The Right to Get Well:
Citizenship and The Politics of Alcoholism in Post-Prohibition America

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INTRODUCTION

Beginning in the 1960s, reformers worked to overturn the moralism and penalization that had traditionally guided the United States' approach to alcohol and those who misused the substance. They instead called for seeing alcoholism as an illness that required medical treatment, not carceral punishment. In doing so, advocates in the fields of law, medicine, social science, and politics began to ask two key questions regarding the citizenship of alcoholics. If alcoholism was a disease rather than a crime or moral failing, what kinds of rights and entitlements did American citizens struggling with alcoholism possess? And what responsibilities did the federal government hold in relation to alcoholics? Like many other political organizing efforts in between the 1960s and 1970s, activists turned to the state to gain national recognition for the idea that alcoholics deserved healthcare for their disease. To codify a medicalized approach to alcoholism within federal law and policy, advocates asserted that alcoholics deserved protections from undue punishment and discrimination. Alcoholics also carried a right to receive certain governmental services, especially publicly subsidized treatment for their disease.

This moment of promise for alcoholic citizens was never absent of contradictions. When these legal and political claims were put into practice, advocates often struggled to determine the practical differences between "rehabilitation" and "punishment." Furthermore, how voluntary and accessible treatment was often varied by who lawmakers were imagining when drafting certain policies and programs. Unlike other social movements happening in this same period around racial justice or gender equity, the effort to medicalize and decriminalize alcoholism relied upon a set of concepts that tended to be ill-defined and vulnerable to critique. Despite the

best efforts of reformers, the questions that they raised around the citizenship of alcoholics and the state's obligations towards these individuals had no easy answers.

The involvement of the state in the lives of alcohol users was not a new development in the United States, nor was social organizing around the issue of alcohol abuse. Particularly in the early 19th century, religious leaders and temperance advocates warned that America was "fast becoming a nation of drunkards."[1] Their chosen solution to halt the spread of this malfeasance was total abstinence, a fight epitomized by the American Temperance Society's and the Woman's Christian Temperance Union's anti-liquor and anti-saloon crusades in the 1800s. As a number of scholars have illuminated, temperance campaigners were guided by a religious moralism and absolutist take on the evil nature of alcohol as a substance and its users as people.[2] In doing so, temperance reformers built on a tradition first instigated by Puritan clergymen in the colonial period. Followers of this religious view believed that those who became "habitual drunkards" had done so "as a consequence of free will."[3] A free-will doctrine towards drunkenness turned the alcohol abuser into someone who was willfully deviant, choosing to drink to the point where there were destructive consequences for the individual, the family, and the community.[4]

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[1] W.J. Rorabaugh, *The Alcoholic Republic: An American Tradition* (Oxford: Oxford University Press, 1979), 5.
[2] Elaine Frantz Parsons, *Manhood Lost: Fallen Drunkards and Redeeming Women in the Nineteenth-Century United States* (Baltimore: Johns Hopkins University Press, 2003); Ian Tyrell, *Sobering Up: From Temperance to Prohibition in Ante-bellum America, 1800-1860* (Westport: Greenwood Press, 1979); and Eric Burns, *Spirits: of America: A Social History of Alcohol* (Philadelphia: Temple University Press, 2003).
[3] Peter Conrad and Joseph W. Schneider, *Deviance and Medicalization: From Badness to Sickness* (Philadelphia: Temple University Press, 1992), 77.
[4] The argument about alcohol's detrimental effects on the family were particularly strong coming from female temperance activists. They contended that drunk men were threats to vulnerable women and children because they wasted their wages on alcohol, turned abusive when inebriated, or abandoned their families. Rather than police the individual behavior of these men, female reformers focused on abolishing the substance as the main way to protect women and families. Ruth Bordin, *Women and Temperance: The Quest for Power and Liberty, 1873-1900* (Philadelphia: Temple University Press, 1981).

This moralistic approach shaped how alcohol and drinkers were handled politically and legally. From the colonial era, civil and criminal statutes policed drinking behavior especially when it was exhibited in public settings. Punishments for visible drunkenness including fines, ostracism, whippings, and imprisonment.[5] These laws parroted the religious perspective that being intoxicated was an inherently sinful action that needed to be controlled by legal authorities. By the late 1800s, temperance campaigners demanded an even more expanded state role in the policing of drinkers. They succeeded initially at the community level, passing local and statewide prohibition laws that increased law enforcement surveillance of the sale and use of alcohol. But as historian Lisa McGirr has argued, it was the enactment of Prohibition on a national scale in the interwar period that had the most far-reaching impacts. Enforcing the 18th Amendment after 1920 resulted in "vigorous" carceral state building with "new prison growth" as well as "expanded and muscular federal policing" in the lives of American citizens.[6] Under the guise that alcohol use was a criminal act, lawmakers greatly increased federal involvement in crime control and in the surveillance of individual behavior.

