per month.

<sup>29</sup>ALCOHOLISM INFORMATION DISTILLER 3 (Issue No. 76-5, May, 1976).

<sup>30</sup>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 re-

the criminal law are avoided."<sup>31</sup> A basic rationale for a 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 not a substitute for the detox process itself. Several jurisdictions we visited emphasized the goal of providing improved short-term services to street inebriates. Pickup agents should deliver such persons who are most in need of these short-term services. 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 service more persons simply by reducing the length of stay at the detox center.

The primary target population for pickups in such jurisdictions is the emergency situation public inebriate. These cases include persons who are unconscious, physically injured, or are suffering from bad weather, hunger, and malnutrition. A study of several thousand patients of the Manhattan Bowery Project showed that approximately 12 percent suffered from diabetes, malnutrition, anemia, neuralgia, cirrhosis or fracture. Eight percent suffered from active tuberculosis, and 20 percent suffered from hepatitis, phlebitis, pneumonia, chronic lung disease, or cellulitis.<sup>32</sup>

The Manhattan Bowery Project in New York, in part due to unique environmental factors evident in the Bowery, primarily emphasizes offering emergency services. Although intoxicated persons occasionally appear at the Project under their own strength seeking admission, they are rejected in favor of those on the street who are incapable of making their way to the center. Inebriates in the worst condition are picked up.

In Salem, Oregon, the police are formally processing only a small number of public inebriates. Police directives clearly call for non-intervention in most cases, informal disposition of most cases requiring intervention, and delivery to the White Oaks Detoxification Center or the Oregon State Hospital of those who are unable to take care of themselves. Interviews with police officers confirm that they intervene and handle only extreme cases. The objective seems to be to provide emergency care to those most acutely needing services.

Civilian rather than police pickup programs such as the Mobile Outreach Program in Salem, the Mobile Assistance Patrol in San Francisco,

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covery 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.

<sup>31</sup>Interview with Ms. Dee Druckenmiller, Head Psychiatric Nurse, Evaluation & Referral Unit, Dept. of Public Health, Santa Clara County, Calif. (June, 1976).

<sup>32</sup>[July 1, 1971-June 30, 1972]. MANHATTAN BOWERY PROJECT, ANNUAL REPORT.

the civilian van pickup programs in Erie, Pennsylvania and Minneapolis, Minnesota, are especially responsive to the goal of humaneness. The civilian pickup agents appeared to be dedicated, understanding persons especially selected for their helpful attitude toward street inebriates. For example, watching an Outreach Assistant in Salem, Oregon, sit and talk with a client for a time impresses one with the patient and humanitarian approach.

In contrast, we observed a police officer handle an inebriate where the person was thrown over his shoulders and carried to the patrol car where the inebriate became increasingly belligerent and finally was handcuffed. When a doctor took over and the officer's blue uniform was not visible, the belligerency ended and the person consented to enter the Oregon State Hospital. This "acting out"—as public health workers term it—seems to be better understood and handled by specially selected and trained civilian treatment-oriented persons manning pickup vans. In San Francisco, we saw police officers roughly push and throw drunkards into a tight, hot wagon. In Salem, we saw one who had consumed too much alcohol helped into a clean, airy, Volkswagen van following a warm, understanding conversation. The difference was dramatic. Further, the Mobile Outreach Program van drivers in Salem carry a stethoscope, take the individual's blood pressure, and have a first-aid kit to permit on-the-street emergency initial diagnosis and simple medical assistance. None of this occurs in a Salem police pickup and delivery. Finally, the van driver's constant involvement with the problems of the inebriate and his background in alcoholism and its treatment help him better appreciate the services needed.

On the other hand, police pickup and delivery of publicly intoxicated people to the drunk tanks of the criminal model, arguably, need not be less compassionate than civilian pickup and delivery to therapeutic facilities. The police have a history of providing community service in addition to crime-fighting and law enforcement functions, whether it be settling a dispute or caring for those who cannot care for themselves. The critical issue may be what type of individual—whether police or non-police—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. We personally observed a civilian counselor involved in intake engage in rough handling and abuse of public inebriates.

Also, the drunk tanks of the criminal model need not be less humane than detoxification centers. In some jurisdictions public inebriates spend fewer hours in drunk tanks than in custody in a detoxification center. Medical model detoxification centers may be providing un-

wanted (and unnecessary) medications without informed consent.<sup>33</sup> There is no reason in principle why drunk tanks cannot be made more humane by providing beds with sheets, access to medical personnel, and other services provided by detoxification centers. In cities such as Pittsburgh and Philadelphia, thousands of both skid and non-skid row drunkards have been regularly released from drunk tanks within four to eight hours after sobering up. A difficult question may be raised: Is it more humane to be picked up and held for seventy-two hours in a more comfortable, therapeutic detoxification center than to be picked up and released from a traditional drunk tank when sober?<sup>34</sup>

Finally, it may be argued that the criminal approach of the drunk tank plus the work farm is more sympathetic than the detoxification center with limited follow-up 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. While no medical studies have been identified, public health workers suggest that frequent three-day detoxifications followed by repeated bouts of drunkenness can be detrimental to physical health. Although people get sobered up in a detoxification center, they do not get the opportunity afforded by occasional thirty, sixty, or ninety days' sentences to the work farm to dry out. While the detoxification center may be a more compassionate, functional equivalent of the drunk tank, no equivalent of the work farm has been provided to persons who formerly experienced their longest periods of sobriety under the criminal model.<sup>35</sup>

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<sup>33</sup>See note 40 *infra*.

