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What shall we do with the Drunkenness Offender?

By HOWARD I. HERSHON, TIM COOK and PETER A. FOLDES

In England, public intoxication has been a criminal offence ever since an Act of Parliament was passed in the reign of James I, somewhat over three and a half centuries ago. Edwards (1970) compiled some figures on these offences for the last two hundred years, showing that the rate of arrest was much higher in the nineteenth century than at present. For example, in 1878 there were 70 arrests per 10,000 of the population, compared with a comparable figure for 1968 of 16. Nevertheless, the latest available figures from the Home Office (1971) show that 82,961 persons were found guilty of simple or aggravated public drunkenness in 1971. In the U.S.A., with its apparently much larger alcoholism problem, there were nearly one and a half million arrests for this group of offences in 1966 (Pittman, 1969); this accounts for one third of all arrests in that country (Chafetz, 1971).

In the last 25 years alcoholism has become increasingly considered as a disease (Jellinek, 1960; *Alcohol and Health*, 1971), and public drunkenness has therefore been perceived not as a criminal act but as the non-volitional behaviour of a sick person (Pittman, 1969; *Alcohol and Health*, 1971). As J. N. Mitchell (1971), then Attorney General of the United State, said : 'Alcoholism as such is not a legal problem—it is a health problem—simple drunkenness should not be handled as an offence subject to the processes of justice. It should be handled as an illness subject to medical treatment.' In fact the climate of opinion supporting this view has been sufficiently strong to bring about changes in the law, changes which have redefined alcoholism and redirected society's responses to it (for example, Criminal Justice Act (U.K.), 1967; Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act (U.S.A.), 1971; Criminal Justice Act (U.K.), 1972).

However, it would not be fair to see these very significant changes purely in terms of medical enlightenment on the part of the judiciary and politicians; there was a growing disenchantment with the repeated fining and imprisonment of drunkenness offenders anyway. Driver (1969), for example, complained that the judicial system's response to the drunkenness offender was inhuman and ethically backward, 'neither seemly nor sensible, neither purposeful nor civilized . . .'. Pittman (1969) estimated that it cost at least a hundred million dollars per annum in the United States to imprison drunkenness offenders and that this was entirely wasted. Chafetz (1971) revealed his concern more for the police, the courts and the correctional institutions, which he considered were being needlessly overburdened. Most consider that to punish such offenders is inappropriate, unconstructive and ineffective (Cook, 1969; Home Office, 1971).

There are earlier reports describing the 'drunk' and his way of life whether on 'Skid Row', in reception centres, courts, or prisons (i.e. Edwards, 1964; Gath *et al.*, 1968; Edwards *et al.*, 1968; Edwards *et al.*, 1971), but the present study attempts to evaluate more specifically whether the drunkenness offender perceives himself and is perceived as bad or ill or both or neither. If medical institutions are to replace penal institutions it would be as well to assess the views of those for whom an alternative is being provided. The public inebriate may no more wish to go to or be taken to hospital than to be arrested by the police. A study of the past behaviour and attitudes of the public drunk will provide some information about the appropriateness of a medical response to his drinking. It is conceded that the public inebriate cannot claim the exclusive right to decide about society's response to his drinking, but on the other hand failure to take into account his perceptions of his problems, his needs and his expectations might make for less than adequate social

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action; and in that case attention might have to be given to a consideration of mass education or even coercion in an attempt to make 'efficient' use of the new medical institutions.

METHOD

It was against this background that this study of drunkenness offenders was mounted. The researchers worked for and had close connections with both medical and social agencies serving the locality. The intention was to interview the drunkenness offenders before their appearance in court and to offer them treatment or help which they could take up after they had been before the magistrate. These recommendations were made known to the court, and in all cases the offenders were immediately discharged to our care. The study monitors these recommendations; thus this datum is clearly different from that obtained directly from the offenders concerning their past contact with agencies and their present attitudes towards drink and its problems.

Camberwell Magistrates' Court, which serves a large part of South-East London, was visited by the researchers (a psychiatrist and two social workers) on twenty occasions between December 1971 and May 1972. The drunks were interviewed privately in their cells before their appearance in court. Each research worker introduced himself by name and profession, stated that he was working for the Alcoholics Recovery Project, and explained that he was there in order to offer his help, if that was required. However, since at times twenty or more people had to be seen in the course of 1–1½ hours, the interviews were necessarily brief. The structure of the interview was agreed beforehand, and replies were noted on small card-sized questionnaires. At the end of the interview the researcher evaluated the needs and likely response of the drunk and in some cases recommended further treatment or care either from the Maudsley Hospital (about half a mile away) or from the Alcoholics Recovery Project services, situated in the locality.

