

statistical report **7**

city drunks – a possible new direction

department of the attorney general & of justice nsw bureau of crime statistics & research

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Acknowledgements

In preparing the present series of reports on public drunkenness, the Bureau of Crime Statistics and Research has had the benefit of close cooperation from the New South Wales Department of Police. We express our thanks to the Commissioner and those of his staff who have participated in the project. Our special thanks are due to Sergeant Don Robertson and members of the Special Purposes Police Patrol.

The field work associated with the study of care and treatment facilities available to the chronic alcoholic, was undertaken by Mr. J. Hayman and Mr. T. Threlfall. Messrs. Hayman and Threlfall, members of the Department of Corrective Services, undertook this work as one of the requirements for the Bachelor of Social Work degree at Sydney University. The Bureau expresses its appreciation to both the students and the University for the contribution made to the present study.

At all stages of the preparation of this final report, the Bureau has had the benefit of constructive criticism from the New South Wales Council of Social Service Standing Committee on Homeless Men and representatives of the Inter-agency Group on Service to Homeless Men. The Bureau has also benefited from the guidance of a special sub-committee of its Advisory Committee. Numerous individuals have contributed information and ideas based on their working acquaintance with the problems of the vagrant alcoholic.

The Bureau conveys its thanks to all those who have helped to shape the recommendations presented in this report. The wide range of experience represented, has contributed to a deeper appreciation of the statistics presented in earlier reports and, hopefully, strengthened the conclusions drawn from the present series of researches.

Background Note

This is the third and final report in a series dealing with the drunkenness offender.* The main aim of the present report will be to draw together the facts uncovered in the previous two inquiries and introduce the findings of a further study dealing with the care and treatment facilities available to the chronic alcoholic.

The facts concerning arrest and prosecution, and the financial and other costs of these procedures, lead almost inevitably to the question of whether society can find a 'better' way of dealing with the problem of public drunkenness. Similar questions were pondered as long ago as 1854 by a Select Committee of the Legislative Council of New South Wales. The present report includes the recommendation that a pilot project (based on the inner-Sydney area) be established to test the feasibility of handling drunkenness as a medico-social problem rather than a criminal matter.

The Bureau's reports have tended to focus on a particular group of drunkenness offenders. We have highlighted the socially isolated, homeless alcoholic who appears time and again before the Courts. This emphasis has been justified for several reasons:

- (i) a hard core of just seven per cent of detainees accounts for more than 20 per cent of the total arrests for drunkenness in New South Wales;
- (ii) men and women who serve short prison sentences in default of payment of fines are drawn from this group of repeated offenders. The Bureau of Crime Statistics and Research has attempted to sketch in some detail the social situation of this homeless, friendless group. They pass out of prison with little or no cash, no real plans for combating their alcoholism and few prospects of breaking the cycle of drink, arrest and prison. Altogether, drunks account for approximately a third of all arrests made in New South Wales and 30 per cent of admissions to our prisons;

- (iii) only a small number (8.8 per cent) of those arrested for drunkenness have a history of 'offences against the person'. This is only fractionally higher than the level found to exist within the general male population of the inner-Sydney area (7.5 per cent);

- (iv) the practice which has existed since at least the mid-nineteenth century of allowing drunks who have sobered up and have the necessary bail money to forfeit their recognizance, works to the disadvantage of the impoverished and socially isolated. An analysis of over ten thousand cases of arrest for drunkenness throughout New South Wales in the first three months of 1972, has shown that 75 per cent terminate with the forfeiture of the recognizance. Essentially, this means that 3 out of 4 of those arrested - those with the necessary bail money (usually a dollar) - are able to avoid the hazard of appearing before the Court. The fact that such a large proportion of those arrested simply absent themselves from the court-penal system is a fact of life warranting the closest consideration when evaluating alternative schemes.

*(a) Statistical Report 3, CITY DRUNKS - CENTRAL COURT OF PETTY SESSIONS - FEBRUARY, 1972.

(b) Statistical Report 3, DRUNKS WHO GO TO GAOL.

Care and Treatment Facilities Available to the City Drunk

Throughout the years a number of organisations have undertaken to provide a variety of services for the vagrant alcoholic and homeless person. The services can be conveniently grouped into four basic categories. Although this list is not exhaustive, it covers the major welfare services available to the city drunk. Naturally, these services are continually changing as the problem changes and is better understood:

- I CITY REFUGES
(commonly known as 'Doss Houses')
- II EMERGENCY ASSISTANCE
('Soup kitchens' and handouts')
- III SPECIALISED TREATMENT
 - A. Medical Care
 - B. Detoxification Units
 - C. Rehabilitation Centres
- IV COUNSELLING AND SUPPORT
 - A. Alcoholics Anonymous
 - B. Specialised assessment and personal counselling

I City Refuges

There are five major 'doss houses' in the inner-city area. They offer temporary accommodation (usually in large dormitories), a fairly limited morning and evening meal, a shower, clean clothes and evening recreation. Four of the five charge a small fee (approximately \$1 a day). Although the fee is often waived, as many have no cash, the pensioners and other regulars have money deducted from their cheques:

Table I Beds and Meals available daily ('Doss' Houses)

	Beds			Meals		
	Available Nightly		Permanent	Breakfast	Lunch	Evening
	Sober	Drunk	Pensioners/ Regulars			
Foster House	244	0	36	300	37	300
Matthew Talbot	309	14	97	420	57	420
City Night Refuge	20	0	60	80	0	80
Central Methodist Mission	25	0	32	58	32	58
Samaritan House (Women)	10	0	15	25	25	25
TOTAL	608	14	240	883	151	883

There are other residential hostels available in Sydney to which the homeless man may be referred for temporary accommodation. For example, the William Booth Hostel and the Combined Services Hostel. However, these centres require a set fee or accommodation voucher, and are generally not used by homeless men.

II Emergency Assistance

A multitude of organisations provide the vagrant alcoholic with some form of 'handout'. Again the following list is not exhaustive but would appear to cover the main sources of emergency assistance. Where possible the (daily) average number of beneficiaries is given.

