MEDICAL PRACTICE

For Debate . . .

Public drunkenness: the failure of reform

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Concluding his article on the problems facing the formulation of a constructive and humane response to habitual drunkenness offenders, Richard Smith asked: "Is our society quite incapable of dealing with these chronic problems?"¹ Six years later the answer still seems to be yes. Though the widespread agreement which exists on the need for reform has been translated into action, somehow most of what has been done has failed to provide any effective improvement in society's response to some of its most disadvantaged members. How has this situation come about and is there a way forward?

Public drunkenness as an offence

Public drunkenness first became an offence in 1606, under "An act for repressing the Odious and Loathsome Sin of Drunkenness," whereas the modern offences of simple and aggravated drunkenness date from the Licensing Act 1872. By 1921 the criminal law had been used to punish drunkards, to offer them treatment, and to compel them into having treatment. With the failure of all these approaches to curtail public drunkenness the law reverted to punishment in the form of imprisonment and fines. The continued failure of this approach, coupled with a recognition of the inappropriateness of imprisonment for offences of drunk and disorderly, led to the passing of the Criminal Justice Act 1967, section 91, which provided for the removal of imprisonment as a sentence for this offence (simple drunkenness had never carried imprisonment, though people were often imprisoned for non-payment of fines imposed for the offence). Section 91 was not to be activated

until sufficient suitable community alternatives for drunkenness offenders were available. The section was nevertheless brought into force in 1978 even though the alternatives had failed to materialise, the intention being simply to remove drunkenness offenders from the jails. But this also failed, as offenders continued to be imprisoned for default in paying fines.

Meanwhile, in 1976 section 34 of the Criminal Law Act 1972 had been brought into force, which enabled the police to take somebody found to be drunk in public to a designated treatment facility; but unless this happened to be in Leeds, possibly Manchester, or, later, Birmingham this also failed, as these were the only three designated centres which were established. The main aim had been to ease the chronic and increasing overcrowding in jails by removing a group of inmates whom everyone agreed should not be there. At the start of the 1980s only some 80 of the average daily prison population of well over 40 000 was made up of such offenders, but they nevertheless accounted for more than 2500 receptions a year. By virtue of their often very deteriorated physical condition these inmates also posed problems out of proportion to their numbers, particularly in prisons in metropolitan areas, most notably Pentonville. Nothing effective, however, was done.

Cautioning schemes

Then, with every good intention, in 1983 a metropolitan police experiment was begun in Hammersmith under which a caution was automatically applied to all cases of simple drunkenness and the less serious cases of drunk and disorderly, provided that the offender had not already received three cautions in the preceding four weeks.² The scheme was later extended to the whole of the metropolitan and many other police force areas, including Bedfordshire, Cleveland, Devon and Cornwall, Dorset, Humberside, Merseyside, Northumbria, north Wales, North Yorkshire, south Wales, Thames Valley, and Wiltshire. And recent figures show that convictions for drunkenness fell from 107 000 in 1983 to 56 000 in 1985, the number of receptions into prison for default of a fine

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imposed for drunkenness falling from the usual 2500 to 1100 in 1985.³

So at last success—at least in areas operating the cautioning scheme—with much reduced use of prison and court; but also failure, because no alternative facilities had been provided. And even the minimal help available in prisons—decent food, a bed and medical care, and so on—was no longer on offer. It is also the case that some drunkenness offenders may appear to vanish as they disappear from the criminal statistics (the number of convictions fell by 51 000 between 1983 and 1985 but the number of cautions increased by only 24 000; and, as all other indicators of alcohol related harm increased during the period, probably many drinkers are now just being left on the streets). Cautioning has also put responsibility for these offenders squarely on the police, who are neither suited (they do not have the training required to diagnose and deal with a person who may be ill, drunk, or injured) nor equipped (police cells do not have the necessary facilities) to deal with them (more than half of the 100 plus deaths in police custody since 1984 were drink related). Not surprisingly, the Police Federation and the Association of Chief Officers of Police have strongly objected to being left with this responsibility.