Characteristics of sample

During the study some data were collected on 208 individuals, but these only represented approximately 15 per cent of all the drunkenness offenders passing through the court during that time. Moreover, for a variety of reasons (Table I), only 63·5 per cent (n = 132) of this number were actually interviewed. Many of the offenders were arrested several times during the study: the data collected and the recommendations made refer to the first occasion only.

Altogether 42 offenders were on bail and were therefore not available for interview. Since these subjects were younger, and were more likely to be female, and to have been arrested in Camberwell on a Friday night (this

TABLE I

Some characteristics of sample

	Interviewed	Refused to be interviewed	No time or pleading not guilty	On bail
Court visited on				
Thursdays (14 visits) ..	79[1]	8	14	16
Saturdays (6 visits) ..	50[1]	3	8	26
Not recorded..	3[1]	1	—	—
All	132	12	22	42
Male ..	126	12	21	35[2]
Female ..	6	—	1	7[2]
All	132	12	22	42
Mean age (yrs.)	48·1[3]	42·3	47·3	39·4[3]
District in which arrested:				
Camberwell	7	0	2	14[4]
Deptford ..	77	10	5	8[4]
Other*	48	2	15	20[4]
All ..	132	12	22	42

* Kennington (43), Brixton (20), Peckham (8), Brockley (6), Streatham (6), Gipsy Hill (2).

[1] Mean number of offenders interviewed on 14 Thursdays (7·8), and 6 Saturdays (14·5). Sig. diff.: $P < 0.05$ ($T = 3.516$; d.f. = 18).

[2] More female (50 per cent) than male (18·9 per cent) offenders bailed: Diff. sig. $P < 0.05$ ($\chi^2 = 8.2$; d.f. = 2).

[3] Those bailed significantly younger than those interviewed, $P < 0.01$ (normal deviate = 3·19).

[4] Larger proportion of the Camberwell offenders (60·9 per cent) bailed than those from Deptford (8 per cent) or elsewhere (26·6 per cent). Diff. sig. $P < 0.01$ ($\chi^2 = 31.8$; d.f. = 2).

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last just NSS) their absence clearly made those detained in custody somewhat unrepresentative of the sample as a whole. This residual group was further distorted by the absence of another 34 offenders who were not interviewed either because they refused, or were pleading not guilty, or because there was insufficient time for interview. The researchers were advised to visit the court on Thursday and Saturday mornings, thereby covering both the weekday and weekend period, but since no data were collected on the other thousand or so arrests made during the period of the study, the representativeness of the 208 offenders seen can only be presumed.

As a presliminary to the study, the offenders who were interviewed were asked about their civil status, current employment, and domicile. Only a minority at the time were married and living with their spouses (n = 7), 9 were divorced, 22 separated, and 2 widowed. However, nearly two-thirds (84) of the sample had remained single in spite of the mean age of the group being 48·1 years.

Only 22 per cent, prior to being arrested, were living at a fixed address, while very nearly half (62) were living in a hostel or a reception centre, and another 31 per cent were sleeping rough. As far as work was concerned, 40 were currently employed, and 79 were, for varying periods, unemployed (<1 month—11; 1–12 months—35; 12+ months—33). The remainder were either retired (7) or receiving sickness benefit (2) or the information was not recorded (4).

Results

(1) *Spontaneously complained-of problems*

At the outset of the interview the drunkenness offenders were asked if they had any problems. The answers were noted and later assigned to one of eight problem areas. This part of the interview was entirely non-directive, and no prompting or probing was carried out. Only 68 (51·5 per cent) in fact complained of anything. Of these, 31 mentioned one problem, 25 two problems, 8 three problems and one person four problems. The complete absence of any complaints about being arrested or spending the night in a police cell is noteworthy, as well as the fact that nearly half (48·5 per cent) had no complaint of any sort to make. Table II shows the prevalence of these problems. As can be seen, more people mentioned alcohol or drink as a problem than anything else, but this still only represented just over 28 per cent of the total. One might have thought that anybody arrested for being drunk and disorderly would have considered that, to him, drink was a problem! Similar discrepancies were noted elsewhere. For instance, only 14·4 per cent actually complained about their domiciles; yet as many as 47 per cent were living in hostels, and another 29·6 per cent were of no fixed abode. Likewise only 4·6 per cent complained about problems with work, though it transpired that very nearly 60 per cent were unemployed, nearly half for over twelve months.