IIb Services provided

	Day Refuge	Clothing	Meal tickets & Accommodation Referrals
Methodist Day Centre	80	-	-
Rescue Society	-	-	**
Kent Street 'Soup Kitchen'	160	-	-
Salvation Army (a) Goulburn Street	-	**	50
(b) Nithsdale Clinic	100	-	-
Churches and Ministers of Religion (e.g. C. of E. Counselling Service Central Baptist Church)	-	-	**
Smith Family	-	20	-

Table II Forms of Emergency Assistance (Daily Averages)

IIa Meals

	Breakfast	Lunch	Evening
Methodist Day Centre*	-	80	-
Rescue Society	150	-	-
Kent Street 'Soup Kitchen'*	105	160	105
Salvation Army Nithsdale Clinic	-	100	-
TOTALS	255	340	105

*The 'Soup Kitchen' charges two cents for a cup of tea, while the Day Centre charges five cents for 'soup'.

**Numbers not available.

III Specialised Treatment

A Medical Care

Many homeless persons attend the casualty wards of the general hospitals (especially Sydney and St.Vincent's).

"They come, are sent, or are brought, for a variety of medical conditions and they also come, symptom free in the hope of a free meal or a bed for the night, or cash." (1)

Those actually requiring medication are treated; those intoxicated are sometimes given a bed until they are sober enough to leave, the remainder are either turned away or referred to one of the 'doss houses'. St.Vincent's Hospital does provide an alcoholics clinic two days a week.

B Detoxification Unit

More specialised, although limited, medical treatment is available for the homeless alcoholic. The Salvation Army's Challenge Hospital is the key treatment centre. 'Drying out', requires the alcoholic to be hospitalised for up to a week, during which time, with the aid of drugs, vitamin therapy and a well balanced diet, his physical condition vastly improves. Unfortunately, the extent of such services is limited within the inner city area.

C Rehabilitation Centres

Once 'dried out', a limited number of alcoholics are accepted for long term rehabilitation. Two agencies are prominent in this field. The Sydney City Mission supervises the House of the Helping Hand (rehabilitation hospital) and another half-way house. The Salvation Army owns two half-way houses in the city and a farm complex about seventy miles north of Sydney.

To a large extent, these centres are run by the participants. In the half-way houses, the men are in regular employment during the day, returning to the centre for an organised evening programme which includes group discussions and Alcoholics Anonymous meetings.

(1) Short, J. 'Helping the Homeless Man', in THE PROCEEDINGS OF A SEMINAR ON HOMELESS MEN, Council of Social Service of New South Wales, July 1969, p.45.

Table III Detoxification and Rehabilitation Programmes

		<i>Accommodation available</i>
'Detox.' Centres	(a) Challenge Hospital	23
	(b) Langton Clinic	<u>25*</u>
		48
Half Way Houses	(a) Challenge Clinic	12
	(b) Bridge House	20
	(c) Sydney City Mission	<u>12</u>
		44
Farm Complex	(a) Miracle Haven	80
	(b) Selah Farm	20
	(c) Wamberal Farm	<u>20</u>
		120
Rehabilitation Hospital (House of Helping Hand)		21
TOTAL		<u>233</u>

*It would seem that very few of these patients are from Skid Row.

IV Counselling and Support

A Alcoholics Anonymous

Alcoholics Anonymous directly sponsors 90 meetings a week in the Sydney Metropolitan area, with an estimated average attendance of 15 members. The basic format of the Alcoholics Anonymous programme is generally known throughout the community, and is based on the individual's acceptance of the fact that he is an alcoholic, needing assistance to overcome this problem. The meetings are organised around 'The Twelve Steps' and the mutual support of members.

Many vagrant alcoholics attend meetings held within the inner city area, while most of the rehabilitation centres include the Alcoholics Anonymous philosophy in their programme.

B Specialised Assessment and Personal Counselling

Both Nithsdale Clinic (Salvation Army), and Erskine Street Clinic (State Psychiatric Services) are concerned exclusively with the personal counselling, specialised assessment and referral of homeless men.

Nithsdale Clinic, staffed by three counsellors, and a psychiatric nurse, interviews an average of ten vagrant alcoholics a day, seven days a week. A day refuge and Alcoholics Anonymous meetings are provided within the same building.

A Social Worker and two psychiatric nurses staff the Erskine Street Clinic. During the Clinic's five day week, an average of six homeless men are interviewed each day.

Interchanges between services

The relationships between the services discussed above can be seen in another perspective. For instance, an individual assessed at the Salvation Army's Nithsdale Clinic may progress beyond receiving a meal and temporary accommodation at Foster House to spending several months at Miracle Haven Farm, or in Bridge House, all the while remaining in Salvation Army institutions. However, other organisations specialise in providing one category of service while the process of reciprocal referral serves as a link between the organisations.

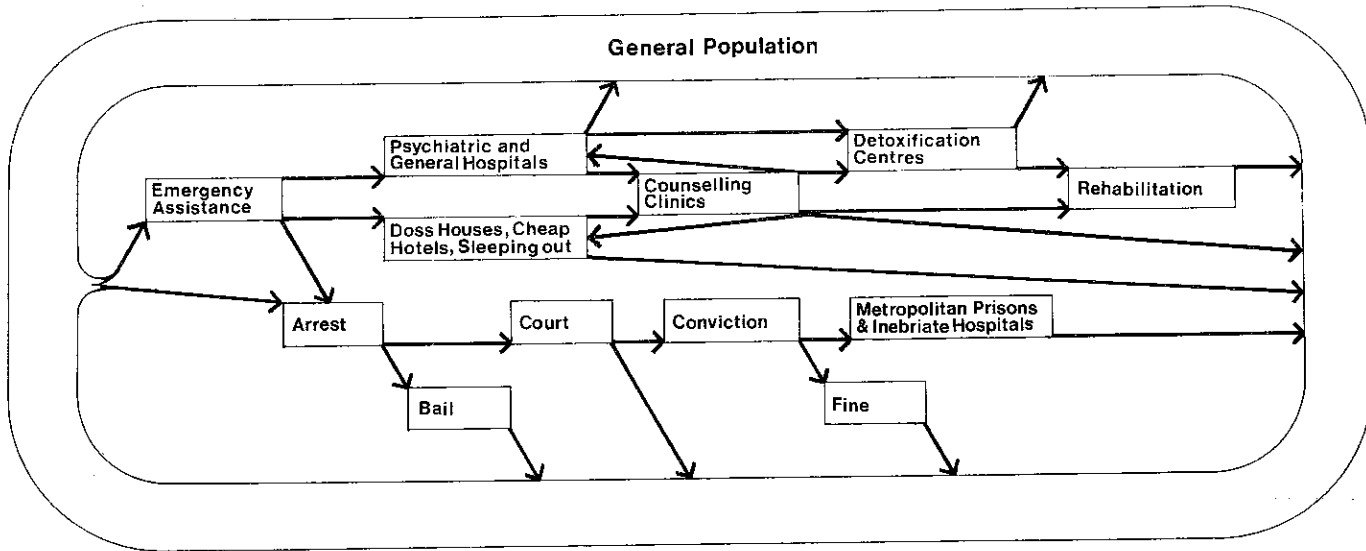
The accompanying diagram illustrates the alternative pathways the vagrant alcoholic may tread during his 'career' on skid-row. It would seem that almost all the homeless persons in the inner city use the 'soup kitchens' and 'handouts' as a means of survival. If not arrested for drunkenness or vagrancy, many homeless persons are forced to spend the night in the open, in partly demolished buildings, or, if they have some cash, in cheap private hotels.