<sup>34</sup>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.

<sup>35</sup>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 twenty-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).

Jurisdictions emphasizing the short-term goal of a more humane alternative to the drunk tank should not be surprised at resulting high recidivism rates. A seventy-two hour detoxification facility cannot be expected to reverse the "revolving door" syndrome.

Rehabilitate, Resocialize or Reintegrate  
Public Inebriates Into the Community  
on a Longer Term Basis

Jurisdictions that emphasize the goal of 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 that results in referrals from detox to other longer term treatment facilities. Detoxification is the beginning of the rehabilitative process.<sup>36</sup>

Jurisdictions that emphasize rehabilitation logically should determine the target population that is most likely to respond to the types of restorative facilities available. It is generally believed that this implies that pickup of public inebriates should emphasize voluntary rather than involuntary pickup. It is also asserted that this implies that

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<sup>36</sup>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. Non-medical 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).

civilian pickup agents are to be preferred to police pickup agents. For example, the philosophy underlying the San Francisco Mobile Assistance Patrol's voluntary, non-police pickup mechanism is that, as an illness, alcoholism cannot be adequately treated or remedied through the use of coercion.<sup>37</sup>

Recognizing that while the detoxification center may be a replacement for the drunk tank no replacement had been provided for the work farm, Santa Clara County, California, initiated a special program for hard core recidivist street inebriates in May, 1975—the Arrested Drinking Program (ADP). This program is for a 30-day period, which may be extended for additional 30-day periods in appropriate cases, for voluntary referrals from the detoxification center. It is directed particularly to those who are habitually drunk in public or have had previous failures in recovery houses or other treatment programs. Since the program began, the average number of admissions to the detoxification center has declined.<sup>38</sup> Although the staff makes an effort to convince clients to accept ADP, the voluntary nature of the program is emphasized.<sup>39</sup>

The aim of reintegration into the community assumes that correction or cure is possible. It has been observed that correction or cure is im-

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<sup>37</sup>See C. Winslow, *supra* note 24, at 6. The Report quotes from the San Francisco project's work program summary as follows: "In order to create an atmosphere conducive to breaking the revolving door cycle, the voluntary nature of the program needs emphasis, and the police role must be greatly diminished." *Id.* at 6. Also, the Report adds:

If a public inebriate is taken to detox, he is free to go at any time, in keeping with the philosophy that an alcoholic must choose further treatment in order for that treatment to have an impact. . . . If a public inebriate is taken into the Criminal Justice System, on the other hand, he is forced into temporary sobriety, and he becomes accustomed to external control of his destiny. Compounding this external control with the dependent nature of his lifestyle, he is in most cases unable to benefit from aid from any source because he has lost the desire to help himself. *Id.* at 43.

<sup>38</sup>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.

<sup>39</sup>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.

PLICIT to some extent in both the Uniform Alcoholism and Intoxication Treatment Act and the Alcoholism and Intoxication Treatment Act (the "Model Act").<sup>40</sup> One of the striking findings of the impact phase of this study implies, ironically, that the goal of restoration may be less likely to be achieved in therapeutic, as compared with criminal, jurisdictions for that portion of public inebriates who are most responsive to rehabilitation programs—the non-skid row street drunkards. For example, in Washington, D.C., during the criminal period, large numbers of skid and non-skid row persons were arrested. This provided identification of non-skid row individuals with alcohol problems and offered an opportunity to steer them to rehabilitative services. During the post-change period, pickup and delivery of public inebriates to public facilities is confined primarily to skid row inebriates.<sup>41</sup> In the therapeutic jurisdictions that we site visited, police officers generally view the de-

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<sup>40</sup>S. Manos, *supra* note 17, at 7-8. The Uniform Act has been criticized in the states that have adopted it, as typically resulting in a compulsory medical model with a three-day holding period which includes forced medications and little or no follow-up facilities. A contrasting social welfare model is being advocated in other states such as California. San Francisco at the time of our site visit had four 20-bed social setting detox centers. The use of medication and expensive medical personnel was discouraged. We were informed that only a small percentage of clients actually needed medication. One social setting detox unit was in operation in Santa Clara County and others were planned with an eventual closing down of the large, medically oriented detoxification center.