Designated centres

Both the Department of Health and Social Security and the Home Office have announced that they will no longer provide funding for designated centres (though the Home Office will consider applications for designation, provided that it does not have to put up any money). Two reports, one on detoxification units⁴ and the other on the Birmingham "wet shelter,"⁵ were used by the government to support these decisions (detoxification units were described as too expensive and unnecessarily elaborate and the Birmingham wet shelter as too basic for proper care). Nevertheless, the detoxification unit at Leeds (a much praised and well equipped facility offering appropriate social and medical care for both immediate health needs and longer term rehabilitation) and a much improved Birmingham wet shelter (a simple overnight facility providing only immediate care and somewhere to "sleep it off") continue to struggle on with voluntary funding; the Manchester detoxification unit has effectively stopped operating as a section 34 centre (its main drawback seems to have been underuse owing to its distance from the skid row area).

There are moves to establish community drying out centres, which aim to provide more than a wet shelter but to be less elaborate and therefore cheaper than a detoxification unit. They are supported by the pressure group Out of Court (Livingstone House, 11 Carteret Street, London SW1H 9DL) and would "accept referrals from the police and other bodies, supervise sobering up and act as a focal point for putting problem drinkers in contact with helping agencies." But though there are plans to open centres in Southampton and London in 1988 and others in places including Manchester, Sheffield, Newcastle, and Dundee sometime in the future, funding remains a serious problem.

Aside from this there is little to show for some 16 years of work since the Home Office report on habitual drunken offenders heralded the latest phase of reforms in 1971. Hence it seems likely that those who work with the skid row population will continue to witness an increase in their numbers, a decline in their physical condition, and no amelioration of the social disadvantages that they suffer as they are processed through the "revolving door" of the cautioning scheme, the prospect of any alternative facilities receding ever further with every official pronouncement.

A new strategy

Responses to the habitual drunken offender have moved through punishment, moral reclamation, compulsory treatment, a return to punishment, medical treatment, and, finally, to a policy of what can only be called benign neglect. All of these have failed, as has the attempt to move on to a welfare response.

This lack of success prompts the question of whether we should attempt to formulate a new strategy; one which recognises that the public drunkenness offender comes very low on the list of social priorities, that judgmental attitudes to "dossers" are widespread, and that this is why it has proved so difficult to provide the services for those who wish to escape skid row or to accommodate those who do not—even though we are dealing with some of the most disadvantaged, deprived, inarticulate, and underprivileged members of society.

It will be difficult to change these attitudes, but an important statement of principle would be made if public drunkenness was decriminalised. The criminal response has been progressively depenalised with the abolition of immediate imprisonment as a sentence, the possibility of diversion to section 34 centres, and the introduction of cautioning schemes; but this is not the same as decriminalisation, which would remove the stigma of criminality and help people realise that "not all tramps are drunken scoundrels."⁶ It would also end an unwise use of the criminal sanction—for apart from the obvious burden placed on the criminal justice system (which the police and prisons are very keen to be relieved of), it redefines a social problem as a criminal one and then goes on to delude us into thinking that we are doing something constructive about it by arresting and processing offenders.

Arguments for decriminalisation

The rationale for the offence of simple drunkenness appears to be twofold. Firstly, the public finds the presence of people drinking in the street offensive, especially if the person doing the drinking is a vagrant. The law is intended to protect moral and aesthetic values rather than protect the public from any physical danger. To retain the criminal sanction merely to assuage the injured moral or aesthetic values of some members of the public is not sufficient justification. Secondly, if someone is so intoxicated as to be drunk and incapable (which carries a power of arrest) it is said that such a person needs to be taken into custody for his or her own good: the person may be suffering from alcohol poisoning or from another condition requiring medical attention; or may be in danger of becoming the victim of an accident or a crime; or may if left unattended die of exposure or even choke to death on his or her own vomit. It is difficult to see why such a person could not be taken into care rather than custody and be treated in the same way as someone who had suffered, say, a heart attack or been the victim of an accident. The reason may be that in the case of a drunk person the condition is self inflicted. But so, too, may be the condition of the accident victim who has walked into something through not looking where he or she was going, and the heart attack sufferer who has become ill owing to a lifestyle of heavy drinking and smoking, coupled with a lack of exercise, too large and cholesterol high an appetite, and grossly overweight physique. These people are not dealt with as criminals. The drunkenness offender may have an alcohol problem and suffer massive social disadvantage, leading not only to drinking but also to his or her not having a private place within which to indulge.

