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Problem-Specific Guides Series
Problem-Oriented Guides for Police

No. 68

Chronic Public Inebriation

Matthew Pate

Center for
Problem-Oriented Policing

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The Internet references cited in this publication were valid as of the date of this publication. Given that URLs and websites are in constant flux, neither the author(s) nor the COPS Office can vouch for their current validity.

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About the Problem-Specific Guides Series

The *Problem-Specific Guides* summarize knowledge about how police can reduce the harm caused by specific crime and disorder problems. They are guides to prevention and to improving the overall response to incidents, not to investigating offenses or handling specific incidents. Neither do they cover all of the technical details about how to implement specific responses. The guides are written for police—of whatever rank or assignment—who must address the specific problem the guides cover. The guides will be most useful to officers who:

- **Understand basic problem-oriented policing principles and methods.** The guides are not primers in problem-oriented policing. They deal only briefly with the initial decision to focus on a particular problem, methods to analyze the problem, and means to assess the results of a problem-oriented policing project. They are designed to help police decide how best to analyze and address a problem they have already identified. (A companion series of *Problem-Solving Tools* guides has been produced to aid in various aspects of problem analysis and assessment.)
- **Can look at a problem in depth.** Depending on the complexity of the problem, you should be prepared to spend perhaps weeks, or even months, analyzing and responding to it. Carefully studying a problem before responding helps you design the right strategy, one that is most likely to work in your community. You should not blindly adopt the responses others have used; you must decide whether they are appropriate to your local situation. What is true in one place may not be true elsewhere; what works in one place may not work everywhere.
- **Are willing to consider new ways of doing police business.** The guides describe responses that other police departments have used or that researchers have tested. While not all of these responses will be appropriate to your particular problem, they should help give a broader view of the kinds of things you could do. You may think you cannot implement some of these responses in your jurisdiction, but perhaps you can. In many places, when police have discovered a more effective response, they have succeeded in having laws and policies changed, improving the response to the problem. (A companion series of *Response Guides* has been produced to help you understand how commonly-used police responses work on a variety of problems.)

- **Understand the value and the limits of research knowledge.** For some types of problems, a lot of useful research is available to the police; for other problems, little is available. Accordingly, some guides in this series summarize existing research whereas other guides illustrate the need for more research on that particular problem. Regardless, research has not provided definitive answers to all the questions you might have about the problem. The research may help get you started in designing your own responses, but it cannot tell you exactly what to do. This will depend greatly on the particular nature of your local problem. In the interest of keeping the guides readable, not every piece of relevant research has been cited, nor has every point been attributed to its sources. To have done so would have overwhelmed and distracted the reader. The references listed at the end of each guide are those drawn on most heavily; they are not a complete bibliography of research on the subject.
- **Are willing to work with others to find effective solutions to the problem.** The police alone cannot implement many of the responses discussed in the guides. They must frequently implement them in partnership with other responsible private and public bodies, including other government agencies, non-governmental organizations, private businesses, public utilities, community groups, and individual citizens. An effective problem-solver must know how to forge genuine partnerships with others and be prepared to invest considerable effort in making these partnerships work. Each guide identifies particular individuals or groups in the community with whom police might work to improve the overall response to that problem. Thorough analysis of problems often reveals that individuals and groups other than the police are in a stronger position to address problems and that police ought to shift some greater responsibility to them to do so. Response Guide No. 3, *Shifting and Sharing Responsibility for Public Safety Problems*, provides further discussion of this topic.

The COPS Office defines community policing as "a philosophy that promotes organizational strategies, which support the systematic use of partnerships and problem-solving techniques, to proactively address the immediate conditions that give rise to public safety issues such as crime, social disorder, and fear of crime." These guides emphasize *problem-solving* and *police-community* partnerships in the context of addressing specific public safety problems. For the most part, the organizational strategies that can facilitate problem-solving and police-community partnerships vary considerably and discussion of them is beyond the scope of these guides.

These guides have drawn on research findings and police practices in the United States, the United Kingdom, Canada, Australia, New Zealand, the Netherlands, and Scandinavia. Even though laws, customs, and police practices vary from country to country, it is apparent that the police everywhere experience common problems. In a world that is becoming increasingly interconnected, it is important that police be aware of research and successful practices beyond the borders of their own countries.

Each guide is informed by a thorough review of the research literature and reported police practice, and each guide is anonymously peer reviewed by a line police officer, a police executive, and a researcher prior to publication. The review process is independently managed by the COPS Office, which solicits the reviews.

For more information about problem-oriented policing, visit the Center for Problem-Oriented Policing online at www.popcenter.org. This website offers free online access to:

- The *Problem-Specific Guides* series
- The companion *Response Guides* and *Problem-Solving Tools* series
- Special publications on crime analysis and on policing terrorism
- Instructional information about problem-oriented policing and related topics
- An interactive problem-oriented policing training exercise
- An interactive *Problem Analysis Module*
- Online access to important police research and practices
- Information about problem-oriented policing conferences and award programs

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The project team that developed the guide series comprised Herman Goldstein (University of Wisconsin Law School), Ronald V. Clarke (Rutgers University), John E. Eck (University of Cincinnati), Michael S. Scott (University of Wisconsin Law School), Rana Sampson (Police Consultant), and Deborah Lamm Weisel (North Carolina State University).

Members of the San Diego; National City, California; and Savannah, Georgia police departments provided feedback on the guides' format and style in the early stages of the project.

Kimberly Nath oversaw the project for the COPS Office. Phyllis Schultze conducted research for the guide at Rutgers University's Criminal Justice Library. Nancy Leach coordinated the Center for Problem-Oriented Policing's production process. Peter Slavin edited this guide.

The Problem of Chronic Public Inebriation

This guide begins by describing the problem of chronic public inebriation and reviewing factors that increase its risks. It then identifies a series of questions to help you analyze your local chronic public inebriation problem. Finally, it reviews responses to the problem and what is known about these from evaluative research and police practice.

What This Guide Does and Does Not Cover

The problem of chronic public inebriation takes many forms and has numerous negative social consequences.† While chronic inebriation occurs in many different settings, such as the home, workplace, and bars, this guide focuses on chronic inebriation in outdoor public spaces, with a particular emphasis on chronic inebriation among those who spend a good portion of their daily lives on the street.

As used in this guide, "chronic inebriation," "chronic inebriate," or "alcoholic" refer to individuals whose lives are dominated by the use or abuse of alcoholic beverages such that they have substantially withdrawn from conventional society.[1, ‡]

Chronic public inebriation is but one aspect of the larger set of problems related to alcohol abuse and street disorder. This guide is limited to addressing the particular harms created by chronic public inebriation. Related problems not directly addressed in this guide, each of which requires separate analysis, include:

† Multiple sources confirm the frequently conjoined issues of mental illness, homelessness, alcoholism and other substance abuse. See Bahr (1973), Finn (1985), Finn and Sullivan (1987), Snow and Anderson (1993), and Wiseman (1979).

‡ According to the World Health Organization, a person is alcohol dependent if he or she has three or more of the following six manifestations, occurring together for at least one month or repeatedly within one year: compulsion to drink, lack of control, withdrawal state, tolerance, salience, and persistent use (WHO 1992). The city of San Diego, California, employs a simple measure to classify an individual as a "chronic inebriate." Their criterion is whether the individual in question has been admitted five or more times to the city's sobering center within a 30-day period.