Subsequent analysis showed that the type of problem complained of was not related to the discipline of the interviewer which might have been expected. The frequency and type of problem was also not related to the age of the offender, for although there were more offenders in the older age groups, the number of problems increased pro rata. On the other hand those who were stably married or were currently employed had fewer problems than those who were otherwise defined (numbers too small for tests of significance).

(2) *Self-perception of being an alcoholic*

The researchers did not attempt to define alcoholism (although frequently asked to do so); therefore the offenders' responses to this part of the questionnaire reflected their own perceptions both of the stereotype 'alcoholic' and of themselves. It can be seen that approxi-

Table II
Spontaneously complained-of symptoms

Problem area	No. of offenders complaining
Domicile	19
Work	6
Money	5
Clothes	3
Drink	38
'Nerves'	15
Physical ailments ..	22
Interpersonal ..	8

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mately one third thought they were alcoholic, a third denied that possibility and a third were not sure. It is interesting, therefore, that some 64·4 per cent had at least entertained the idea that they were alcoholic, although, as is shown below, only 28 per cent felt that alcohol was actually a problem.

TABLE III
Self-perception of being an alcoholic

Self-perception of being an alcoholic	No. of offenders
Definitely yes ..	47
Not sure	38
Definitely no ..	44
N.K.	3

Nevertheless there is a clear relationship between these two sets of statements: drink *was* a problem to 53·2 per cent of self-perceived alcoholics compared with 2·3 per cent of those who denied the possibility (26·3 per cent for those undecided) (difference significant $P < 0·01$; $\chi^2 = 29·4$; d.f. = 2).

The differences for the other problems were not so clear, and in any case the numbers were smaller. It is, however, possible to summate all the problems complained-of to give a total problem score. The mean problem score for the 'definitely alcoholic' group is 1·32; for the 'not sure' group 0·95; for the 'definitely not' group 0·27). (Alc. vs. not alc. difference significant $P < 0·05$) (normal deviate). (Not alc. vs. not sure difference significant $P < 0·05$)

TABLE IV
Past contact with agencies and present perception of being an alcoholic

Contact with agencies in past		Perception of being alcoholic		
		Def. yes	No sure	Def. no.
A.A.	No ..	34	34	42
	Yes ..	13	4	2
Social agencies	No ..	30	32	43
	Yes ..	17	6	1
General Practitioner ..	No ..	24	29	44
	Yes ..	23	9	0
Psychiatric treatment for alcoholism	No ..	36	34	38
	Yes ..	10	4	4
Drunkenness convictions	0 ..	1	2	10
	1–10 ..	9	15	27
	11+ ..	37	21	5
Other convictions ..	0 ..	16	19	26
	1+ ..	28	19	15

N.B. Some data missing.

(1) A.A.:	Alc. vs. not sure — N.S.S.	($\triangle$ 1·89)
	Alc. vs. not alc. — $P < 0·01$	($\triangle$ 2·72)
(2) Social agencies:	Alc. vs. not sure — $P < 0·05$	($\triangle$ 2·04)
	Alc. vs. not alc. — $P < 0·001$	($\triangle$ 3·59)
(3) General Practitioner:	Alc. vs. not sure — $P < 0·05$	($\triangle$ 2·32)
	Alc. vs. not alc. — $P < 0·001$	($\triangle$ 4·18)
(4) Psychiatric treatment:	Alc. vs. not sure — N.S.S.	($\triangle$ 1·32)
	Alc. vs. not alc. — N.S.S.	($\triangle$ 1·52)
(5) Drunkenness convictions:	Alc. vs. not sure — $P < 0·05$	($\triangle$ 2·26)
	Alc. vs. not alc. — $P < 0·001$	($\triangle$ 5·67)
(6) Non-drunkenness convictions:	Alc. vs. not sure — N.S.S.	($\triangle$ 1·23)
	Alc. vs. not alc. — $P < 0·05$	($\triangle$ 2·44)

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(normal deviate). Quite clearly, what problems there were tended to be reported by those who also saw themselves as alcoholic or at least were not sure they weren't.

The age of the offenders did not seem to have much bearing on the self-perception, except that those aged 40–49 years were rather more likely to believe they were alcoholic (48·6 per cent) than those of other age groups (30·5 per cent) (N.S.S.).