<sup>41</sup>Our site visits to therapeutic jurisdictions confirmed that detoxification centers tend to concentrate on the skid row inebriate. Ms. Sybil Bullock, Director of the Marion-Polk-Hamhill Council on Alcoholism, observed that the Uniform Act's emphasis on the disease model ignores the fact that most of the clients at the White Oaks Detoxification Center in Salem, Oregon, are very different from client populations at other alcohol rehabilitation facilities. Interview with Ms. Bullock (June, 1976). Referring to the skid row inebriate, the former Director of the Manhattan Bowery Project noted:

Methods of curing the public alcoholic, by almost any standard of cure, are extremely weak. Indeed, the reported success rates are sufficiently low as to make speculation that the cure would have occurred without intervention at least plausible. On the other hand, the reported cure rates for those (non-skid row) alcoholics who have not torn themselves loose, or drifted from a social matrix are high, say 70%. Since the public alcoholic is intractable by present methods and standards, there has been and will continue to be pressure to warehouse him. S. Manos, *supra* note 17, at 20.

Jurisdictions where detoxification centers are voluntary may tend to have a higher proportion of non-skid row public inebriates as clients, especially where intake comes from non-police sources. Public health workers prefer to treat the more motivated client. Examples of detoxification centers emphasizing voluntary intake from non-police sources are the St. Louis Detoxification Center (in the recent period after its location at Agnew State Hospital) and the Guerrero Street detoxification center in San Francisco. The latter accepted very few clients from the civilian MAP pickup team, preferring hospital and other sources of referral.

toxification center as a place primarily for lower status or skid row persons.<sup>42</sup>

The objective of rehabilitation for the skid row public inebriate has generated controversy. In most jurisdictions, it is clear that inadequate resources and facilities impede implementation of the continuum of care approach.<sup>43</sup> Also, the diverse treatment modalities available and the civil liberties implications of longer term confinement create disputes. And, most fundamentally, it is contended that the primary needs of skid row drunkards relate to housing and other resource needs rather than the need for treatment of alcoholic problems. Mr. Loren Archer, Director, Alcohol Program, State of California, states: "The public inebriate problem is primarily a housing problem, not a treatment problem. The problem is drinking in public—the need to keep people who drink in public out of public view."<sup>44</sup> In several cities, those interviewed emphasized the need for the drop-in centers to keep intoxicated people off the streets.

The high recidivism rates in all therapeutic jurisdictions visited provide some evidence of the limited success of the rehabilitation goal.<sup>45</sup>

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<sup>42</sup>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 four 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.

<sup>43</sup>See note 36 *supra*, for a discussion of the continuum of care approach.

<sup>44</sup>Interview with Mr. Loren Archer, Director, Office of Alcohol Program Management in Sacramento (June 14, 1976).

In a survey of 118 skid row men in Sacramento, the respondents were asked to identify their "most important immediate problem." The responses were as follows: drinking—8%; "general survival"—41%; work—33%; food—5%; health—1%, none—3%. The survey also attempted to determine how people survive on skid row. Some of the findings were: Source of Immediate Housing: Missions—49%; Residential Hotels—10%; Rooms, Apt.—17%; Friends—9%; Recovery Home—1%; Detox—1%; No Housing—10%; Source of Last Meal: Missions—61%; Restaurant—11%; Self-Prepared—8%; Friends—15%; Recovery Home—1%; Detox—1%; "had not eaten in last day"—3%; Source of Finances: Employment—3%; General Assistance—13%; Social Security—5%; other government aid—5%; No Financial Support—74%. S. Thompson, *supra* note 18, at 9-11.

For a description of the life of skid row public inebriates, see D. PITTMAN & C. GORDON, *REVOLVING DOOR: A STUDY OF THE CHRONIC POLICE CASE INEBRIATE* (1958); J. WISEMAN, *STATIONS OF THE LOST: THE TREATMENT OF SKID ROW ALCOHOLICS* (1976); J. SPRADLEY, *YOU OWE YOURSELF A DRUNK* (1970); S. WALLACE, *SKID ROW AS A WAY OF LIFE* (1965); *Skid Row Lifeway* (1950) (unpublished M.S. thesis, Chicago: University of Chicago); D. BOGUE, *SKID ROW IN AMERICAN CITIES* (1973); L. BAHR, *SKID ROW: AN INTRODUCTION TO DISAFFILIATION* (1973).

<sup>45</sup>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,



However, these figures are widely criticized as an indicator of the failure of reintegrating drunkards back into society. Recidivism rates computed longitudinally tend to increase in detoxification centers that have a longer operating history because over a greater period of time a street inebriate's chances of contact with the detox center are greater. Also, it has been argued that the return of a public inebriate to a detoxification center, especially in a voluntary program, may be an indicator of recognition by the individual of his need for help, which is a prerequisite to rehabilitation. It may require several visits to a detox center before a person will "bottom out" or otherwise determine to make a serious effort to modify behavior and accept referral to other longer term programs. Other measures of progress toward rehabilitation are needed, such as increased time between benders, holding of a job for a longer period of time, improvement in learning to use health resources, and improved ability to combat stress via sources other than alcohol.