Problems Associated with Street Disorder

- Panhandling
- Disorderly behavior by mentally ill persons
- Homeless encampments
- Day laborer sites
- Student party riots
- Disorder in entertainment districts
- Disorderly youth in public places
- Indecent exposure
- Open intoxicants in public

Problems Associated with Chronic Inebriation in Private Places

- Domestic violence
- Child abuse and neglect
- Suicide
- Accidental death and injury
- Accidental fires
- Underage drinking

Other Problems Associated with Chronic Inebriation in Public Places

- Drunken driving
- Pedestrian injuries and fatalities
- Disorder in public libraries
- Disorder in public transportation systems
- Assaults in and around bars

Some of these related problems are covered in other guides in this series, all of which are listed at the end of this guide. For the most up-to-date listing of current and future guides, see www.popcenter.org.

General Description of the Problem

When chronically inebriated individuals disruptively or persistently violate community standards by being intoxicated, panhandling, acting aggressively, or passing out in places not "approved" for such behaviors, the police may be called to intervene. As is also the case in dealing with mentally ill and homeless populations, it is important to recognize that chronic public inebriation is not, in and of itself, solely a police problem. It is also a medical and social services problem. That said, a number of the problems caused by, associated with, or resulting from chronically inebriated individuals often manifest themselves as police problems, such as disorderly conduct, threats, public urination and defecation, passing out in public, thefts, and assaults.

Chronic public inebriates are nearly as likely to be victims of crime and other hazards as they are to be offenders, and some of that victimization will not be reported to police. Their inebriation leaves them less capable of defending and caring for themselves and their property. From a moral, legal, and professional standpoint, it is important to acknowledge that chronic inebriates do not forfeit the rights and expectations afforded all other members of the community just because they are caught up in a harmful or negative dynamic.

Chronic inebriates such as the one pictured here may become victims of crime, as they are less capable of defending and caring for themselves.

Evolution of Chronic Inebriation Law and Policy

As far back as ancient Egypt, public policymakers battled problems associated with chronic public inebriation.[2] Public intoxication was first criminalized by the English in 1606.[3] By 1619, criminalization of public drunkenness reached the American colonies, but it took until 1810 before treatment of public inebriates began with Benjamin Rush's "sober houses."[4]

In the United States, beginning in the mid-1960s, law and public policy began shifting away from criminalizing public inebriation to treating it as a medical and public health problem,[5, †] a shift that helped foster the idea that effective responses to chronic public inebriation would not be solely a police responsibility but would require broader community action. In 1970, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act went into effect. This act provided state and local governments with financial resources to support alcohol-abuse reduction programs. It also created the National Institute on Alcohol Abuse and Alcoholism. By 1973, states were being pressed to decriminalize public drunkenness in favor of a social model based in treatment.[6] In 1987, the federal government began funding alcohol-dependency treatment programs for homeless people.[7]

Harms Caused by Chronic Public Inebriation

Chronic public inebriation is commonly entwined with a number of specific behavioral problems and conditions, including the following:

- Sleeping in public[‡]
- Undiagnosed, untreated, or inconsistently treated mental illness[8]
- Disorderly conduct (noise, fighting, obstreperous behavior, etc.)
- Inappropriate use of public places (e.g., public libraries, sidewalks, benches, parks)
- Other substance abuse (e.g., use of or addiction to drugs)
- Public urination and defecation
- Panhandling, harassment, or intimidation of others

† U.S. courts have considered whether a homeless person might successfully invoke constitutional protections, such as the Eighth Amendment's prohibition against "cruel and unusual punishment," because they lacked a private place to drink. See, for example, Robinson v. California, 370 US 660 (1962) and Powell v. Texas, 392 US 514 (1968) for leading cases on this issue. See also McMorris (2006).

‡ The likelihood of rehabilitation among individuals who are both alcoholics and homeless is exceedingly low (Argeriou and McCarty 1993; Podymow et al. 2006; Castaneda et al. 1992; Richman and Smart 1981; Richman and Neuman 1984; Cox et al. 1998). Another body of research, however, observes success among strategies predicated on stabilizing residency as an element of substance abuse counseling (Larimer et al. 2009; Grella 1993; Coffler and Hadley 1973).

- Illegal lodging (e.g., sleeping or passing out in public places, or homeless encampments)
- Thefts and robbery (e.g., pickpocketing, robbery at ATMs, thefts from vehicles)
- Trash picking (for food or to salvage cans and bottles)
- Litter and increased public sanitation burdens
- Blocking pedestrian traffic (which can disrupt business and access to public transportation systems)
- Drug dealing
- Intimidation of other citizens (which can cause some to avoid or retreat from parks and other places where chronic inebriates gather)

Beyond street-level consequences, chronic inebriates pose a significant and disproportionate drain on public resources. In Anchorage, Alaska, almost 2,000 chronic inebriates accounted for approximately 19,000 visits to that city's sobering center in a single year.[†] Moreover, a mere 200 individuals accounted for 56 percent of all visits to the center during 2007.[9] A study in San Diego, California, reached similar conclusions,[‡] noting that the episodic emergency care demands created by chronic inebriates have a significant cumulative impact on the community's safety-response system through emergency room overcrowding, ambulance diversion, and a shortage of available bed space.[10, §] Roanoke, Virginia, provides a similar example: an analysis of that city's drunk-in-public arrests revealed that 2,642 different individuals were responsible for 4,099 incidents during 1997. Within this group, 45 individuals (1.7 percent) were responsible for 919 incidents (22.4 percent).[11, ¶]

† Throughout this document, the terms "sobering center" and "detoxification center" are used interchangeably to indicate a short-term facility where inebriated individuals can sober up in a protected environment.

‡ The City of San Diego studied the impact of 529 homeless alcoholics, many of whom also had other medical or mental illness issues, on public resources. From 2003 to 2005, 308 individuals (58 percent) were transported by emergency medical personnel 2,335 times, 409 individuals (77 percent) accounted for 3,318 emergency-room visits, and 217 individuals (41 percent) required 652 hospital admissions, resulting in 3,361 inpatient days. Health care charges totaled $17.7 million. Payment for only 18 percent of charges was received.

§ A study in the United Kingdom found that an alcoholic patient's use of health care services before getting treatment for alcohol abuse is up to 15 times greater than that of the general population, but after alcohol treatment these costs decline significantly (Malone and Friedman 2005).

¶ While a dated statistic, Bahr (1973:228) recounts that just six "alcoholic" individuals in the mid-1960s had been arrested in Washington, D.C., 1,409 times and had been incarcerated a combined total of 125 years. Figures like this are common even today.

The traditional police approach to the management of chronic inebriates has been characterized as "a rare mixture of almost paternal indulgence, strictness and an ad hoc decision-making not found elsewhere."[12] Dealing with chronically inebriated individuals also exacts an emotional toll on police officers.[13] It can lead, for example, to the following:

- Increased frustration stemming from officers' inability to render meaningful help, while at the same time knowing that the public demands they "do something."[14]
- Increased stress as a result of being thrust into situations for which they have little or no specialized training (e.g., resolving situations where a person is behaving irrationally or is mentally ill or under the influence of alcohol or other drugs).[15]
- Increased stress because they feel they are being asked to handle situations that aren't really "police problems."[16]
- Feeling overburdened at having to locate appropriate resources for or facilities willing to accept individuals in need of specialized accommodations or treatment.[17]

Taken together, chronic inebriates create a demand for service widely disproportionate to their numbers. Moreover, chronic inebriation (and its companion offenses) is often processed rapidly through criminal courts. Because individuals charged under public drunkenness statutes typically spend little time in custody, this creates a "revolving door" system in which all stakeholders suffer and service demands stay high. Beyond this, the prospect of reintegration into mainstream society is a daunting proposition for many chronic inebriates. Those individuals, who have spent so much of their lives on the streets, must relearn the basics of normal daily living. Many chronic inebriates have long-term cognitive damage from their rough lifestyles as well as underlying mental illnesses.[18], †

Factors Contributing to Chronic Public Inebriation

The level and degree of harm caused by chronic public inebriation is affected by a number of contributing factors, which may include the following:

Lack of Adequate Alcohol Treatment, Rehabilitation, and Counseling Services

This can compel police to deal with the problem solely as a criminal issue, with less than optimal results.