As the first two reports in this series pointed out, those arrested and unable to pay their dollar bail, appear in court, and are charged with drunkenness. If unable to pay a fine, they must spend a short time in prison (usually 24 or 48 hours). Frequent offenders may be sent to Inebriate Hospitals.

A third alternative available to the homeless person is the 'doss' house'. He may be accepted for one night's accommodation if he arrives before all beds are taken or he may be referred there from any of a number of agencies. Many men remain within this circle of survival for a considerable time.

Following assessment, the specialised counselling or assessment centres (Nithsdale Clinic and Erskine Street Clinic) may refer people to either a 'doss house', the detoxification unit (Challenge Hospital), Callan Park Psychiatric Hospital or the casualty ward of a general hospital. Some may be sent directly to rehabilitation centres. Those who have undergone specialised

Interrelationships between Agencies



treatment either return to the general population or are referred back to the assessment unit, possibly to be sent on to rehabilitation centres. There is no limit to the length of stay at these centres although most men return to society after a stay of approximately six months.

Future Plans

The Sydney City Mission has started construction of a \$1.4 million centre at Surry Hills. The project has attracted a heavy subsidy from the Commonwealth Government and will include a detoxification unit, an assessment centre, a hostel and a sheltered workshop. The centre will accommodate 180 persons and is expected to be opened in June, 1973, replacing the City Night Refuge in Kent Street. The Society of St. Vincent de Paul is currently considering the possibility of replacing the present Matthew Talbot Hostel with a number of similar but smaller hostels. The Sydney Rescue Society and the Central Methodist Mission are in the process of examining alternative uses for their existing facilities.

Shortcomings of the present system

The first two reports in this series have highlighted some long standing deficiencies in the State's methods of handling public drunkenness. It is equally important to recognise that the existing voluntary system also suffers from problems which impair its efficiency. As the proliferation of organisations has evolved from many separate sources, there has been little general policy-making or sharing of experience in this particular field.

In very recent times there have been signs of increasing cooperation and interest in coordinating services. For example, the Council of Social Service of New South Wales has formed a sub-committee to discuss the problem of the homeless man. A proposal for a detoxification unit in Sydney was formulated by this group and published in July 1970. (1)

In recognising the need for better co-ordination of services, staff members from most agencies meet regularly at Erskine Street Clinic in an attempt to improve inter-agency relations and discuss the overall problem of the homeless man. The point has now been reached where a unique opportunity exists for the state, in partnership with the voluntary organisations, to forge a more comprehensive system of care for the vagrant alcoholic who is otherwise destined to finish up in gaol. Before discussing this system, it may be as well to acknowledge some of the other problems which bedevil work in this field.

Agency records are inadequate. The response to the pressure of numbers on overworked staff is to rely on memory only.* Hence many men use the system, shuffling from one agency to another - the revolving door phenomenon - to the detriment of any semblance of orderly planning for the individual vagrant or the total 'skid-row' population.

The voluntary organisations are short of funds. These services are almost exclusively financed by public subscription. The lack of funds is reflected in the low salaries paid to staff members, making this work unattractive to professionally qualified staff.

The estimated number of homeless men in the inner city area far exceeds the number of beds available daily. Preliminary analysis of statistics gathered by the Research and Planning Section of the N.S.W. Health Department suggests that homeless men in Sydney number 3000 to 3500. Table IV shows that there are only 1075 beds available in the inner city hostels and treatment centres.

* Some individual agencies do keep detailed records, but there is no centralised system.

(1) Council of Social Service of New South Wales, A PROPOSAL FOR A DETOXIFICATION UNIT IN SYDNEY, Report of the Detoxification Centre Subcommittee, July, 1970.

Table IV Summary of Accommodation available

	Sober	Drunk	Pensioners/Regulars	
I City Refuges	608	14	240	
II Detoxification Units	28	-	-	
III Rehabilitation Centres	-	-	185	
	<u>636</u>	<u>14</u>	<u>425</u>	Total = 1075

However almost one in four of these beds (22.4%) are permanently taken by pensioners. This constitutes a regrettable overtaxing of a scarce community resource - cheap accommodation. To the extent that the material needs of aged or handicapped persons are intended to be covered by social benefits, this dependence on hostel accommodation represents either an exploitation of cheap accommodation or the inadequacy of the present pension rates. Studies by Henderson et al. suggest that the latter interpretation may be more correct. (1)

Apart from the voluntary organisations, there are several hundred more vagrant alcoholics accommodated in inebriate hospitals, police cells and prisons. At any one time an average of 120 vagrant alcoholics are accommodated by inebriate hospitals; a further 30-40 are treated at Callan Park Psychiatric Hospital while the police cells and prisons would accommodate approximately 140 drunks and vagrants.

Enquiries at four public hospitals in the inner-city area have shown that a drunk who is in need of medical attention may be admitted, but this would account for only a small number at any one time.

Where do the others sleep?

John de Hoog, a sociologist and a temporary visitor to Skid-row (who estimated the population to be between three and four thousand) has this to say:

"There are probably as many again (2000) sleeping in the cheap snores, flea houses and dingy private hotels in the Haymarket, Wollomooloo and Darlinghurst areas. Others sleep on railway stations, in parks and in derelict houses."*

Present management policy of the city refuges creates special difficulties for the less hopeful through restriction of admission hours, and exclusion of those intoxicated. Some individuals are therefore, more exposed to the possibility of sleeping in the open and arrest. As table I shows, THERE ARE ONLY 14 BEDS AVAILABLE FOR THOSE WHO ARE INTOXICATED AND APPEAR LIKELY TO BE A NUISANCE.