Nonetheless, questionnaires and interviews with police officers suggest that they tend to 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 officers develop a negative attitude toward the detoxification center.<sup>46</sup>

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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 estimate recidivism rates are: 1969—2.03; 1970—3.32; 1971—3.15; 1972—2.87; 1973—2.68. This data is 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.

<sup>46</sup>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

Prevent Crime Either by or Against  
Public Inebriates, Particularly Prevent  
and Suppress Disorder in and Around Honky-Tonks  
and Places Where a Congregation of Public  
Inebriates, Usually Non-skid Row Persons,  
Is Likely To Result in Assaultive Behavior

Public inebriate pickup may serve the objective of crime prevention. It has served as a law enforcement tool, much like vagrancy arrests,<sup>47</sup> when a police officer suspects that prompt intervention may prevent more serious disorderly conduct and other crimes by or against people intoxicated in public.

Houston, Texas, a criminal jurisdiction, has emphasized this objective. Former Police Chief Herman B. Short observed in an interview that much of the violence in Houston is precipitated by public inebriation, especially if driving while intoxicated is included. Arresting individuals for public drunkenness before they have a chance to commit a more serious crime, therefore, prevents many additional police problems. He noted that this goal is not usually addressed in discussing and dealing with proposals to decriminalize.

Pursuing this goal, an officer must exercise judgment on a case-by-case basis to determine which pickups are likely to aid crime prevention.<sup>48</sup> Questionnaires and interviews with police officers suggest that the non-skid row inebriate is more likely to engage in fighting and assaultive behavior, especially when confronted by police officers, than his skid row counterpart.<sup>49</sup>

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up and then get back to the wine.”; respondent #248: “. . . I further feel it is a waste of time because Detox is like a big revolving door. They do nothing for the drunk but give him a place to sleep and eat until his next check comes in, then they return to the street.” In Washington, D.C., respondent #013: “Detox is a joke. They just keep the inebriate until they are sober and release them, only to be returned again and again. . . . To the drunks it is only a temporary place to sleep.”; respondent #005: “My time is wasted, by the time I get back to my district, it seems they are right back on the street. . . .”

<sup>47</sup>See *Papachristou v. City of Jacksonville*, 405 U.S. 156 (1972).

<sup>48</sup>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 cleaning the streets.

<sup>49</sup>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 non-alcohol city ordinance charge or criminal charge (peace disturbance, assault, etc.). Respondent #172 to Question 15, *supra* note 46, of St. Louis Questionnaire distributed to patrol officers.

In the District of Columbia, in the pre-change criminal era, public drunkenness was also used as a crime prevention tool. Former Police Chief Jerry V. Wilson cited "arresting inebriates to suppress disorder in and around honky-tonks" as one of the major purposes of public inebriate arrests. He stated:

[T]he bars which cater both to neighborhood residents and to soldiers tend to create fights between patrons, which require intervention by the police, and which evolve into assaults upon the police. . . . In the event some particular barroom began to grow temporarily more troublesome than was 'tolerable,' the commanding officer, or the section sergeant, or perhaps the beat patrol officer on his own initiative, might direct closer than usual attention to the arrest of inebriates in and around the premises. This emphasis would continue until the problem was abated, either because the proprietor became concerned about his license and began 'cutting off' patrons who were nearing a state of drunkenness or disorderly conduct, or because regular patrons would sense that the area was not one where public drunkenness was tolerated by the police, or both.<sup>50</sup>

Since detoxification centers that we visited are not generally used for non-skid row inebriates, and, unduly disruptive persons are not usually taken to detox, intoxicated people taken to therapeutic facilities for crime prevention purposes are more likely to be potential victims than potential offenders. Police are more likely to arrest potential offenders for related crimes, especially for disorderly conduct, when the charge of public drunkenness is not available. In Minneapolis and Erie, we found that disorderly conduct arrests increased following the introduction of therapeutic program.<sup>51</sup>

As the above discussion of public policy goals suggests, we have found that wide diversification exists among the objectives emphasized in different jurisdictions. 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 drunk persons on the streets; (3) the availability of scarce funds and personnel amidst competing claims for funding or other alcohol and

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<sup>50</sup>J. Wilson, *Police Discretion and the Public Inebriate* 5, 9 (1975) (unpublished paper on file with the Project on Public Inebriation).

<sup>51</sup>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.

public health programs; and, (4) the attitudes and influence exerted by community members, especially certain elite community groups.