† Deni McLagan with Mental Health Systems in San Diego talks about the difficulties of changing decades of dysfunctional behavior among long-time chronic inebriates: "The first 30 days we're modeling social behaviors with them, such as hygiene, riding the bus, feeding themselves, taking medications. We're just trying to get the guy to shave and bathe in the first month. In the second or third, we'll get them employment."

High Concentrations of Businesses that Sell Inexpensive Alcohol

An area with many retailers of alcoholic beverages may attract chronic inebriates to the area and facilitate their problem behavior. However, hot spots—places where inebriates tend to concentrate and cause problems (e.g., parks, transit stations, the periphery of shelters, near liquor stores)—near businesses that sell alcohol do not necessarily coincide with dense clusters of the establishments themselves, nor do they coincide with areas in which general crime levels are high or with areas with a high level of lethal violence related to alcohol use.[19]

Densely Populated Areas

These areas are more likely to attract chronic inebriates, because they often are accompanied by better opportunities for procuring alcohol and the money needed to purchase it, as well as providing some measure of anonymity for inebriates.

Public Transit Stations, Trains, and Buses

Public areas tend to often serve as points of congregation for chronic inebriates, and poorly designed and managed ones facilitate problem behavior.

Laws and Regulations

While normally designed to eliminate problems, sometimes laws and regulations that facilitate the sale of single-serving containers, fortified wines, malt liquor, and other low cost/higher alcohol-content beverages are likely to increase chronic inebriates' consumption and intoxication levels, and, thereby, their problem behavior.

Laws and Public Drunkenness

The existence of laws that criminalize—and the absence of laws that decriminalize—public inebriation provide resources for a medical-treatment response will shape how police and others are able to address the problem.

A High Rate of Homelessness

Whatever its cause, homelessness is likely to coincide with a high level of chronic public inebriation, because residential stability is an important predicate for effective substance abuse treatment.[20]

Predominant Local Standards for and Sensibilities about Public Order

Each community usually has its local standards and sensibilities about public order. Some communities are considerably more tolerant than others of deviant or disorderly behavior in public. General community attitudes are usually then reflected in elected officials' attitudes towards the problem.

Police Department Operational Priorities

Like individual communities, police departments also vary. Some police agencies can afford to devote personnel to the careful management of chronic public inebriation; others cannot.

Understanding Your Local Problem

Understanding the factors that contribute to your problem will help you frame your own local analysis questions, determine effectiveness measures, recognize key intervention points, and select appropriate responses.

Stakeholders

Any systematic understanding of your particular local problem also begins with identification of those individuals and organizations within your community who are affected by or are called to respond when chronically inebriated individuals create a service demand.

The various groups of community stakeholders will likely have divergent—and sometimes conflicting—priorities, perspectives, and goals that will have to be effectively reconciled. In addition to criminal justice agencies, the following groups have an interest in the problem of chronic inebriation and should be considered for the contribution they might make in gathering information about the problem and forming systematic responses to it:

- *Social services agencies.* Government agencies and nongovernment organizations serving chronic inebriates have an interest in improving living conditions for their clients, but they also are interested in reducing the level of resources consumed by relatively few chronically needy clients. They also have data specific to certain individuals, service areas, and groups that police may not have as well as expertise and resources to improve responses. These agencies and organizations may include those focused on issues related to the homeless, alcohol or substance abuse and addiction, mental illness, veterans, probationers and parolees, the chronically unemployed, and displaced persons.

- *Health care and emergency medical service providers.* These organizations may be public or private. Along with the police, these organizations interact with many chronically inebriated individuals on a routine or repeated basis, or both. Like social service agencies, they may have data, expertise, and resources otherwise unavailable to other system actors. These organizations are frequently the frontline portal through which chronic inebriates are offered sobriety counseling; they also identify physical and mental health issues that might otherwise go unattended. They also bear a considerable share of the financial burden associated with the treatment and care of chronically inebriated individuals.

- *Religious and charitable organizations.* As with social services agencies, these groups are interested in improving the daily lives of the populations they serve. Rather than seeking broader solutions to individual problems, religious and charitable organizations may tailor their efforts to more immediate needs, such as food, clothing, heat, and shelter. These organizations may also provide monetary support for programs. Likewise, their staff and congregations can be valuable sources of volunteers. Religious organizations may help shape the moral or ethical content of public policy discussions about community responses to chronic public inebriation.

- *Residents who live near, work, or travel through areas where chronic inebriates routinely gather.* People who live near parks, liquor stores, public transit stations, clinics, or other service locations frequented by chronically inebriated individuals may be especially prone to unwanted interaction with this population. This part of the community often suffers disproportionately from crimes committed by chronic inebriates. They may be the victims of aggressive panhandling, petty theft, property damage, or verbal or physical assaults. They may simply experience annoyance or discomfort at their "forced" proximity to individuals whom they may take to be irrational, diseased, unclean, bothersome, or criminal. Their interests may be satisfied by simply displacing or pushing the problem individuals out of their immediate area. Even so, these residents may be able to provide you with information about specific chronically inebriated individuals and the particular nature of crime and disorder in their area.

- *Businesses.* Businesses can be both the frequent targets and unwitting enablers of crime and disorder that can accompany a population of chronically inebriated individuals. Where certain merchants and restaurant owners may regard this population as a liability (for having to begrudgingly tolerate the use of their premises or imposition upon their clientele), a liquor or convenience store owner may have a vastly different view. Because of this duality, local business owners may or may not be motivated to support a given local solution. That said, business owners may need to be educated as to how a given response might benefit them, even if it appears on its face to hold negative consequences (e.g., a decline in sales due to sales restrictions).

- *Media.* Local media coverage can influence how the public perceives the problem of chronic inebriation. Media reports centered on chronic inebriation and the broad public costs associated with it will doubtless raise awareness of the issue. Good investigative journalism about chronic public inebriation can supplement your own analysis of the problem. Unbalanced or overly editorialized coverage of the problem, however, may work against you. Therefore, it is essential to involve members of the press early in your planning efforts. If properly managed, the media can be a potent ally in communicating program goals and tailoring public expectations to the realities at hand.

- *Chronically inebriated individuals.* It is perhaps an obvious point, but the chronically inebriated themselves have a central stake in the public response to them. Though little publicized, chronic public inebriates may experience victimization at the hands of both the public as well as other chronic inebriates, some of which goes unreported. Chronic inebriates themselves have information you need about criminal victimization and risky behavior within their community. Understanding chronic public inebriates as both "victims" and "offenders" is key to a more effective response. Understanding their perspectives, attitudes, and expectations is an important part of developing effective strategies to combat the problem.

- *Regulatory agencies.* The cooperation of organizations that regulate or license the sale of alcohol may be crucial to the success of any response predicated on changing alcohol availability. Moreover, these agencies may have a familiarity with sales patterns and practices that could be useful in understanding your local problem.

Asking the Right Questions

Based on the data and input from community stakeholders, the nature and scope of local problems will start to come into focus. Before planning your response, you need to establish the basic scope and dimension of your problem. Some relevant questions might include:

Incidents

- What are the primary types of incidents related to chronic public inebriation (e.g., disorderly conduct, medical distress, panhandling, loitering) that generate calls for police service?
- How do the nature and seriousness of incidents involving chronic public inebriation vary across the service area?
- What is the cost to the local government to respond to these incidents (including police, emergency medical services (EMS), and detoxification costs)?