The latter finding is of crucial significance to any proposals regarding alternative methods of handling public drunkenness.

There are limited resources available for the treatment of the city drunk. Table III shows the paucity of detoxification beds available to the vagrant type while a maximum of 185 persons can be accommodated in long term rehabilitation centres.

There is an even greater shortage of care and treatment facilities available for women. The second report in this series showed there is certainly a need for such facilities; at the present time Samaritan House with 25 beds (Table I) is the only refuge for homeless women.

(1) Henderson, R.F.; Harcourt, A; Harper, R.J.A.; PEOPLE IN POVERTY - A MELBOURNE SURVEY, Institute of Applied Economic and Social Research, University of Melbourne, 1970.

* De Hoog, J; "Chronic Unemployment in Sydney" Council of Social Service, Seminar on Unemployment, May, 1969.



Home for three city drunks



Reappraisal of present system

The previous report in this series indicated that the majority of those gaoled for drunkenness offences are poorly integrated into society. Their living arrangements are unsettled and they generally maintain very shallow contacts with others in the community. In these respects, the findings of the local study match closely those of comparable overseas research. For example, a survey of 187 drunkenness offenders by Pittman and Gordon (1967) in New York, showed that 41% of the drunks interviewed had never married. Of those who married, 96% reported broken marriages.(1)

The same investigation revealed a pattern of dependent institutional living among the chronic inebriates:

"The minimum requirements for living are met through institutional organisations which relieve the incumbents of individual responsibility to cope with food, housing and related needs. They become habituated to dependent living which further limits their capacity to re-establish independent modes of life".

Whatever else it accomplishes, it is questionable whether the court-penal system does anything to help the vagrant alcoholic overcome these problems of social maladjustment. Moreover, the startling recidivism rate of many of this State's drunkenness offenders, documented in the Bureau's earlier report on 'city drunks', suggests the futility of using a penal approach to deter alcoholics from drinking. Indeed, Pittman and Gillespie (1967), describing the American situation, have urged that the current procedure tends to aggravate the problem by further demoralising the drunk and removing any chance he may have had of regaining a foothold in society:

"By constantly being officially labelled by the Police, Courts and Correctional institutions as a public drunk, he begins to see himself as a public drunk; the jail becomes little more than a shelter to regain his physical strength."(2)

The Bureau's study of city drunks who go to gaol has suggested that much the same comment could be made about our own situation. At the point of leaving gaol to go back into the community, two out of every three prisoners say they want to do something about their drinking. However, the majority of the men lack the personal and social resources necessary to translate these intentions into constructive action. Their own words tell the story of their bewilderment:*

"I'll get a permanent job, permanent place to live - but I've been saying that for quite a while"; "I'll try and get off it. I don't think I will be successful indefinitely"; "I'll try, but the trouble is I finish up putting the bottle to my mouth just like a little baby", "If I go out broke what can I do?"

(1) Pittman D.J., Gordon W.C., "The Chronic Drunkenness Offender" in Pittman D.S., (ed) ALCOHOLICS Harper and Row, New York 1967.

(2) Pittman D.J., and Gillespie D.G., "Social Policy as Deviancy Reinforcement: The Case of the Public Intoxication Offender", *ibid*, p.118.

* A selection of statements made by prisoners who said they intended to try and overcome their drink problem. (see the Bureau's earlier report, DRUNKS WHO GO TO GAOL - No.5 of 1972).

Students of social behaviour are finding it increasingly helpful to view individual problems from the point of view of the way social institutions sometimes contribute to a person's breakdown. At first glance this breakdown often seems to be the result of some disorganising process within the person himself. However, social researchers are becoming increasingly familiar with the way service systems of one kind or another subvert their announced treatment goals and indirectly create further illness.(1)

Any discussion of the part society plays in a person's descent into skid row is unlikely to go beyond unproductive platitudes. Of greater importance for the moment is the extent to which our present social response to public drunkenness helps to stigmatise the individual and thereby maintain his socially unacceptable behaviour.

Society is placed in a quandary. On the one hand there are the limitations of our present system; on the other, the community either for 'aesthetic', self protective or humanitarian reasons is not prepared to allow the drunk to lie about the streets. The problem basically is:

How can the community show a proper concern for the care and treatment of the derelict person, at the same time maintaining its required standard of public order?

The survey of care and treatment facilities has shown that, despite limited resources, an increasing range of services is becoming available to the vagrant alcoholic. If the policy dilemma mentioned above is to be resolved, two main courses of action are required:

- (i) it is necessary to fill a vital gap in existing services by providing at least temporary shelter and basic care for people who are visibly drunk,
- (ii) it is necessary to help integrate and render more efficient the overall system of care for the vagrant alcoholic.

(1) Long, L. and Hoffman, M. "A System Dilemma" in FAMILY PROCESS Vol. 8 No. 2, Sept. 1969.

Alternatives to the present System

It lies beyond the charter of the Bureau of Crime Statistics and Research to develop a detailed administrative plan for implementing the findings of its research. Questions of administrative responsibility and competing priorities may affect the way in which results are applied. On the other hand, it would be a wasted opportunity if we ignore certain broad lines of action which have been indicated as socially and individually desirable. These indications can best be conveyed in the form of a series of relatively concrete proposals for changes in the one locality on which our research has concentrated, namely the inner-Sydney area. A pilot scheme introduced in this area could be properly evaluated before any attempts made to restructure the method of handling public drunkenness throughout the state.

Our main proposal turns on a single fact:

there are only 14 beds regularly available in the inner-city area to accommodate drunks who are likely to be a nuisance

Even if they had the discretionary right to do otherwise, under present circumstances the police would have little option than to take most drunks to the cells.

No realistic proposal can overlook the necessity for increasing the funds available to the voluntary organisations which already exist. Nevertheless, a new facility, a centralised INTAKE CENTRE could act as a point of integration for the present system (including the voluntary agencies, courts, prisons and hospitals) and help make the total system of care and social protection more rational as well as more humane.