The other common public drunkenness offence, drunk and disorderly, has a wider aim than the merely aesthetic: it is aimed at deterrence and is intended to provide for the removal of those who are troublesome or causing a nuisance. There are those who would advocate the decriminalisation of simple drunkenness only, as to decriminalise both offences would, they claim, lead to disorderly behaviour by intoxicated people going unchecked. Such behaviour may be tolerated in the habitual and vagrant offender whose offences are precipitated by medical, social, and personal problems but would be unacceptable in relation to other offenders, such as the rowdy, drunken football fan or the overindulgent partygoer. This is not the case, as other offences relating to public order, such as behaviour likely to cause a breach of the peace and criminal damage, are available and apply whether or not the offender is drunk.

Another argument claims that to decriminalise public drunkenness would lead to a sudden and massive increase in its incidence. And current concern over the increase in the general level of alcohol

abuse militates against measures which might appear to condone or even encourage such abuse. But the public drinker, albeit the most obvious and visible aspect of alcohol misuse, is certainly not the most prevalent. Such a large scale social problem has and will not be solved by the criminal law. Those brought under the control of these prohibitions are likely to be social outcasts, suffering a whole range of disadvantages, for whom the criminal process is inappropriate. The problems posed are political, medical, and social rather than legal; the criminal response is ineffective and wasteful of resources.

After decriminalisation there would in practice be little change in areas operating the automatic cautioning scheme: ill drunks will (should) still be taken by the police to hospital, and those in danger or likely to pose any danger—for example, by wandering on the highway—would be taken into custody. The commission of any publicly unacceptable behaviour could be dealt with under other legal (for example, public order) provisions. The rest would be left alone.

It is also necessary to re-examine our focus on the drunkenness offender. So far the main issue has been to formulate an appropriate response to public intoxication, but when we look at the arrest patterns we find that it is the “dosser” type who gets arrested, sometimes when not even drunk. Why should drunkenness be the focus of concern when there are so obviously many other substantial and diverse needs—shelter, medical care, food, hygiene, employment, and so on?

Conclusion

Efforts should continue to be directed towards providing facilities such as detoxification and drying out centres which offer valuable services for those who need them,⁸ but it is essential to place the issues in their wider setting. Firstly, there is a need to improve police custody facilities, not just for public drunkenness offenders but for all who find themselves in police custody; after all most are presumed innocent and not even the guilty should be kept in inadequate and degrading conditions. Secondly, the skid row population needs to be properly looked at to establish the full range

of service requirements; and these services must be provided, including housing and health care. Health care is often sadly lacking, hospital staff showing a “lack of enthusiasm” for people with no fixed address (Week-end Drink Crisis Campaign (1986), unpublished) and homelessness making it impossible to register an address with a general practitioner.^{9,11} This, combined with the need for three written refusals before a local health authority is obliged to find an applicant a general practitioner, means that many homeless people are denied medical treatment. One welcome development would be the introduction of more centres for the homeless, such as that at Luther Street in Oxford, which includes a general practitioner’s branch surgery (the work of this centre was recently the subject of an *Open Space* television programme (BBC2, 12 August 1987)), which provide shelter and medical care. Thirdly, the general nature of alcohol related problems must be seriously tackled, the alcohol dimension of skid row being seen as just another, albeit highly visible, example of alcohol abuse in society.

Judgmental attitudes to the homeless and destitute must be changed and we must learn to respond to their needs rather than their behaviour. Without these things it is unlikely that the next 16 years will be any more successful than the past in terms of removing habitual drunken offenders from the criminal justice system and providing them with the opportunity to escape from skid row.