Table IV demonstrates the relationship between past contact with agencies, to be described in more detail later, and the offender's self-perception of whether he is an alcoholic or not. As perhaps might be predicted, those who had in the past been to A.A. or had contact with some social agency or attended their general practitioner or even those who had most frequently been convicted of drunkennes or other offences were more likely to see themselves as alcoholics. The one exception was that those who had actually received psychiatric treatment in the past were *not* now more likely to accept the view that they were alcoholic.

(3) *Past contact with agencies*

Table V perhaps reflects the fact that some agencies are more energetic in 'contacting' the drinker than others. Clearly the most frequent contacts in the past had been with the penal system. Thus, all but 13 offenders had been previously convicted of drunkenness offences and no less than 48 per cent overall had had 11 or more such convictions.

Non-drunkenness criminal behaviour was less frequently reported, but even here approximately 50 per cent had been found guilty of offences. On the other hand only 24·2 per cent had consulted a doctor for drink-related problems, and only 13·6 per cent had actually received psychiatric treatment. Similarly, 18·2 per cent had been in contact with one of the social agencies, usually the A.R.P., and 14·4 per cent had attended A.A. meetings.

TABLE V
Past behaviour and contact with agencies

Drink-motivated contact with	Yes	No	N.K.
General Practitioner ..	32	98	2
Psychiatric services ..	18	110	4
Previous convictions for drunkenness offences	116	13	3
Convictions for non-drunkenness offences	63	62	7
Social agencies ..	24	107	1
A.A.	19	112	1

(4) *Action recommended*

Details can be seen in Table VI.

TABLE VI
Action recommended

Action recommended	Yes	No
Medical	1	131
Psychiatric	10	122
Social	43	89

The single offender recommended for medical treatment had an acute exacerbation of his chronic bronchitis and was given appropriate antibiotic therapy as an out-patient. Several others were physically ill, but they were all currently receiving medical attention, so no new arrangements were necessary. Psychiatric action implied referral to the Maudsley Hospital, either directly to the emergency clinic whence the offenders were admitted (3)* or indirectly by being seen at a later date as an out-patient in the alcoholism clinic (7)†. The 43 who were referred to the offices of the A.R.P. were all in need of counselling, advice or direct material help. Results of these interventions are, however, outside the scope of this paper.

The 43 who were referred to the A.R.P. tended to have complained of more problems, especially drink, and had a higher mean total problem score (1·49) than those who were not so referred (0·55) (just not statistically significant). A similar picture emerged for those who were put in contact with the psychiatric services (1·7 vs. 0·79) (different significant ($P < 0{\cdot}05$) (normal deviate).

Those who considered that they were alcoholic were more likely to be recommended for the psychiatric and social services. Thus, while 70

* These were all experiencing severe withdrawal symptoms with hallucinations.

† They required psychotropic medication for anxiety, depression or tremulousness.

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The data collected from the drunkenness offenders suggested that on the whole they were a rather uncomplaining group of men and women. In fact, the lack of complaints rather surprised the investigators. The total absence of recrimination against the police and the courts is somewhat surprising, but perhaps to some, the constant succession of drinking bouts, public drunkenness and arrests (punctuated by imprisonment and sobriety) was so much a way of life that this did not feel alien; and the others —the less indoctrinated weekend drinkers— may have considered it injudicious to complain of such things before their court appearance. More complained that drink was a problem to them than anything else, but still over 70 per cent did not think so. Reference was made to drinking too much or not being able to control the amount drunk or that drink was bad for them, but none invoked concepts of immorality, criminality or disease to explain these difficulties. Apart from that, only one person in ten described what might be considered a symptom of a psychiatric disorder, and rather more (about one person in six) seemed to have some ailment requiring medical or surgical attention. This would seem to be consistent with the work of Pollak (1969) and Gibbens and Silberman (1970) who found that the alcoholics they studied were surprisingly healthy. It might be conjectured that the frequent periods of time spent in prison were not entirely wasted from the medical point of view at least, since there they would be withdrawn from alcohol and given adequate food (Cook, 1969).