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The centre's clients could be expected to come from three basic sources:

- (i) self referrals. Some clients will simply walk in off the street;
- (ii) from other agencies, including courts and prisons. Since even under our proposed scheme some vagrant alcoholics will still be arrested for other offences there is a need to offer service to those referred by the courts and prisons. (The Bureau's earlier report on imprisoned drunks, showed just how urgent is the need for post-release assistance);
- (iii) as a result of the work of the police and the centre's own staff. More will be said about the centre's fieldwork in the sections which follow.

The recommended centre will provide a 24 hour service offering:

- (i) physical and personal care - including attention to basic hygiene, replacement of contaminated and filthy clothing and treatment for body lice;
- (ii) a unit to house those drunk on arrival;
- (iii) a temporary hostel to house those awaiting referral to other centres;
- (iv) initial assessment - a brief discussion will be held with each person and salient personal details noted. Available care and treatment services will be explained.

The proposed scheme will help introduce a greater degree of order into what is sometimes a very haphazard process. Individuals could be directed to the part of the system which best caters for their needs and a note kept of their progress.

Once the client has undergone initial assessment a number of basic alternatives will be available. The individual:

- (i) simply returns home - the Bureau's earlier reports suggest that as many as 3 out of every 4 people would simply return home after sobering up at the centre;
- (ii) is encouraged to undergo detoxification at one of the available units (discussed below). Once this process has been completed he may return to the centre for referral to the next stage of care or treatment,
- (iii) is referred to other care and treatment services - farm, half-way houses, sheltered workshops, general hospitals, psychiatric hospitals;
- (iv) is referred to a 'doss house' for accommodation purposes if he is not motivated to undergo other forms of treatment.

The overall aim would be to encourage greater cooperation between the independent agencies, while at the same time placing more emphasis on individualised forms of care.

But what about the substantial capital cost involved in establishing such a centre?

Fortunately, in recent months it has been possible to attract the interest of an established welfare organisation with suitably large and conveniently located premises. The policy of this organisation has always been to provide assistance for the homeless and for people in crisis. The Board of Management may now be prepared to develop the intake centre and its associated services. The organisation's city premises would seem ideal in that they include a private rear entrance and reception room adjacent to a large 'sobering up' area with shower and toilet facilities. (Court records show that the daily number of arrests in the city can range from a low of about 30 to a high of approximately 110). The premises also contain a second large room where the clients could

await transfer to other agencies. Next to this holding centre, there is office space and a number of interviewing rooms. Upstairs there is a small hostel for temporary accommodation. Limited accommodation could be made available at the intake centre for intoxicated women and referrals could be made to Samaritan House. Other assets include a suitably large car-park. In the event of this particular organisation not being able to help, at least two others have expressed interest in the proposed scheme and may be able to provide the necessary premises.

Provided it has the cooperation of the voluntary organisations, the centre as a point of entry into the caring system, could help to make the best possible use of the resources available. This goal could be enhanced by the centre maintaining, on behalf of the total system, elementary records of procedures that seem to have worked or failed with individuals in the past. These efforts would need to be backed by regular meetings between the centre's staff and representatives of the other services to discuss individual cases and the functioning of the total system.

Another requirement is the need for additional detoxification services. In this respect the Bureau concurs with the earlier recommendation of the N.S.W. Council of Social Service. Such centres for the treatment of public drunkenness cases have been in operation in Eastern European cities such as Prague and Warsaw for a number of years. (1) More recently, similar services have appeared in many other countries including England and America.

A number of considerations need to be weighed in deciding whether or not the detoxification unit should be located in the intake centre. The health needs of the drunks may be better served if those responsible for providing treatment operate from an appropriate professional base like a general hospital and are encouraged to maintain standards of service which apply to 'ordinary' members of the community.

(1) Pittman, D.J., "Existing and Proposed Treatment Facilities in the U.S.A.," in Cook, T., Garth, D., Hensman, C., (eds.) THE DRUNKENNESS OFFENCE. (London: Pergamon, 1969).

An administrative framework for providing health and welfare services to unattractive and nondemanding groups like chronic alcoholics needs to have a measure of built-in protection against the lowering of professional standards. Attaching the detoxification unit to a general hospital may help to create the required degree of accountability to prevent the erosion of service standards.

Another reason for developing a close working relationship between the centre and a general hospital is the fact that chronic alcoholics and the skid row population in general suffer from a variety of serious ailments. Intoxication may cause serious medical complications and because the symptoms closely resemble other more serious illnesses, it is often difficult to detect or to diagnose these illnesses.

It would seem both advantageous and consistent with the overall philosophy of the centre as a referral and coordinating agency, to transport drunks in need of detoxification and other forms of medical treatment to a general hospital equipped to provide these services. The centre would need to have staff capable of assessing the need for such referrals. There is also an implied need for adequate means of transport. Both these points are discussed below. First, it would be well to recognise some dangers of the proposed scheme.

Overseas experience and the already noted disinclination of our own hospitals to provide continuing treatment for chronic alcoholics, indicates the difficulty of securing a firm commitment to provide adequate medical care for drunks. The experience of the city of St. Louis illustrates the point.

In 1963 the St. Louis Board of Police Commissioners made it mandatory for all individuals 'picked up' from the streets to be taken to the emergency rooms of the two city hospitals for physical examination. Individuals in need of medical care were to be hospitalised instead of being gaoled. If medical care were deemed unnecessary, the intoxicated person was 'held until sober' - not more than 20 hours - and released to the community.

The Board of Police Commissioners soon became dissatisfied with the large number of inebriates who were not admitted to the hospitals for medical care. The physicians simply returned them to the police for processing so that the Commissioners were forced to develop their own Detoxification and Diagnostic Evaluation Centre in order to remove chronic inebriates from the city courts and gaols.

Experiences like that of the city of St. Louis indicate the necessity for securing a definite undertaking from a public hospital to provide detoxification and other necessary medical services. Reliance on a general hospital should, however, help to combat another undesirable trend which, in many places, has followed the termination of criminal prosecution for public drunkenness. This has been the attempt to make greater use of civil commitment procedures. As Stern (1967) has pointed out, civil commitment need not always be less pleasurable for alcoholics than gaol, but it will, in all likelihood, remain strikingly similar:

"The incarceration of people for treatment raises many serious problems, one of which is that successful treatment programs do not presently exist. The 'hospital' will be nothing more than a detention facility and the length of detention is likely to be far greater..."(1)

Stern cites the example of a Washington, D.C., gaol recently "transformed" into a civil commitment, "health" facility. Under the new programme, patients are quartered in "dormitories" which formerly housed them as prisoners. The only attempt at rehabilitation noted has been the colour of the uniforms, which have changed from blue to white.