Since many cities have roughly similar public drunkenness problems and access to resources, the last factor mentioned above is of the utmost importance in understanding—and influencing—the process of goal formulation. The objectives emphasized in any jurisdiction will emerge from the policy subsystem or the influence exerted by particular individuals and groups in the authority structure. For example, in Washington, D.C., the reform effort was coordinated by the Washington Area Council on Alcoholism and Drug Abuse. There was a lack of input from the Washington Metropolitan Police Department. One consequence was that none of the members of the coalition for reform focused on the goals of keeping the streets clear of “transient” inebriates and removal of public inebriates from the streets for crime prevention.<sup>52</sup> Likewise, the Minneapolis Police Department was only marginally involved in deliberations concerning decriminalization.

In contrast, other police departments have exerted major influence in the process of goal formulation. In Kansas City, Missouri, the police played a central role in the development of a non-criminal alternative. The origins of the St. Louis detoxification program, the first in the nation, also reflect the central role of the police department.

## II. CONFLICTS AMONG PUBLIC POLICY GOALS

A major finding of this study is 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 the resulting tensions or strain. Conflicting objectives in handling public inebriates are primarily addressed by the police officers

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<sup>52</sup>The District of Columbia Alcoholic Rehabilitation Act was influenced by members of city and federally chartered criminal justice reform commissions, the news media, civil libertarian groups, public health institutions and alcohol reform groups. While all of the coalition members backed the Alcoholic Rehabilitation Act, their reasons for supporting this reform varied and, of course, reflected the differences in professional expertise and interest that existed within the subsystem. The criminal justice reform commissions and civil libertarians stressed the constitutional protections and their desire to free the courts from a responsibility that was “non-criminal” in nature. The alcoholic reform groups and public health officials 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 chronic drunkards. Of particular significance, the Washington Metropolitan Police Department neither volunteered nor was drafted to participate in this policy subsystem. Some members of the coalition assumed that the department would simply be opposed to a non-criminal approach.

on the beat—not at the top levels of administration where public policy directives are issued. Individual discretion is exercised in deciding whether or not 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, adjust to conflicting goals by instituting practices to control which intoxicated men and women are the recipients of their services. As will be seen from the following discussion, the ends emphasized by police officers and public health workers may be very different.

It is erroneous to simply assume that traditional order maintenance goals can be met while also meeting a set of additional objectives articulated in reform legislation. The implicit assumption appears to be that somehow public inebriates can be removed almost entirely from the criminal justice system, while keeping the streets reasonably clear of “public nuisances” and situations likely to lead to more serious public peace disturbances. It is also assumed humane care and rehabilitation may be at relatively modest costs (or even savings) to the taxpayers. Those formulating and administering public policy in the jurisdictions that we site visited generally failed to recognize goal conflicts that significantly influence street level decisions concerning inebriate pickup and delivery. Recognizing the existence of goal conflicts can lead to: (1) improved processes for evaluating trade-offs and setting priorities; (2) policy directives, workable guidelines, and rules to determine which public inebriates are to be picked up; (3) improved methods of pickup and delivery of public inebriates; and (4) techniques of administration and implementation designed to increase the attainment of public policy goals.

During our site visits we observed two major sources of conflicts among public policy objectives. The first source of clashing interests is between traditional order maintenance ends and decriminalization aims. The second source of antagonism is among the decriminalization goals themselves. These sources of conflict and some of the responses of therapeutic jurisdictions to them will be the focus of this section.

#### Traditional Order Maintenance v. Decriminalization Goals

##### *Clearing the Streets v. Humane Services to Emergency Case Public Inebriates*

These two aims appear to cut in opposite directions—respectively indiscriminate and discriminate pickup. Providing emergency services is discriminate in that it is directed to picking up people who are in

really serious trouble; clearing the streets is indiscriminate in 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 bed space available.<sup>53</sup>

In order to insure that the streets are clear of publicly intoxicated individuals, the police stress the need for detoxification centers able to provide bed space twenty-four hours each day, seven days each week. Occasionally, detoxification personnel complain that police will deliver some skid row derelicts who are either non-inebriated or just barely intoxicated. In Santa Clara County, the detoxification center screening unit has a breathalyzer for testing persons to make sure that they are intoxicated at time of admittance.

Various approaches are used by pickup agents to deal with both the goal of clearing the streets and of servicing the emergency case skid row inebriate. If the police officer is willing to make dispositions often not formally sanctioned, the goals can be reconciled by dealing with the non-emergency skid row inebriates by just getting them off the streets and, for example, sending the non-skid row inebriates home. Indeed, not only police officers but the whole system tacitly accepts such informal norms for processing inebriates. In some cities, the police confine skid row inebriates to parks and places where they are not bothersome or visible and where pressure, especially from owners and

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<sup>53</sup>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.

managers of businesses, seems non-existent. In San Jose, the police department has been using the jail for overflow, when detox is filled to capacity. The inebriate is held under "protective custody" and not booked.<sup>54</sup> Protective custody pick ups have also been widely used in other jurisdictions.<sup>55</sup> In St. Louis, the alleged practice of taking intoxicated persons to the banks of the Mississippi River where they could sleep off their drunk on the grassy areas not frequented by the general public, led police officers informally to dub the area as "Detox East." Police officers in one of the counties adjoining St. Louis told of the occasional practice of transporting drunkards across county lines in the expectation that the individual would be eventually transported by their St. Louis counterparts to the detoxification center. When the law enforcement official is faced with a "problem" on his beat, such as a business complaint of a public inebriate, the officer will usually take some action, formal or informal, to "solve" the problem. They learn of favorite out-of-the-way places, occasionally in the territory of another officer's beat, to deposit the inebriate and remove him from the street.