Offenders

- Do a majority (or even a significant number) of incidents involve the same core group of chronic inebriates?
- Are there situational or background characteristics common to frequent or recurrent offenders (e.g., homelessness, mental illness, veterans' status)?
- How much prior contact have individual chronic inebriates had with police? What has been the nature of that contact (e.g., as victim, serious-crime offender, petty-crime offender, nuisance offender)?
- Are chronic public inebriates long-time residents of your community or recent arrivals?

Victims

- Who commonly complains about the behavior of or conditions created by chronic public inebriates (e.g., merchants, passersby, residents, or other street people)?
- What specifically is the nature of the complaints (e.g., loss of business revenue, reduced access to public spaces, intimidation, unsightliness or odor, concern for inebriates' welfare, criminal victimization)?
- How commonly are chronic public inebriates victims?
- What is the nature of chronic public inebriates' victimization (e.g., theft of their property, assault, harassment, exposure to hazards)?

Locations and Times

- Do complaints and incidents tend to cluster around particular places; or around particular seasons, days, or times of day? (The identification of chronic inebriation hot spots in your community may be apparent upon casual observation, or it may require detailed mapping and analysis to discern.)
- What features of identified hot spots or times seem to contribute to the complaints and incidents?

Current Responses to the Problem

- How are officers currently authorized, trained, and expected to handle incidents involving chronic public inebriation?
- How do officers actually handle incidents involving chronic public inebriation? (Some officers might have developed novel ways of handling these incidents; some of these will be appropriate and effective, and some will not).
- What facilities and resources are available to officers to assist them in responding to the needs of chronic public inebriates?

Measuring Your Effectiveness

Measurement allows you to determine to what degree your efforts have succeeded and suggests how you might modify your responses if they are not producing the intended results. Even though the seriousness of a given problem may drive a desire for immediate action, the most successful responses are borne out of careful planning. As such, you should take measures of your problem *before* you implement responses to determine how serious the problem is and *after* you implement them to determine whether they have been effective. You should take all measures in both the target area and the surrounding area. For more detailed guidance on measuring effectiveness, see Problem-Solving Tools Guide No. 1, *Assessing Responses to Problems: An Introductory Guide for Police Problem-Solvers* and Problem-Solving Tools Guide No. 10, *Analyzing Crime Displacement and Diffusion*.

In thinking about the relative success or failure of a given response, you will want to consider exactly what goals and outcomes are desirable, appropriate, and realistic for your community. Some communities that have employed the following responses regard success as the mere removal of an obvious problem from public view (e.g., reducing the number of chronic inebriates in the city parks). Some are much more holistic, defining success not only in terms of removing public disorder or lessening certain service demands, but as a measure of facilitating positive change in the lives of the chronic inebriates themselves. While broad proclamations of success or failure are often difficult to make without some qualification, you will likely need to assess any response with a mixture of both qualitative and quantitative techniques to gauge your effectiveness.

Evaluation (or assessment) measures are of two types: process measures and outcome measures. Process measures show the extent to which responses were properly implemented. Outcome measures show the extent to which the responses reduced the level or severity of the problem. Because your local circumstances may differ from those of other places, you might develop additional questions unique to your local problem. The following are potentially relevant measures:

Process Measures

- Improved understanding of providers' respective roles, responsibilities, and options at each point in the process
- Adequacy of resources (e.g., personnel, facilities, vehicles, and programs) to meet the service demand
- Reduced volume of intoxicating beverage sales to chronic inebriates
- Increased participation among chronic inebriates in alcohol- or drug-treatment programs
- Reduced public costs of responding to chronic public inebriation

Outcome Measures

- Reduced number of arrests or involuntary detentions of chronic public inebriates
- Reduced number of calls for police service related to chronic public inebriation
- Reduced number of incidents in or near homeless shelters and sobering centers
- Reduced victimization of chronic inebriates (e.g., fewer crimes, fewer deaths and injuries)
- Reduced number of calls for emergency medical service related to chronic inebriation
- Reduced number of emergency room visits, hospital admissions, and hospital stays by chronic inebriates
- Reduced recidivism among chronic public inebriates, especially among most frequent offenders
- Reduced public costs for chronic public inebriates
- More positive perceptions of the problem of chronic public inebriates in affected communities
- Increased legitimate use of public areas (e.g., parks and sidewalks) once abdicated to chronic inebriates

Responses to the Problem of Chronic Public Inebriation

Your analysis of your local problem should give you a better understanding of the factors contributing to it. Once you have analyzed your local problem and established a baseline for measuring effectiveness, you should consider possible responses to address the problem.

The following response strategies provide a foundation of ideas for addressing your particular problem. These strategies are drawn from a variety of research studies and police reports. Several of these strategies may apply to your community's problem.

It is critical that you tailor responses to local circumstances, and that you can justify each response based on reliable analysis. In most cases, an effective strategy will involve several different responses. Law enforcement responses alone are seldom effective in reducing or solving the problem. This has proven especially the case in confronting chronic inebriation.[21]

Do not limit yourself to considering what police alone can do: carefully consider whether others in your community share responsibility for the problem and can help police better respond to it. In some cases, the responsibility of responding may need to be shifted toward those who have the capacity to implement more effective responses. For more detailed information on shifting and sharing responsibility, see Response Guide No. 3, *Shifting and Sharing Responsibility for Public Safety Problems*.

For further information on managing the implementation of response strategies, see Problem-Solving Tools Guide No. 7, *Implementing Responses to Problems.*

General Considerations for an Effective Response Strategy

1. **Educating the community about the problem.** Unless community members are directly affected by chronic public inebriation, they may be unaware of the broader harms caused by the problem or fail to understand the factors that give rise to it and, as a result, fail to support your planned responses. It is especially important to convey to local people that arrest and punishment of chronic inebriates alone will not solve the problem.

2. **Developing community support for your response.** Community support is crucial to the long-term viability of your response strategy. Many of the specific responses described below require changes that will directly affect business, government, and social service practices. If, for example, the police response is perceived—rightly or wrongly—by community advocacy groups, charities, or social service providers as being heavy handed or counter to human dignity, community support for your efforts may suffer.

3. **Decriminalizing public inebriation.** Many, but not all, states and local jurisdictions have shifted toward a medical treatment model to address chronic public inebriation. Decriminalizing chronic inebriation shifts the bulk of the processing of this group from criminal justice to social service agencies. This can lead to confusion, resentment, and misunderstanding among the professionals who are involved. If your jurisdiction is newly shifting toward decriminalizing public inebriation, it is important that you understand and anticipate the following implications:

Combined responses. Most jurisdictions blend therapeutic and punitive mechanisms for processing chronically inebriated persons.[22] Try to avoid allowing decriminalization and a medical treatment model to be characterized as a soft or weak approach to the problem.