(1) Stern, G., "Public Drunkenness; Crime or Health Problem" ANNALS OF THE AMERICAN ACADEMY OF POLITICAL AND SOCIAL SCIENCE, Vol. 1; 1967 pp.147-56.

The hospitalised care of inebriates in New South Wales generally has not progressed beyond the provision of work and various forms of restraint.* A recent unpublished survey of staff attitudes in inebriate wards has shown that those charged with the responsibility of treating the chronic alcoholics are pessimistic about the prospects of accomplishing anything constructive with this group.**

Of the 102 staff members interviewed, 64 per cent considered a psychiatric hospital an "inappropriate setting for the treatment of alcoholics". An almost equal number (60 per cent) indicated that "the treatment prospects of the legally restrained alcoholic are worse than those of the voluntary alcoholic".

Nearly all (94 per cent) considered that "the successful rehabilitation of the discharged alcoholic is dependent on the support he receives from community agencies". However, in the majority of cases, discharged patients return to centres some distance from the hospital. None of the respondents in the survey claimed that their hospitals could establish adequate contact with relevant community based health services beyond the area serviced by each hospital.

* Some recent changes have been introduced into state psychiatric hospitals to improve the quality of service to inebriate patients.

** The survey was conducted by Mr. K. Llewellyn, an experienced post-graduate student of the New South Wales College of Nursing. The Bureau is very grateful for the opportunity of citing some of the more general findings of Mr. Llewellyn's research.

To Summarise:

we recommend the establishment of an intake centre which will provide temporary accommodation and basic physical care services for drunks. It will refer these clients to appropriate community agencies and work closely with a detoxification and medical care facility in one of the City's general hospitals. The centre will provide a viable alternative to the present procedure of arresting drunks and holding them during their sobering up period in city cells. It will offer better opportunities for identifying people in the early stages of alcoholism and more orderly planning of care and treatment programmes.

If the centre is to provide an effective alternative to the present procedures, the following steps will need to be taken:

- (a) the necessary manpower must be provided;
- (b) the centre will require adequate transport facilities;
- (c) the law will need to be amended.

Manpower

The success of the intake centre depends on the ability of its staff to build and maintain close working relations with a large number of other agencies. The centre will obviously provide some direct services to vagrant alcoholics but its essential organisational role is to serve the network of community agencies which specialise in direct services. The management and staff of other agencies must feel that the centre is working alongside them in the interest of a more rational system of care and treatment for the chronic alcoholic.

Since the centre will play a pivotal role within this system, the associated organisations should be in a position to influence its policies and procedures. They should be represented on the centre's board of management.

Inter-agency relations should be the primary responsibility of the Director of the intake centre. The Director should join with other community agencies in evolving joint policies and progressively improving methods of care and treatment of the vagrant alcoholic. Of course, these developments need not necessarily be based on the centre but the role it will perform provides an excellent opportunity for building integration within the total system.

For effecting inter-agency cooperation on a case basis, the Director will need the support of the whole staff but especially two Welfare Coordinators. These officers will be responsible for maintaining the case record system, making social assessments of individual clients, helping to organise assistance in selected cases and generally administering welfare services within the centre. They will be expected to help train other staff members in social welfare techniques.

Because of the medical complications surrounding chronic alcoholism and the need to assess which clients should be referred for medical treatment, it is obviously necessary that the centre should have its own paramedical staff.

In particular, three nurses with certificates in both psychiatric and general nursing, will be required. The centre should also be able to draw upon the nursing resources of the general hospital when necessary. The nursing staff will need to be supported by a total of 10 orderlies who will provide such immediate health and care services as are needed by the drunks, assist in making referrals and help maintain the records of the centre. The orderlies will provide a necessary degree of flexibility in the centre's work force. Apart from the functions already mentioned, they will need to man the two vehicles used for collecting and transferring drunks to other agencies.

The staff of the intake centre will need to work closely with the police on a day to day basis. It is imperative that good communication be maintained between these two groups. To help promote cooperation between the police and the centre's staff,

two police liaison officers should be appointed. These officers should be seconded from the Police Department. They could provide a measure of restraint when needed. Fortunately, as a study at a similar centre in Columbia (U.S.A.,) has shown, very few of the drunks are likely to be unmanageable. (1) However, the opportunity provided by our own police to observe the behaviour of drunks at the time of their arrest, has left the Bureau in no doubt that a small number of drunks can be extremely aggressive.

The amount of clerical work involved in the day to day operation of the centre will necessitate the appointment of a secretary.

Other Staff

The proposed intake centre will be a cooperative venture. The State will work in partnership with the voluntary agencies. Subsidies will need to be provided so that the host organisation is not overburdened with increased expenditures (see section on costs, below). On the other hand, the intention is not to stifle voluntary participation in a scheme which could attract added community support and generate increased income.

The organisation which has expressed interest in sponsoring the centre, is already obliged to maintain its city premises and provide sustenance for a section of the city's vagrant alcoholics. It is envisaged that it will expand these services at its own expense.

(1) Taxham, R.S., "Detoxification Centre, A Public Health Alternative for the 'Drunk Tank'", FEDERAL PROBATION, No.33, 1969 p.47.

Removing drunks from the streets

In our cities the main burden of removing the homeless alcoholics from the streets has been placed upon the police, the courts, and the gaols. The U.S. President's Commission on Law Enforcement and the Administration of Justice has attacked the practice of arresting homeless alcoholics as a misuse of the criminal process and inappropriate response to a social and medical problem.(1) Many social scientists believe that the arrest process, rather than 'teaching derelicts a lesson' merely reinforces attitudes of self contempt and self abuse.(2) Countless hours of police, court and correction time are in their view 'wasted' on the cycle of arrests, court appearances and re-arrests, placing a heavy burden on the criminal justice system.

Despite these claimed shortcomings of the existing system, alternative approaches obviously entail their own special difficulties. One such difficulty is the question of the voluntarism of a scheme where drunks are forced to decide between either going to the cells or to a place like the proposed intake centre. For that matter, is a drunk capable of exercising choice about anything? On the other hand, with what moral justification can society intervene to remove drunks from the streets?