In San Francisco, even the civilian pickup agents of the Mobile Assistant Patrol use informal dispositions, such as transporting an intoxicated man or woman to a park, when detox is filled to capacity in order to provide a safer environment and also to avoid the likelihood of an arrest.

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 a "public nuisance" and providing more humane services to the emergency case public inebriate. Subject to certain exceptions, street inebriates picked up by the police have an option of being arrested for being drunk in public or being voluntarily taken to Sober House. Sober House, which is located within the Salvation Army Center in the downtown area, is a short-term non-medical sobering up facility with counseling and referral facilities oriented toward destitute

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<sup>54</sup>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.

<sup>55</sup>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-1960s, 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 twenty hours, and then released. The police do not seek an 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.

public drunkards. If an individual is in need of obvious medical treatment, he is taken by the law enforcement official to a participating hospital and may subsequently be transferred to Sober House by a Sober House vehicle. A person is free to leave Sober House at any time.

Having these options, the police officer can readily handle both the cooperative and the unruly intoxicated person. Goals of those who are interested in street cleaning (e.g., businesses and other groups) and those interested in better care for the inebriate (public health groups, public inebriates, and citizens generally) are considered under the Kansas City model. Problems with this model include the criteria for determining which inebriates are taken to which facilities and the fact that under this police diversion program the pressure for decriminalization is reduced. However, this mixed model may be a viable approach for cities unwilling to go to the pure decriminalized approach or which lack resources to fully implement decriminalization.

A variant of the mixed model within a "decriminalized framework" is used in Boston, Massachusetts. Public drunkenness became decriminalized on July 1, 1973. Pursuant to Chapter III B, Comprehensive Alcoholism Treatment and Rehabilitation Act, the police officer has four options: take home, to a hospital, to the detoxification center, or lock up for protective custody. A public inebriate picked up for protective custody is taken to jail and cannot be held for more than twelve hours. He is classified as an "incapacitated person" and no record of arrest is maintained. The detoxification center is voluntary and a street drunkard can be transferred from the lockup to the detox center. This approach provides formal options both for clearing the streets and for obtaining 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.<sup>56</sup>

### *Clearing the Streets vs. Rehabilitation or Reintegration*

If clearing the streets is emphasized, the pickup agent is going to be delivering many individuals to therapeutic facilities who are incapable of rehabilitation. The very limited capacity of the therapeutic facilities may be flooded, restricting the room for the potentially curable. Again,

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<sup>56</sup>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).



this conflict may be avoided. The police officer may clear the streets by channeling the skid row inebriate into alleys and other special areas and channeling other intoxicated people that are perceived as "curable" (usually middle class types) into the rehabilitation system. Through the use of informal dispositions, pickup methods adapt to achieve both goals. The way they adjust, however, often violates the intent of the law.

Detoxification centers may adjust to this clash by shifting emphasis to encourage voluntary, non-police sources of referral of inebriates who are more highly motivated for treatment. Law enforcement personnel, finding the detoxification center often filled to capacity, will respond by increased use of informal dispositions or substitute criminal charges, such as disorderly conduct, drinking in public, urinating in public, etc. For example, in 1973, the St. Louis detoxification center stopped specifically reserving beds for police cases. Later, increasing the number of voluntary admissions to the detoxification center was stressed.

Another way in which detoxification centers cope with adverse goals is through the use of exclusions. The most obvious is the existence of formal or informal "Do Not Admit" lists. In nearly every therapeutic jurisdiction we visited, we found indications of this practice. Lists of persons whom the detoxification center is unwilling to admit are communicated to the pickup agent. Although in some areas the existence of these compilations is a guarded secret, in Kansas City these sheets are formally published by the police department in memorandum form and read at roll calls and posted on bulletin boards. They are generally updated monthly and typically include between five and eight "troublesome" inebriates. In contrast, the Detoxification Center for Sacramento, California has a "Do Not Admit" list which has approximately eighty persons at any given time 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 overtly hostile to rehabilitation referral.<sup>57</sup> In San Francisco, the Mobile Assistance Pa-

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<sup>57</sup>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.

trol, the civilian pickup agent, has developed a sense of which types of inebriates should be taken to each of the four social setting detoxification centers. Since pickup is voluntary, troublesome cases are avoided.