Diverse special populations. Local populations of chronic inebriates are diverse in composition. Some chronic inebriates will be homeless; others will not (conversely, some homeless persons will be chronically inebriated, and others will not). Some members of both the homeless and chronic-inebriate populations will also have mental illnesses, other substance abuse problems, or other serious problems. In short, the homeless and the chronically inebriated are neither wholly discrete nor wholly overlapping groups. Decriminalization efforts should recognize the diverse and complicated issues these special populations present.[23]

Dispersed problem areas. In a previous era, "skid rows" served as a concentration point for the destitute, drunk, and disaffiliated. The combined forces of urban renewal, gentrification, and preservation have led these concentrations to disperse. Instead, smaller "mini-skid rows" have emerged in many places.[24]

Local enforcement attitudes. Those responsible for enforcing applicable laws have differing sensibilities and priorities. Many factors influence the character of local law enforcement: community culture, dominant policing style, administrative priorities and style, individual officers' priorities, beat conditions for patrol officers, and so forth.[25]

Inadequacy of judicial action alone. Decriminalization of chronic inebriation tends to reduce rather than end the use of criminal processing to deal with public drunkenness.[26] When chronic inebriation is effectively decriminalized by court decrees alone, rather than by carefully planned legislation and properly resourced alternatives, it can cause confusion among police who might perceive decriminalization as undermining their capacity to deal with the problem. Deprived of the ability to charge individuals with public drunkenness, police may simply reclassify other behaviors to align with available sanctions (e.g., charging inebriates with such catch-all offenses as disorderly conduct), thus defeating the diversionary goal of decriminalization.[27, †] Ideally, police should be involved in planning a decriminalization model and be continually involved as implementation strategies are developed.[28]

Organized change. For decriminalization of chronic inebriation to have sustainable and positive outcomes, it must be undertaken by a group of organizational-level stakeholders whose shared goals are mirrored in the policy change.[29]

Anticipating and resolving goal conflict. Because interorganizational goals may not be aligned or reflected in the simple act of decriminalization, it can result in conflict or confusion as to new roles and responsibilities.[30] Decriminalization invariably places police in closer contact with therapeutic service providers (i.e., sobering centers, hospitals, and social workers). Criminal justice and social service staff often have differing operational mandates, and the tension between the two spheres must be addressed.[31]

Shifting costs. Reducing the role of the criminal justice system in processing chronic inebriates implies that other actors and organizations in society will assume the associated costs.[32] Some of the costs that might have to be redistributed in a decriminalization model are: personnel to provide custodial and medical care of inebriates and perhaps to actively seek out chronic inebriates in public places; detoxification facilities in lieu of jail cells; transportation of inebriates to sobering centers; judicial hearing officers to hear contested involuntary commitments; and new recordkeeping systems.

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† The police manage Skid Row residents in ways that are often only obliquely matters of law enforcement (Bittner 1967). Police often rely on "outdated, ambiguous and possibly unconstitutional laws" in dealing with chronic inebriates (Gammage, Jorgensen, and Jorgensen 1972:39).

Legal interpretations. Even as legal and social sensibilities have changed with regard to the problem of chronic inebriation, the decriminalization question has not been settled fully. Some courts continue to see police enforcement of various laws prohibiting conduct associated with routine life activities (such as sleeping and bathing) in public places as unconstitutional.† Such legal decisions greatly influence and complicate the police role in dealing with chronically inebriated individuals.[33]

Community attitudes. Efforts to address chronic inebriation as a social problem may be met with hostility or indifference from the public. Some community members may regard chronic inebriation as self-induced and resent the allocation of public resources to address it. Because the chronic inebriate is seen as unproductive (and by extension, morally flawed) or "infectious,"[34] rendering assistance may be regarded as enabling the negative behavior. As such, some community members may prefer that chronic inebriates be kept "out of sight and out of mind."

4. **Tailoring interventions to individual needs.** Because not all chronic inebriates have the same medical, psychological, and social needs, the system must have sufficient flexibility if it is to effectively address individual circumstances. [35], ‡ At a minimum, interventions should differentiate among individuals in each of the four general behavioral/need classifications of chronically inebriated persons described below.§

† In *Jones* v. *City of Los Angeles* [444 F.3rd 1118 (2006)], the Ninth U.S. Circuit Court of Appeals ruled that the homeless plaintiffs had been subject to "cruel and unusual punishment" as a result of the city's enforcement of a local ordinance aimed at preventing people from sitting or sleeping on city streets, sidewalks, and alleys.

‡ Chronic alcohol abuse is known to cause or contribute to the following health problems: *Central nervous system:* alcoholic dementia, blackouts (anterograde amnesia), central pontine myelinosis, cerebellar degeneration, epilepsy, Marchiavia-Bignami syndrome, polyneuropathy, sleep impairment, Wernicke-Korsakoff syndrome, withdrawal, and delirium tremens; *Muscles:* acute or chronic myopathy, cardiovascular system, Beriberi heart disease, cardiac arrhythmias, cardiomyopathy, and hypertension; *Metabolism:* hyperlipidaemia, hyperuricaemia, hypoglycaemia, and obesity; *Endocrine system:* pseudo-Cushings syndrome; *Respiratory system:* chest infections; *Gastrointestinal system:* acute gastritis: carcinoma of mouth, oesophagus, or large bowel; liver disease; and pancreatic disease; *Haemopoiesis:* macrocytosis, thrombocytopenia, and leucopenia; *Bone:* osteoporosis and osteomalacia (Kumar and Clark 2002).

§ While a more comprehensive taxonomy might be possible, this simple distinction is sufficient to distinguish among the major categories of client need. For a fuller explanation of this scheme, see Vermont Public Inebriate Task Force (2010).

A Sample Triage Plan

To determine an inebriated individual's needs, first responders should ascertain whether:

1. **Subject is inebriated, but not incapacitated.** Subject may be processed without medical or mental health placement.
2. **Subject is medically unstable due to physical or mental health issues (or co-occurring diagnoses).** A medical or mental health placement is needed.
3. **Subject is incapacitated, medically stable, and cooperative.** Subject could be held at supervised shelter or sobering center.
4. **Subject is incapacitated, medically stable, but exhibits aggressive, uncooperative, unpredictable, or violent behavior.** Protective custody should be available as a placement option.

While the four categories of the Sample Triage Plan do not address all contingencies—such as pending criminal charges or warrants—policy makers should ask whether decision-making mechanisms of this kind are in place to direct inebriated subjects to the proper level of service and supervision. As above, this also implies that relevant system staff will be trained to perform this triage and that all parties adhere to a consistent scale for assignment.

Source: Adapted from Vermont Public Inebriate Task Force (2010).

5. **Providing integrated social and health services.** Because many chronic public inebriates are homeless as well as having other physical and mental health issues, any effective program of responses must recognize this broad constellation of needs. Necessarily then, a well-conceived response to the problem of chronic inebriation must also include elements that address these other issues. For example, responses focused on reducing homelessness—that lead to greater residential stability for an individual—might also position that person to receive regular alcoholism counseling and mental and physical health care. Increased residential stability, receipt of regular counseling, and health care, in turn, might reduce that person's motivation to commit petty crimes or to engage in inappropriate uses of public space and other negative acts.[36]

6. **Training service providers to respond appropriately.** While many community service providers—such as police officers, EMTs, doctors, social workers, and lawyers—already possess extensive technical and specialized training in their particular area of competency, most successful responses involve a level of coordination, shared goals and integrated procedures across professional boundaries. With any changes to a given agency's standard operating procedures—especially those that require the cooperation of individuals in other organizations—a period of retraining to establish new policy or procedural guidelines will be necessary. As with community and business leaders, those individuals who are responsible for implementing your programs will need to be educated as to what the new expectations and procedures are, and why these changes are necessary and important.

Building on the research concerning alcoholism and homelessness, stakeholders in Seattle, Washington, developed a unique response that took aim at the enormous resource burdens chronically inebriated individuals were placing on the area. A group of 199 individuals who presented among the highest costs on the system were selected for no-cost housing in the Housing First residential facility. They were offered free meals and on-site health services, but there was no requirement for substance abuse treatment placed on them. Costs associated with these services averaged $1,220 per person per month. After one year, a program evaluation revealed that in the year preceding placement at Housing First, the program participants had incurred over $8 million in collective costs (jails, EMS, hospital, emergency department, detoxification, Medicare, and so forth). After one year in the program, participants' costs had dropped to $4 million. The average daily alcohol consumption among residents had dropped from 15.7 to 10.6 drinks per day. From these results, researchers concluded that stable housing, coupled with ready access to health services, while posing considerable up-front expense, could yield marked reduction in several related system costs (Levin 2009). A subsequent study observed similar results: after one year in the Housing First residential program, average associated monthly costs per person dropped from $4,066 to $958. The total average monthly cost per person—after factoring in housing costs—was $2,449 (Larimer et al. 2009).