For as long as debate on such issues remains inconclusive, policy may have to reflect less sophisticated conceptions of the problem. At the moment, only a very small proportion of the adult population holds the view that the community should take no action in respect of public drunkenness. An unpublished opinion survey of more than 600 Sydney residents* puts the figure at 14 per cent. Another 17 per cent would require the drunk's participation in one or another form of therapy. The remainder consider that the "best way" to deal with drunkenness is to impose a fine (42 per cent of respondents), impose probation (19 per cent) or a term of imprisonment (8 per cent).

Taking drunks into some form of temporary custody would appear to be consistent with established practice in other fields where, for example, a measure of protection is afforded the immature and the mentally unbalanced. However, the yardstick of value compatibility would require that the period of protection and control be limited to the phase of physical and mental incapacity and that the individual should be free to avoid the 'entanglements' with welfare which he rightly or wrongly perceives to be inevitable should he go to the intake centre. As Brandon (1969) has argued, to take services out to people does not necessarily mean the enforcement of use.(3) However, "The services must provide adequate channels of escape".

There is some encouraging evidence from overseas that social isolates and drunks are capable of exercising such elementary freedoms and that helping agents are able to offer help without imposing on people who may reject their services (see, for example, the discussion of the Bowery Project, next page). In the final analysis, the main safeguard must be that of respect for people's rights and decisions.

(1) The President's Commission on Law Enforcement and Administration of Justice, "Drunkenness Offences", THE CHALLENGE OF CRIME IN A FREE SOCIETY. (Washington: U.S. Government Printing Office, 1967).

(2) The Criminal Justice Coordinating Council of New York City, IN LIEU OF ARREST, THE MANHATTAN BOWERY PROJECT. (New York: Vera Institute).

* The full results will be published by the Bureau of Crime Statistics and Research in the first half of 1973.

(3) Brandon, D., "Homeless single persons", in BRITISH JOURNAL OF PSYCHIATRIC SOCIAL WORK, Vol. 10 1969 pp. 80-84.

It is inherent in the nature of the work of the police that they should be the point of contact between society and some of its most basic human problems. Nevertheless, in order to allow police resources to be focused on the major crime problems facing modern society, it would be wise to make it less necessary for them to perform the front line welfare task of coping with public drunkenness.

It is recommended that the intake centre use its own vehicles to collect drunks from the city streets. Two radio controlled vehicles should be acquired for this purpose. It would obviously still be necessary to rely heavily on the help of the police in transporting drunks to the centre. However, regardless of whether the initial contact is made by the police or the centre's staff, an individual should not be pressured into attending the intake centre. The present law relating to public drunkenness would need to be modified to allow the police to exercise their discretion in making a referral to the centre or arresting the drunk in the usual way.

The proposed scheme resembles in many ways the well known Manhattan Bowery Project. It may be useful to round out the discussion of what could be done in the inner-Sydney area by sketching what has already been accomplished by the Bowery project.

In 1966 the mayor of New York initiated a combined effort of city agencies and private groups to develop a socially-oriented method for removing destitute alcoholics from the criminal justice system. A new centre was established to seek out alcoholics in public distress, offer voluntary admission and provide five days of treatment and referral services to rehabilitative, residential and medical facilities. A social service department donated the use of its premises and a nearby hospital accepted responsibility for all medical care associated with the project. The New York City Police Department assigned four patrolmen and two unmarked vehicles for street rescue work.

Seven days a week a two man rescue team patrols the Bowery in the

unmarked vehicles. One member of the team is a rescue aid who is a recovered alcoholic; the other is a plain clothes policeman. Noticing a derelict in need of assistance, the aid approaches and offers to take him to the project centre to dry out. The Bowery man is never coerced; he may reject the team's offer if he wishes, and he remains free to leave the project at any point in his treatment. It has been found that this voluntary approach by the street patrol is accepted 67 per cent of the time. No further action is taken by the rescue team on the 33 per cent refusals.

Various extensions of the project have taken place in recent years. However, its essential principles have remained unaltered. From May to July 1968 Bowery arrests for disorderly conduct, loitering, and public intoxication totalled 1,964; during the corresponding period in 1969, arrests dropped to 170.

In planning the Bowery project, it was recognised that few men would achieve substantial improvement in their long term alcoholism problems as a result of five days care. Nevertheless, it was deemed an important goal of the project to substitute a socio-medical facility for the police-court-prison system - even if it only served as a more humane form of 'revolving door'. Moreover, steps were taken to influence the behaviour of the men through after care referrals, and over 60 per cent of those coming to the project have accepted such referrals. Many men who, on the first occasion refused after care programmes, have later become amenable to referrals.

The Cost

In 1970 the New South Wales Council of Social Service estimated that the cost of handling drunkenness offenders throughout the whole of New South Wales was approximately \$147,000. This cost was based on information derived from statistics and consultation with senior officers of the various departments concerned.

The Bureau of Crime Statistics and Research has had the added advantage of being able to observe directly each phase of the established procedures from the street patrol to the transfer of a convicted drunk to prison. The operation of the Drunks Court at Central Court of Petty Sessions has also been observed. In the light of this additional information and taking into account general increases in salaries, the Bureau has arrived at an estimate of the cost of handling drunkenness offenders which exceeds considerably the earlier estimate of the Council of Social Service. Even so, for reasons set out in Appendix A, we believe our figure is a very conservative one. Its main value is that it helps to place in better perspective the cost involved in establishing the proposed intake centre.

The estimated annual cost of involving the police, courts and prisons in the legal processing of drunks apprehended within the inner-Sydney area is \$122,000 (see accompanying map of the area involved). The subsidy required to cover the salaries of the director, welfare coordinators, nurses, medical orderlies and secretary of the intake centre is estimated to be \$75,000 per year. In addition, it would be necessary to purchase and maintain the two radio-controlled vehicles which are necessary for the successful operation of the centre.



Costing present procedures
Photo by courtesy of Mirror Newspapers Limited

Basis of Costing Present Procedures (Appendix A)

On average, 68 persons are arrested for drunkenness and processed at Central Police Station, 6 days a week. Of those arrested, 51 (75 per cent) are normally released having been held for some four hours. These people usually forfeit their recognizance and do not appear in court. About 17 (25 per cent) appear at the Drunks Court.