The drinker who admits he is an alcoholic in our society is no doubt aware of some drink-related problem and is presumably willing to do something about it or get somebody else to do something about it. It might be assumed, therefore, that approximately one third of this particular sample of drinkers, since they perceived themselves as alcoholic, would find some alcoholism service appropriate while another third might be persuaded that this was the case. Nevertheless, if past experience with the helping agencies is anything to go by, these predictions are over-optimistic. Contact with the courts was very much more frequent than with the medical profession or social agencies: this is no doubt a reflection of the initiative of the police. Although the overall number of offenders offered further help or treatment was fairly small (about 40 per cent), these were generally people who had received these services previously. But whether the offender was referred to the psychiatric or the social services could not be predicted from the type of agency with which that person had been in contact in the past. Furthermore, even a high conviction rate was associated with an increased chance of some recommendation being made, and so one might conclude that such recommendations were more a reflection of severity than of specificity of problem.

At the time when the law concerning public drunkenness is changing, it is important to try to appreciate how the drunken 'man (and rarely the woman) in the street' feels about himself and the options open to him. Does he, for instance, accept that his drinking is a disease requiring treatment in medical institutions rather than a criminal offence subject to the processes of law? When one is discussing 'doing something' for alcoholics, those for whom the service is being provided must perceive themselves in need of that service for it to be effective. The data collected in this study suggest that only a small number of drunkenness offenders conceive their problems in terms of an illness or make use of medical or psychiatric facilities for their drinking problems. Similarly the researchers considered that some sort of community help was appropriate for something like four times as many offenders as were referred to hospitals. That should not detract from the importance of hospital facilities, but does at least put the hospital's function into perspective. The three men who were admitted to hospital were severely ill with withdrawal symptoms, and had the reserachers not been there they would probably have not had the opportunity for medical treatment. It could also be argued that the seven offenders who were given outpatient appointments at the hospital were not likely to have been referred from other sources, but each of these presented with specific problems considered to be within the sphere of competence of the psychiatric services. They were not being offered treatment for their

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drinking *per se*, for if that had been the criterion of selection very many more would have been pulled into the medical sphere of influence. Rather it was felt that their drinking was more appropriately considered as a learned behavioural response to a variety of personal and social pressures than a disease in the medical sense (Hershon, 1972; Hershon, 1973). That being the case, priority was given to directing the offender to those community services which are intended to relieve these pressures and teach new non-drinking modes of coping.

Talking about Skid Row alcoholics, Edwards *et al.* (1966) recommended that the rationale of treatment should not be seen as a cure of an illness but as the support and rehabilitation of a troubled and damaged person. This concurs with the views of those of the social work discipline (i.e. Cook, 1969), as well as being the essential element of most of the 'integrated and comprehensive treatment programmes' envisaged in law and recommended by reports both here (Home Office, 1971) and in the United States (*Alcohol and Health, 1973*). These programmes attempt to place treatment, care and rehabilitation in their proper perspective. The different treatments have to be disentangled, because each carries its own goals, modus operandi, scenario, and expectations of outcome. Nevertheless, they should be fully integrated so that all the needs of the alcoholic may be attended to promptly and comprehensively. The results from this study would seem to support the idea of a service providing freely accessible hospital treatment for detoxification, back-up psychiatric clinics for those few who need further psychiatric assessment and treatment, and, probably most important of all, a social welfare department which can effectively help the alcoholic in the community—whether by the provision of hostel accommodation, assistance with work or the fostering of group support. Such ideas have already been put into practice elsewhere (Myerson and Mayer, 1966; Weisman, 1972).

Summary

During a six month period, 132 persons charged with drunkenness offences and who were kept in custody overnight, were interviewed before their appearance in Camberwell Magistrates' Court. As well as obtaining information about personal and demographic characteristics, an attempt was made to assess the nature of their drink and drink-related problems, if any. This was considered relevant since public drunkenness is the subject of certain envisaged and actual changes in the law whereby such behaviour would be seen not as an offence but as the symptom of the disease of alcoholism and that such persons should be offered medical treatment rather than being fined or imprisoned.

Nevertheless it could also be argued that it is not conceptually valid to consider alcoholism a disease in the medical sense, but rather that it is a learned behavioural response and that it should be possible to decriminalize public drunkenness without invoking concepts of disease. Such a humanitarian proposal does not actually need a medical justification.

The data collected from the drunkenness offenders suggested that they did not on the whole perceive themselves or their problems in medical terms, and this was supported by the small number who had previously been in contact with the medical profession and by the equally small number who were subsequently recommended for medical or psychiatric treatment. On the other hand, a larger proportion were considered by the interviewers to be in need of community support and help. 'What shall we do with the drunkenness offender?' is a question raised but not answered by the recent changes in the law. A proper understanding of the concept of alcoholism as well as an awareness of the actual needs and expectations of those for whom it concerns should help frame a suitable and relevant answer.

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