Specific Responses to Chronic Public Inebriation

Restricting Alcohol Sales to Chronic Inebriates

7. **Prohibiting alcohol sales to chronic inebriates.** The central element of this response is to prohibit the sale or distribution of alcoholic beverages to specific individuals deemed to be chronic inebriates and who engage in a disproportionate amount of undesirable behavior. Decreased alcohol availability should yield a similar decrease in problems caused by chronic inebriates.†

   Some communities implementing this response have "dusted off" existing, but unenforced, laws prohibiting alcohol sales to "habitual drunkards."[37] For others, new enabling legislation may be required. The Green Bay (Wisconsin) Police Department established a "no-serve" list as one element of their overall response to chronic public inebriation.[38] The criteria for being placed on their no-serve list included: having three or more alcohol-involved arrests in a 3-month period; being incapacitated by alcohol, requiring detoxification three or more times in a 3-month period; or involvement in behavior within a particular area of town that resulted in a police call for service. The police then sought to educate business owners in the area as to their legal responsibility to decline service to listed individuals. An interesting dimension of Green Bay's response is that the initiative survived a challenge by a local civil rights group, although not through a formal court ruling.[39] You should consult your legal counsel to ensure that a similar approach would be valid in your jurisdiction.

   A similar approach was taken by the Pinellas Park (Florida) Police Department.[40] Its analysis of the problem revealed that a very small group of individuals (28) was responsible for the bulk of arrests and other alcohol-involved calls for service. Pinellas Park police similarly relied on a disused "habitual drunkard" ordinance to target individuals. To be placed in what the Pinellas Park police refer to as "the Book," one must have been convicted of driving under the influence, or have three convictions for disorderly intoxication.[41] Once compiled, the Book was annotated with photographs of the identified individuals. As in Green Bay, the police then educated area business owners as to their legal obligations. The Book was presented to 25 area alcohol vendors. As enforcement of the ordinance began, there was an immediate drop in calls for service related to chronic inebriation. To make certain the information contained in the Book was current, it was reviewed on a monthly basis and revised as necessary.

† Although the circumstances were somewhat unique, a total ban on alcohol sales and possession in Barrow, Alaska, provided further evidence that reducing the availability of alcohol reduced alcohol consumption and attendant problems, even among chronic public inebriates (North Slope Borough Department of Public Safety 1995).

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Many cities have instituted alcohol impact areas that either restrict or prohibit alcohol consumption.
http://en.wikipedia.org/wiki/File:Streetdrinking24102008148.jpg

8. **Establishing alcohol impact areas.** Alcohol Impact Areas (AIAs) are designed to address the problem of chronic inebriation by placing geographically linked restrictions on the sale, consumption, purchase privileges, or licensing related to alcoholic beverages. Cities that have established AIAs include Spokane, Seattle, and Vancouver, Washington, and Portland, Oregon.

   There are a number of different strategies by which cities have approached AIA regulation. Perhaps the most common response is to enact restrictions on the sale of particular types and sizes of alcoholic beverages—with an emphasis on those most commonly purchased by chronic inebriates—within a specific geographic area. Restricted items might include fortified wine, high-alcohol-content beer,[42] malt liquor, and beverages packaged as single servings or containers under a certain volume.† Generally, what evolves is a list of banned beverage brands, types, and sizes that is disseminated to liquor vendors in the AIA. Once developed and distributed, the list must be monitored and amended as new products enter the market.

   Responsibility for enforcing AIA regulations might shift from police to an alcohol license regulating agency. Establishing an AIA may require changes in laws at both a state and local level. In Washington State, the state legislature enacted guidelines for AIAs that were then implemented by local governments.[43]

† Under Washington State law regarding AIAs, restricted beer and wine products must have minimum alcohol content of 5.7 percent by volume and 12 percent by volume, respectively.

9. **Restricting panhandling.**† Controlling panhandling in areas where chronic public inebriation is prevalent can reduce a primary source of money that chronic inebriates use to purchase alcohol. Some police agencies have discovered that increasing the time and effort required of chronic inebriates to acquire the money needed to buy alcohol has the effect of reducing the quantity of alcohol they consume in a day, reducing the likelihood that they will reach levels of alcohol incapacitation on any given day.[44]

Facilitating Counseling, Treatment, and Social Services

Programs that offer counseling, treatment, and/or social services in lieu of incarceration often identify program candidates on the basis of their histories of alcohol-related offenses.[45] Whereas enforcement responses rely on police action, diversion interventions usually occur during, after, or in lieu of a period of incarceration, and accordingly, prosecutors, courts, or corrections agencies are more likely to assume responsibility for administering and managing diversion programs. [46] These programs vary greatly in their duration and level of comprehensiveness. They may be brief intervention strategies with a reduction in alcohol consumption as the primary goal.[47] They may focus on increasing residential stability,[48] providing medical and therapeutic services,[49] or some combination of efforts designed to align the interests of the criminal justice system with the social service and therapeutic community. Two common response techniques are described below.

10. **Using sobering centers.** Sobering centers are short-term (a few hours to overnight) facilities where individuals not in need of medical treatment can safely sober up. Sobering centers may be publicly or privately run, or some combination of the two. Under the facility's supervision, inebriated individuals use sobering centers in lieu of "sleeping it off" in local jail "drunk tanks" or out in public. These facilities afford temporary protection from predators while the individual has a diminished capacity to care for himself. Individuals are often taken to a sobering center by a special shuttle or police patrol. There they may be screened for medical problems and can be referred for medical treatment, if necessary. Many facilities provide case management services and referrals to substance abuse counseling. Sobering centers offer alternatives to more expensive hospital emergency departments and often-overcrowded jails.[50]

† See Problem-Specific Guide No. 13, *Panhandling*, for further information.

While many communities have found sobering centers to be an important element of their response strategies, when they are the primary response (or combined with a predominantly criminalization model), there is evidence they do little to interrupt the problem of chronic inebriation.[51] Other researchers have argued that the success of so-called "brief intervention" strategies is strongly dependent upon the willingness of the individual to change and the context in which the intervention is made.[52] Regardless of that debate, there is evidence that providing a safe place for chronic inebriates to sober up can help reduce calls for service and reduce victimization of the inebriates. On the other hand, inadequate detoxification resources (either the number of sobering centers or the bed space in them) is likely to result in increased behavioral problems on the street, such as panhandling.[53]

A common strategy for integrating sobering centers into the process of dealing with chronic inebriates positions these facilities as a point of assessment and decision-making for responders. For example, Escondido Community Sobering Service, run by the nonprofit group, Interfaith Community Services in Escondido, California, provides a place for noncombative and other low-risk inebriates to "sleep it off." The center enjoys both police and community support, because it reduces taxpayer expenditure associated with inebriates and frees the police to attend to other matters.[54] This partnership demonstrates one way in which public-private partnerships can facilitate mutual goals.

Prior to the center's opening, officers might spend as much as 3 hours booking an inebriate into jail. The availability of this center greatly shortens the officer's investment of time. Moreover, inebriates who agree to sober up at the center aren't necessarily given a criminal citation, so long as they are cooperative. Faced with the choice between 4 hours at the center or 12 hours (or more) in jail, many find the center attractive. The center also represents considerable savings for the community. According to the nonprofit that manages the center, the average cost per intake is approximately $38, compared to $138 for jail housing and an additional $100 in police salaries associated with processing.