The Bureau's earlier reports have indicated that of all those arrested, 12 per cent are fined or in default, sentenced to 24 hours imprisonment and 2 per cent fined or sentenced to 48 hours. This means that an average of 9 people receive one or another of these two penalties each day. Very few of the defendants have the necessary funds to meet the fine imposed.

In arriving at an estimate of the cost of police involvement in the various stages of arrest and detention of drunks, it has been convenient to base certain of the calculations on the handling of individual cases:

	Police Involved			Time Minutes
	Constable	Senior Constable	Sergeant	
Patrol, arrest, conveyance to police station	1	1		10
At police station - charge, search, note property, escort to cell	5	2		8
Discharge - release from cell, check and return of property, payment of bail, paperwork	3	2		5

The procedures involving those who are not released on bail, are better described in terms of daily averages for the whole group:

	Police Involved			Time Minutes
	Constable	Senior Constable	Sergeant	
Preparation of charge sheets and list for court	2	1		120
Court appearance				
(a) Transfer from cell to court	3	2		30
(b) Court hearing, discharge where appropriate	3		1*	15
Transfer to prison	1	1		45

*Prosecutor

Estimated Annual Costs

On the basis of these figures the following annual cost schedule has been prepared.

1	Arrests Average 68 per day, 6 days per week, charge, hold etc.	\$ 68,000
2	Discharge without court appearance. An average 51 persons are released on bail each day	\$ 16,800
3	Preparation of charge sheets and antecedent list for court	\$ 5,000
4	Preparation of, and transfer of prisoners to court and the court appearance	\$ 2,800
5	The minimal annual cost of meals involved in the care of people appearing at court	\$ 3,700
6	Transfer of committed persons from Central police cell to prison	\$ 1,300
	TOTAL POLICE MANPOWER COSTS	\$ 97,000
7	(i) Magistrate/Clerk of Petty Sessions	\$ 352
	(ii) Clerical services	\$ 468
	TOTAL COURT COSTS	\$ 820
8	DEPARTMENT OF CORRECTIVE SERVICES*	\$ 24,000

Thus, the estimated cost of handling drunkenness offenders in the inner city area is the total cost to the Police, the Courts and Corrective Services:

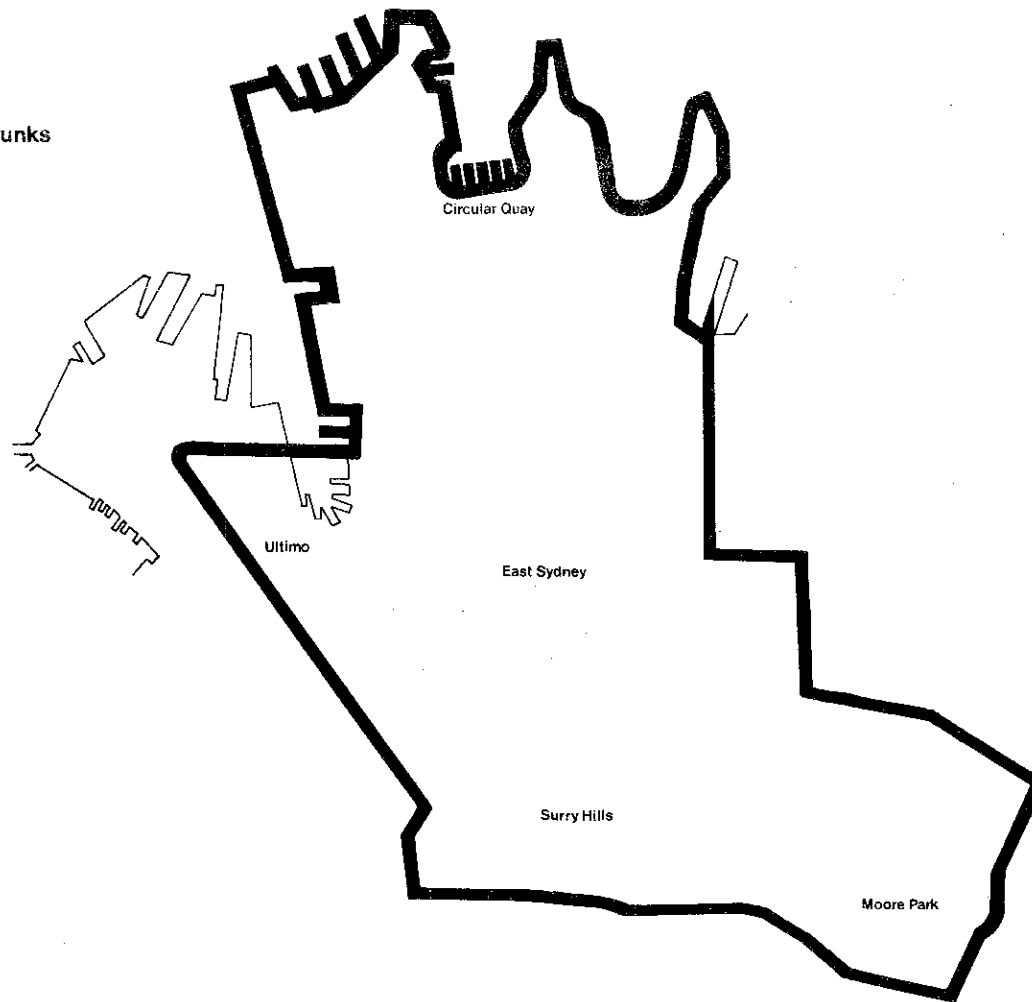
Police	\$ 97,000
Courts	\$ 820
Corrective Services	\$ 24,000
	<hr/>
	\$121,820

Police from neighbouring stations (for example, Regent Street, Darlington and Phillip Street) also deliver drunks to Central Police Station. While the drunks arrested and brought to Central from other stations have been included in the drunkenness statistics, no estimate has been made of any additional cost incurred by the use of these police. The estimates made are therefore, extremely conservative. Furthermore, no account has been made of the running costs of the Police vehicles.

Costs have been assessed on a 6 day a week basis when the 'routine' patrol and collection takes place and when hotels are open. On Sundays the character of the Police work changes and more concentration on public parks is required. We have not been able to observe the Sunday arrests and procedures and have not attempted to cost them. This is another factor indicating the overall estimates are understated.

*Considering the costs are based on a flat rate and that a great deal of time is involved for prison staff in the process of reception and discharge, this figure must be regarded as an understatement.

Catchment Area for Sydney City Drunks



100

100

100

100