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WORDS COCAINE FOR ADELAIDE. It seems to be the fashion these days to use eye catching titles for fear that a truly descriptive title might induce an abrupt loss of interest. I must now declare that this article is primarily about the suffix -INE.

The suffix -INE, pronounced “-een,” occurs, according to the *Oxford English Dictionary*, in the names of some derived substances. In the nineteenth century, when it was obvious that a specific substance or active principle was present in a crude natural product, the technical means of identifying and determining the chemical nature of the specific substance were not then in existence. Meanwhile a provisional name was needed for these active principles. The convention was adopted of adding the suffix -INE to the name of the crude product, or to its mode of action. An attempt was originally made to limit this suffix to the names of alkaloids. Here are some examples, together with the dates of first usage: nicotine and strychnine (1819), quinine (1826), morphine (1828), atropine (1842), aconitine (1847), papaverine (1848), and colchicine (1853). These dates place the advance of pharmacological discovery in historical context. But -INE was too useful to be limited to alkaloids, and other substances acquired the needed suffix. Here is a selection: caffeine (1830), guanine and aniline (1850), pyridine (1851), amine (1863), guanidine (1864), choline (1869), pyrimidine and adenine (1885), cytosine and thymine (happily together in 1894, and now known to be close neighbours in DNA), and, lastly, epinephrine (1899), adopted in the USA, and as adrenaline (1901) in Britain. Humphrey Davy seems to have started the custom in 1810 when he applied it to the first halogen to be identified, chlorine—adapted from the Greek *chlōros*, from the yellowish green colour of the gas. Within a few years the other halogens were discovered—fluorine, obtained from fluorspar, which was so named from its fusibility (L *fluo*, to flow); iodine, from the colour of its vapour (Gk *iōdēs*, violet); and bromine, from its nasty odour (Gk *brōmos*, stink).

I turn now to the vagaries of English pronunciation, which bears a tenuous and irregular connection with orthography, and with special reference to

-INE. In accordance with contemporary practice, the active principle obtained from the coca leaf was called coca/ine (1874), and pronounced in all languages, I believe, except English as “coca-een.” In Britain the pronunciation of words ending in -ain, as in “pain,” pre-empted the more logical “coca-een” to give us “co-kayn.” This has turned out well, since any drug whose name ends in “-aine” and is pronounced “-ayn” is immediately identifiable as a local anaesthetic, just as -ase tells us we are dealing with an enzyme, and -ose with a sugar. Similar vowel shifts have occurred with the following examples. The digitalis-like drug, ouabaine, was pronounced by the French as “wa-ba-een,” since it was obtained from the African plant known in Somali as “wabayo,” and they ensured preservation of the terminal “-een” sound by placing a diaeresis over the “i.” This substance is now used as an analytical reagent, minus the two dots, and is called “oo-ah-bayn.” The same shift has occurred with “maize.” Originally transcribed into Spanish from the Cuban as *mahiz* (with silent “h,” now lost), and spelt *maiz*, it is pronounced “ma-eeth.” Likewise, Ukraine, the name of a republic in south west Soviet Russia, is pronounced “yoo-crane” by Brits, but “oo-kra-eena” by Russians. A unique example of retention of the French “ah-ee” sound in English is found in “naive.”

At last we meet Adelaide, and I draw attention to the last of her three syllables. In the Australian town of that name it often sounds, when uttered by its denizens, like Ad-lyde, shrinking to two syllables. But in German it gets the full treatment and has no less than five, thus—Ah-de-la-ee-de. This is enshrined in the poem by Friedrich von Matthiessen, and set to music by Beethoven in the *Lied* of that name, wherein it would be unsingable without all five:

In der spiegelden Flut, im Schnee der Alpen,
In des sinkenden Tages Goldgewölken,
Im Gefilde der Sterne strahlt dein Bildnis,
Adelaide! [Ah-de-la-ee-de!]