Permitting an inebriate use of this alternative is, in part, a matter of police discretion. Not everyone taken into custody has the option of going there. They cannot be a flight risk nor can they have been taken into custody as the result of fighting. Additionally, the inebriate must heed the direction of center staff, which includes waiting for clearance to leave.

Many communities have used analysis of sobering-center admissions to develop more informed strategies. Analysts for the San Diego Serial Inebriate Program discovered that detoxification of chronic inebriates in area hospital emergency rooms created an overflow crisis; inebriates used so much bed space that emergency rooms had to divert incoming patients to other hospitals. Moreover, they discovered that local detoxification center policy was inadvertently fostering a "revolving door" of serial offenders by refusing to admit individuals who had been through its intake five times within the past 30 days; those individuals would then commonly be booked into jail, only to be released 4 to 24 hours later, without criminal charges. Realization of the detoxification crisis prompted the police and community to develop a program in conjunction with a local detoxification center, the prosecutor's office, and local courts. The program was based on a model developed for drug courts in which reduction of repeated offending was a primary goal. This was accomplished through graduated sentencing in which mandatory attendance at Alcoholics Anonymous meetings was a central feature. In so doing, the demand was reduced both on sobering centers and area emergency rooms.[55]

11. **Providing alcohol treatment in jail or under court order.** The place of rehabilitation and substance abuse treatment as an alternative or adjunct to incarceration has been studied for many decades.[56] Arrest and prosecution can be the gateway to treatment.

    In a study of responses that presage modern drug courts, researchers near Los Angeles tracked the re-arrest rates of individuals who, in exchange for a suspended sentence, agreed to enter residential treatment for alcoholism.[57] The recommended length of stay was 90 days, and the facility could not legally compel an individual to remain for the duration. If individuals successfully completed treatment, they were given 177 days' credit. If they were rearrested within 12 months from the date of referral, the suspended sentence was enforced. The researchers found a nearly 15 percent decline in the re-arrest rate of people who completed the program. Interestingly though, the average number of days spent incarcerated during the first post-treatment year rose markedly. The researchers note that judges had a tendency to impose longer jail terms after discharge from a rehabilitation center, but there were nonetheless significant savings for the justice system. The researchers attribute these savings to less frequent arrests and arraignments.[58]

Some research also notes a connection between initial sentence length and receptivity to treatment. In a study of the San Diego Serial Inebriate Program, researchers found that the threat of jail is an important inducement for treatment. Only about half of those who entered the system chose treatment, but they chose it more often when the jail term they faced was longer. Treatment was accepted by 20 percent of those who faced a sentence of 30 days or fewer as opposed to 63 percent of those looking at 150 days or more in jail.[59]

Another example of jail diversion treatment can be found in St. Louis. Mirroring what has already been well established, almost half of the St. Louis study subjects reported "stable housing" as the one area of life in which they most needed help. This was followed very closely by "problems of mental stability and coping with everyday life."[60] The St. Louis jail diversion project was successful in fostering many positive outcomes for individuals, and also produced improved organizational cooperation and coordination between criminal justice system staff and mental health/substance abuse treatment providers.[61]

Changing the Way Public Spaces Are Used

12. **Restricting chronic public inebriates' access to public spaces.** Managers of public spaces, including police, using the legal principles of eviction, trespass, and conditional release from incarceration, might ban targeted chronic inebriates from specific public spaces.[62] Banishment might, with the cooperation of merchants and facility managers, extend to businesses and social service facilities, such as homeless shelters, so as to avoid simply displacing the serial offenders and their problematic behavior. You should consult with local legal counsel to ensure that any place bans are implemented lawfully.

    In instances where a very small number of individuals is at issue, responses that simply disperse or move the problem may be acceptable on some level. In situations where larger groups of individuals are involved, more comprehensive responses may be necessary.

An analysis by San Diego police revealed that the bulk of problems related to chronic inebriation at the Clairemont Town Mall was traceable to the actions of just four individuals. Moreover, it was discovered that officers from the private security company (contracted by mall management) had developed a complacent attitude with regard to these four people. The police worked with the property manager and interviewed merchants, mall patrons, and the inebriates themselves, and devised a solution. The interviews disclosed that the inebriates used the mall because panhandling, drinking, and improper lodging were tolerated there. Remarkably, the private security officers had permitted the individuals to live in an inoperable motor home located in an adjacent parking lot. When those involved took a series of measures—educating mall business owners and staff about appropriate responses to the problem, analyzing the environmental conditions that facilitated property misuse, replacing the security company, and obtaining restraining orders—the four individuals left the property and did not return.

Source: San Diego Police Department, Northern Division (2001).

13. **Altering environmental conditions to discourage chronic inebriates' offensive behavior.** Managers of places where chronic inebriates tend to congregate or cause substantial problems should analyze and alter the characteristics of a given location to reduce opportunities for its inappropriate use.† Stakeholders should give particular thought to those environmental features of known hot spots that might make it more or less inviting to chronic inebriates as a place to drink (e.g., proximity to alcohol outlets, seclusion from eyes of police, sufficient privacy to relieve themselves, access to foot traffic for panhandling, comfortable seating, protection from the elements). In short, responses should be informed by asking what changes to a given area might discourage misuse.

† For more detailed guidance on analyzing crime opportunities at particular places, see Problem-Solving Tools Series Guide No. 8, *Using Crime Prevention Through Environmental Design in Problem-Solving.*

Police in Santa Ana, California, addressed a significant set of problems in the Harbor Plaza Shopping Center through a combination of efforts, including changes to the surroundings that facilitated misuse of the area. Most of the latter changes were simple: locking a dumpster that had been used as shelter and for foraging, closing access to secluded areas with locked gates, encouraging merchants to lock and restrict use of restrooms to customers, replacing burned-out lights, and removing pay phones that were serving as a "business center" for prostitution and other undesirable activities. None of these actions was particularly expensive or logistically complex, but in concert, they had an impact.[63]

Responses with Limited Effectiveness

14. **Increasing criminal penalties.** Increased criminal penalties in and of themselves do little to curb crime associated with chronic inebriation.[64] The primary flaw in this approach owes to the simple fact that the deterrence supposedly induced by harsher sanctions assumes the would-be offender is engaged in a calculation of costs and benefits, either before making the decision to become a chronic inebriate or in deciding to sustain that pattern of behavior.

    There is, however, one caveat to the general ineffectiveness of increased jail terms for alcohol-related offenses. In jails where chronic inebriates may receive alcohol counseling while serving time, they need to be incarcerated long enough that the treatment can be effective.[65] Where this is possible, longer incarceration might position the inebriate to receive more sustained counseling than otherwise. For some treatment models, legal coercion may be a necessary component,[66] but coercion or extended incarceration, except under carefully defined circumstances and usually in conjunction with other responses, appears insufficient to cause meaningful change.†

† When the St. Petersburg (Florida) Police Department began aggressively enforcing chronic inebriation laws in the city's downtown, many of the "regulars" relocated to other jurisdictions. When interviewed about their decision, these regulars reported what motivated them to move was not the threat of more jail time but the fact no smoking was permitted in the St. Petersburg jail (St. Petersburg Police Department 1997).

15. **Conducting enforcement sweeps or crackdowns alone.**† As with increased criminal penalties, any police response that is predicated solely on a deterrence model typically has little lasting value in addressing chronic inebriation. Crackdowns on chronic inebriates often focus on "hot spots" like parks, transit stations, and near shelters and liquor stores where inebriates tend to cluster and cause problems.‡

    An increase in crackdowns and "zero tolerance" policing of uncivil behavior (drunkenness, loitering, and so on) gained favor as police agencies moved away from traditional-style policing and embraced "broken windows" approaches.[67] While crackdowns and similar approaches can produce change that is sudden, obvious and drastic, as a stand-alone response, they hold little promise of engendering a lasting impact on chronic inebriation.§ As noted above about increases in jail time, in some instances crackdowns might be used to put a large number chronic inebriates in (albeit coerced) contact with treatment and other therapeutic, medical, or social service resources, provided jail-based programs are in place to receive them.