Selective exclusion by the detoxification center communicates to police officers that they cannot rely on detox to solve their problems on the beat. This also may contribute to strained relations between public health workers and police. The possibility of refusal by detox is a negative incentive toward intervention.

On the other hand, the detoxification center may design intake policies with a view toward accommodating law enforcement needs. For example, Erie will not accept referrals from sources other than police officers. Citizens must first contact these officials who then may contact Crossroads Center. The St. Louis Detoxification Center at first handled only police cases, but after expansion it set aside certain beds for policy referrals (a course of action since abandoned). These formulations are also designed to further the objective of saving criminal justice resources and providing short-term services to the emergency case public inebriate in contrast to an emphasis on rehabilitation.

#### *Clearing the Streets vs. Saving Criminal Justice Resources*

If one is going to clean the streets effectively, it requires a substantial commitment of police resources. Officers would have to deliver some inebriates to detox, send others home, tell others to move on, and so on.

On the other hand, where a jurisdiction has a high volume of arrests in the pre-change or criminal period, the continued investment of police resources diverting inebriates to detox and other facilities may serve to reduce the time law enforcement officials spend in court and also free up correctional resources.

### Conflicts Among Decriminalization Goals

#### *Service the Emergency Case vs. Rehabilitate*

A detoxification center which begins providing emergency services finds that this does not yield much success in restoration. Staff personnel and the police see the same intoxicated persons again and again, and become disenchanted with the program. Others in the system (e.g., political leaders, the public, news media) complain because they do not understand the limited-purpose emergency character of the facility. Public health workers generally prefer to work with the more motivated client (e.g., the middle class inebriate as contrasted with the

skid row inebriate). When they seek permanent funding through the public health bureaucracy, organizational pressure increases to show "rehabilitative success."

Under such pressures, a system may change its goals and attempt to become a rehabilitation facility. But, if improved reintegration results are to be produced, a change of focus may be needed. It may well require dealing less with the emergency cases—the resourceless skid row individuals who lack alternative means of assistance—and more with the non-skid row inebriate. Since the police, as pickup agents, usually emphasize the delivery of skid row type emergency cases, it becomes necessary for the detoxification center to stress voluntary intake mechanisms rather than the police delivery system. Thus, starting out with an emergency pickup process, the system becomes, over time, more specialized and more discriminate regarding who will be treated. Success becomes defined not in terms of servicing the emergency case, but rather in terms of recidivism rates or other measures of rehabilitation.

The above pattern is illustrated by the St. Louis Detoxification Center. In the fall of 1966, the St. Louis Detoxification and Diagnostic Evaluation Center opened a thirty-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 one month, the Third District was added, and in March, 1967 the Ninth District was included. 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 accepted the marginal success in restoration while providing emergency services to those in need of assistance. When federal funds were exhausted, the Center was required to move to the grounds of the state hospital in order to secure state funding. This location was far removed from the primary areas of drunkenness arrests—approximately a twenty- to thirty-minute ride each way. As new officials took over and the Center became larger and more institutionalized, there was an increasing loss of the sense of the original mission and a rising concern over the continuing frequency of readmissions. It was possible, however, that recidivism might be reduced if the population serviced by the Center changed. In 1973, detox stopped reserving beds for police cases. After that time, patients were taken on a first come, first served basis. There are indications that the Center increasingly accepted more volunteer admissions which produced a smaller skid row patient population. The ratio of voluntary admissions to

police admissions radically altered.<sup>58</sup> In any case, police officers report that they frequently found the Center filled—there was less room for the emergency chronic police-case inebriate. Police referrals to detox decreased substantially in 1974, after four years of increase. Detox officials were said to have shown increasing reluctance to take the chronic case and to have released inebriates before the end of the seven-day period.

### *Rehabilitate vs. Save 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, such as Washington, D.C. and Minneapolis, substantial savings are likely to result,<sup>59</sup> as police tend to

<sup>58</sup>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 fourteen-year period from 1960 to 1974. Relevant administrative and detox changes are noted.

	ARREST	DETOX		TOTAL
		<i>Police</i>	<i>Voluntary</i>	
1960	2853			2853
1961	2768			2768
1962	2978			2978
1963	7847			7847
1964	3786			3786
1965	2488			2488
1966 <sup>a</sup>	1719	60	—	1779
1967	796	1120	—	1916
1968 <sup>b</sup>	551	1174	—	1725
1969	333	946	—	1279
1970 <sup>c</sup>	540	1251	215	2006
1971	463	1317	203	1983
1972	300	1301	217	1818
1973 <sup>d</sup>	168	1449	533	2150
1974	301	801	1698	2800

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, non-police 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.

<sup>59</sup>A savings of criminal justice resources, however, does not mean there will be an overall resource savings. See note 25 *supra*.

deemphasize the pickup of the non-skid row type of drunk. 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 case.