† See Response Guide No. 1, *The Benefits and Consequences of Police Crackdowns,* for further information.

‡ While beyond the scope of this guide, an expansive literature on the subject of "hot spot" policing exists. See Weisburd, Maherand, and Sherman (1991), Clarke (1983), Brantingham and Brantingham (1981, 1984), Bursik and Grasmick (1993).

§ See Response Guide No. 1, *The Benefits and Consequences of Police Crackdowns*, for further information.

Appendix: Summary of Responses to Chronic Public Inebriation

The table below summarizes the responses to chronic inebriation, the mechanism by which they are intended to work, the conditions under which they ought to work best, and some factors you should consider before implementing a particular response. It is critical that you tailor responses to local circumstances and that you can justify each response based on reliable analysis. In most cases, an effective strategy will involve implementing several different responses. Law enforcement responses alone are seldom effective in reducing or solving the problem.

Response No.	Page No.	Response	How It Works	Works Best If…	Considerations
General Considerations for an Effective Response Strategy					
1	24	Educating the community about the problem	Increases stakeholder acceptance of responses; improves police understanding of community needs and concerns	…done consistently and broadly at each stage of response planning and execution	Community is not single-minded; may be multiple constituencies with divergent perceptions of the problem and different sensibilities as to what constitutes an appropriate response
2	24	Developing community support for your response	Enhances resources needed to address problem; reduces criticism of police efforts to address problem	…done consistently and broadly across many parts of the community and at each stage of response planning and execution	May require considerable resources and effort to develop mutual understanding of the problem's scope and appropriateness of the proposed response; requires continual reinforcement and cultivation

Response No.	Page No.	Response	How It Works	Works Best If…	Considerations
3	24	Decriminalizing public inebriation	Shifts resources from punishment to medical treatment which is more likely to reduce chronic inebriation	…if undertaken by organization-level stakeholders whose shared goals are mirrored in the change	System staff may have conflicting organizational cultures that are resistant to change; staff may not accept new procedures or responsibilities without considerable retraining; can be cost intensive and logistically complicated; public may perceive change as condoning negative behavior
4	26	Tailoring interventions to individual needs	Differentiates between the various needs of chronic inebriates	…resources and procedures are in place to address the demands created by each group	Can be resource intensive; may require a great deal of planning to make category-appropriate responses available
5	27	Providing integrated social and health services	Addresses various issues that compound one another	…mental health, housing, and other social services are integrated into the broader strategy	Requires that system staff coordinate responses to ensure individuals are given access to whatever services or treatment they need
6	28	Training service providers to respond appropriately	Improves understanding of goals and organizational roles and responsibilities which improves overall response	…each responder understands his/her role and responsibilities in the process as well as that of others	May require a great deal of planning and education of system staff, some of whom may be resistant to new duties or procedures

Response No.	Page No.	Response	How It Works	Works Best If…	Considerations
Specific Responses to Chronic Public Inebriation					
Restricting Alcohol Sales to Chronic Inebriates					
7	29	Prohibiting alcohol sales to chronic inebriates	Increases chronic inebriates' difficulty in procuring alcohol which reduces overall consumption and intoxication levels	…police and alcohol merchants coordinate efforts to identify restricted individuals and restrictions are honored and enforced	May be resource intensive to identify and process restricted individuals; typically requires enabling legislation; requires compliance of alcohol vendors, who may perceive restrictions as detrimental to their business; requires consistent database management of restricted individuals
8	30	Establishing alcohol impact areas	Increases chronic inebriates' difficulty in procuring alcohol which reduces overall consumption and intoxication levels	…supported by alcohol vendors in the alcohol impact area and if done in conjunction with the provision of other social, medical, and treatment services	Typically requires enabling legislation; requires compliance of alcohol vendors who may perceive the restrictions as detrimental to their business; requires regular updates to banned products lists; requires additional oversight of alcohol vendors; some displacement of problem to other areas may occur

Response No.	Page No.	Response	How It Works	Works Best If…	Considerations
9	31	Restricting panhandling	Increases chronic inebriates' difficulty in procuring alcohol which reduces overall consumption and intoxication levels	…panhandling restrictions are enforced	Laws prohibiting panhandling should be carefully drafted to survive legal challenges; some displacement of chronic inebriates to other areas might occur; some increased theft of alcohol might occur
10	31	Using sobering centers	Reduces inebriates' risks to themselves and others; promotes follow-up alcohol treatment; reduces criminal justice system costs	…done in conjunction with the provision of other social, medical, and treatment services	May be resource intensive to provide shelter for a large population of inebriates; often requires public-private coordination; may be negatively perceived as facilitating chronic inebriation; short-term treatment may be perceived as wasteful of resources by treatment staff
11	33	Providing alcohol treatment in jail or under court order	Increases inebriates' motivation to accept treatment	…the inebriate is receptive to the treatment and the treatment is provided in a sustained and consistent manner	May be resource intensive to provide treatment for a large population of inebriates; success may depend heavily on inebriates' motivation to participate in the program

Response No.	Page No.	Response	How It Works	Works Best If…	Considerations
Changing the Way Public Spaces Are Used					
12	34	Restricting chronic inebriates' access to public spaces	Removes inebriates from places where their behavior causes problems for others; discourages inebriates from misbehaving in public	…small groups of individuals cause the bulk of problems and if done in conjunction with the provision of other social, medical, and treatment services	May be resource intensive to identify and process the formal removal of each individual; requires careful attention to individuals' due process rights; some displacement of problem individuals to other areas may occur
13	35	Altering environmental conditions to discourage chronic inebriates' offensive behavior	Alters the characteristics of an area that facilitate undesirable behavior	…changes are predicated on a systematic analysis of problem area with consultation of design, engineering, or transportation specialists	Environmental changes can be costly; may require major changes in traffic flow, architecture, or other system-level features; underlying design problems can be difficult to detect
Responses with Limited Effectiveness					
14	36	Increasing criminal penalties	Intended to deter public intoxication and disorderly behavior	…used as leverage to promote alcohol treatment	Chronic alcoholism undermines deterrent effect of punishment; most problematic individuals already spend lengthy periods incarcerated with little deterrent effect
15	37	Conducting enforcement sweeps or crackdowns alone	Can quickly remove large numbers of inebriates from public view	…done in conjunction with the provision of other social, medical, and treatment services	May be perceived as unduly harsh and risks violations to individuals' due process rights; may be resource intensive; likely only to remove inebriates from public view for short term

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About the Author

Matthew Pate

Matthew Pate is senior research fellow with the Violence Research Group in the School of Criminal Justice at the University at Albany. He was formerly director of institutional security with the Department of Arkansas Heritage; a field agent with the Arkansas Crime Information Center; and an officer with the Pine Bluff (Arkansas) Police Department. He has served as an advisor and consultant to hundreds of police agencies. He is also the former editor of the *Journal of Criminal Justice and Popular Culture*. Pate holds a doctoral degree in criminal justice from the University at Albany, where his dissertation was selected as the Distinguished Doctoral Dissertation for 2010-2011. Pate also holds master's degrees in criminal justice from the University of Arkansas at Little Rock, in environmental design from the University of Georgia, and in sociology from the University of Central Arkansas as well as a bachelor's degree in history from Hendrix College.

Correspondence should be sent to pate.matthew@gmail.com.

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