However, a goal conflict may arise, as described in the example of the St. Louis detoxification center, when the objective of rehabilitation results in taking large numbers of voluntary admissions. When this occurs, beds that could be made available for police admissions are taken away, when detox is filled to capacity.

In jurisdictions that do not retain the public inebriate arrest, emphasis on voluntary admissions may increase pressure on the police—where the detox center has reached capacity—to substitute other charges, such as disorderly conduct. In Minneapolis, the Alcohol Rehabilitation Center staff has encouraged self-admissions of problem drinkers from more stable socio-economic backgrounds through advertising and by working closely with businesses and government agencies. This approach may have contributed to and, perhaps, partially compensated for the reduction in police attention to the problem of public inebriation, although disorderly conduct arrests have increased. For example, in June through August, 1974, the total number of admissions to the detoxification center increased 17 percent (from 2,299 to 2,689) while police referrals were reduced from 844 to 480 admissions. The civilian pickup squad transported almost 50 percent of the total admissions to the Center. Disorderly conduct arrests, which averaged just under 700 during 1960–1966, jumped to a yearly average of nearly 2,000 during 1971–1975. Of course, those formulating the reform legislation neither anticipated nor desired the continuation of criminal arrests for public drunkenness. Many of these arrests appear to be in response to the need for a reliable means of formal disposition in order to keep the streets clear of public inebriates and prevent crime.

In jurisdictions that permit both arrests for public drunkenness and diversion to a detoxification program, emphasis on rehabilitation through voluntary admissions may have a substantial adverse impact on saving criminal justice resources. For example, in Sacramento, California, a principal goal of the detoxification center was a reduction of public drunkenness arrests by 50 percent over a twelve-month period. Since voluntary admissions were 28.4 percent of total admissions from June 5, 1973 through December 1, 1974, the actual decline in public drunkenness arrests was less than 30 percent.<sup>60</sup> When detox is filled to

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<sup>60</sup>Increased "recycling" of the public inebriate on the street and thus increased police contacts with the public inebriate resulting in more involuntary admissions

capacity, every voluntary patient occupying a bed may result in the arrest of a public inebriate if the police officer feels he has no other viable option.

The dilemma of the voluntary admissions policy is that refusal of voluntary admissions denies treatment to those having the highest rehabilitation potential while acceptance of voluntary admissions reduces the potential of achieving maximum savings in criminal justice resources and results in the inappropriate channeling of many chronic alcoholics through the criminal justice system. It also produces an arbitrary channeling of public inebriates through the criminal justice system when the detoxification center happens to be filled to capacity by voluntary admissions. Programs in Kansas City, Erie, the Manhattan Bowery Project in New York City, and San Jose, prohibit or discourage non-police, voluntary admissions. In these jurisdictions, the system also seems arbitrary in that a person in need of detoxification may not be able to come or be brought to the door and receive assistance. A policy limiting voluntary admissions may be a reasonable compromise.<sup>61</sup>

Although the foregoing discussion has emphasized conflicts among public policy goals and between police officers and public health workers, compatibilities among these goals have also been noted. The degree to which the goals will conflict or be compatible depends upon the particular circumstances of each jurisdiction. For example, in Kansas City and Salem, there are sufficient facilities for public inebriates that trade-off problems when detox is filled are not serious. 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 centers that have their central focus on providing improved care to the emergency police case inebriate seem to be most compatible with goals emphasizing a maximum impact on reducing the processing of public inebriates through the criminal justice system and saving scarce criminal justice resources. Jurisdictions such as St. Louis, which stressed "quality" (non-inebriate) arrests and the informal disposition of street drunkards during the criminal period, will have much less conflict and tension in adjusting to a decriminalized approach.

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also contributed to the fact that the decline in arrests was less than anticipated. S. Thompson, *supra* note 18, at 27, 35.

<sup>61</sup>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. See S. Thompson, *supra* note 18, at 35.

One of the discouraging conclusions to emerge is that although, theoretically, there should be a compatibility between the therapeutic goals of providing more humane care and emergency services and rehabilitation or reintegration of the public inebriate into the community, in practice a conflict or tension exists. Theoretically, following the so-called "continuum of care" approach,<sup>62</sup> it is supposed to be possible to channel the emergency case from the detoxification center into the rehabilitation system. As noted above, a goal conflict tends to emerge with a greater emphasis on rehabilitation of middle class voluntary admissions at the expense of emergency care of the skid row intoxicated individual brought in by the police.

One of the encouraging lessons is that effective planning and implementation of therapeutic programs, including close cooperation and communication between law enforcement and public health workers, can go a long way toward minimizing and reconciling the conflicts and strains of diverse goals. Part II of this article will address this crucial problem of implementation of effective pickup mechanisms for achieving public policy goals.

*[End of Part I]*

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<sup>62</sup>See note 36 *supra*.