While the historical scholarship of alcohol use in this country has been dominated by an analysis of these earlier periods, this dissertation examines the more recent legal and political history of alcoholism in the United States. Subsequent chapters dissect the ways in which the transition to a medicalized understanding of alcohol addiction in the years after the repeal of Prohibition merged with shifting conceptions of state responsibility in the second half of the twentieth century. Though governmental intervention around excessive drinking was obviously not a new development, this was the first time that advocates successfully pushed lawmakers to

[5] Conrad and Schneider, *Deviance and Medicalization*, 79.
[6] Lisa McGirr, *The War on Alcohol: Prohibition and the Rise of the American State* (New York: W.W. Norton & Company, 2016), xxi.

approach the issue from the standpoint of health and welfare rather than crime and policing. In doing so, I argue that individuals involved in the alcoholism reform efforts of the post-Prohibition era significantly altered the relationship between citizens struggling with alcoholism and their government. Just over 40 years after the moral absolutism of Prohibition led to a growth of the carceral state, the medicalized view of problem drinking resulted in a different kind of state expansion. Because of the political pressure and demands made by activists throughout the 1960s, the federal government became the primary leader in funding and creating a therapeutic system of medical aid for alcoholics by the 1970s.

Two movements that shared similar ideological views brought about this political transformation. The decriminalization and modern alcoholism movements developed in response to ideas revitalized after the failure of Prohibition.[7] Beginning in the 1940s, medical professionals, social scientists, and other "expert" voices promoted a disease framework regarding alcohol abuse. They argued that excessive drinking was an illness that could be brought under control through medical help and scientific knowledge. For advocates in the post-Prohibition era, this disease concept had major implications for how the law and public policy handled the issue of alcoholism. Labeling alcoholism as a disease and thereby putting it in the purview of medical authorities was seen as a necessary move to destigmatize alcoholics and provide them with more opportunities for care. But as historian Janet Golden has written, the medicalization of alcoholism was always "a highly contested and uneven process with equivocal

[7] Benjamin Rush, a colonial physician and political leader, was one of the initial thinkers to provide an "alternate explanation to the traditional moral account offered by colonial religious leaders" towards intoxication. He believed it to be a mental disease that developed gradually and became more aggressive over time. This view found support especially amongst physicians who fought to move "habitual drunkards" out of jail cells and into state-run asylums in the late 19th and early 20th centuries. But these their efforts were effectively halted by Prohibition. Conrad and Schneider, *Deviance and Medicalization*, 81; Sarah W. Tracey, *Alcoholism in America: From Reconstruction to Prohibition* (Baltimore: The Johns Hopkins University Press, 2005).

results."[8] The following chapters will illustrate how medicalization was never fully absent of coercion and force. They will also illuminate the ways in which the concrete experiences of medicalization varied based on the socioeconomic, racial, and gender identity of individual alcoholics.

The first of the political drives which mobilized around the disease framework was the decriminalization movement. Civil liberty lawyers, municipal judges, social scientists, presidential commission members, and people with Skid Row experience made up this effort which gained major traction in the sixties. These individuals were largely concerned with the criminal law's handling of indigent alcoholics- a population they identified as "Skid Row alcoholics," "chronic public inebriates," or "homeless alcoholics." The public nature of this groups' alcoholism made them consistent targets of the law. Reformers labeled this process a "revolving door" of injustice in which alcoholics were consistently being arrested and imprisoned for exhibiting a symptom of their disease (intoxication) in public. Participants in the decriminalization movement contended that the penalization of public drunkenness and by extension alcoholism was a vestige of the moralist view that alcoholics were either moral failures or criminals who deserved punishment. Under the leadership of ACLU-backed lawyers such as Peter Barton Hutt and researchers like David Pittman, advocates contended that the legal treatment of homeless alcoholics needed to catch up with the newly accepted medical view of problem drinking. Throughout the 1960s, they won noteworthy victories in federal courts supporting the claim that alcoholics needed to be legally recognized as sick and therefore protected from punishment for visibly displaying their illness.

[8] Janet Golden, *Message in a Bottle: The Making of Fetal Alcohol Syndrome* (Cambridge: Harvard University Press, 2005), 11.

The other activist effort happening around the disease concept during this time was the modern alcoholism movement. Middle- and upper-class folks in recovery involved in advocacy organizations like the National Council on Alcoholism (NCA) made up this effort. Guided by leaders like Marty Mann, this movement was concerned with a group they referred to as "average alcoholics." These individuals were employed, housed, and far less visible to the public eye. Though their problems were more private than homeless alcoholics, reformers claimed that the "average" alcoholic was just as in need of governmental help and protection. Although private alcoholics were not being incarcerated, they still were being unfairly penalized for being sick. This punishment was seen most clearly in how alcoholics could be summarily fired from their jobs, denied treatment in general hospitals, and refused coverage by insurance companies. While groups like the NCA had been around since the 1940s, their work did not translate into political attention until about twenty years later when Harold Hughes, a recovering alcoholic, was elected to the Senate. His leadership helped result in the passing of comprehensive alcoholism legislation at the end of 1970.

This dissertation examines how conceptions of citizenship, rights, and state obligation were central to the decriminalization and modern alcoholism movements. Legal scholar Karen Tani has written how, in the postwar era, "the most important level of government was the federal government" and "the most important body of law was constitutional law." Constitutional rights were what structured the relationship between the individual citizen and the federal government, "both the right to be free from government interference and the right to demand government action and beneficence."[9] This rights rhetoric was utilized by most social

[9] Karen Tani, "Constitutionalization as Statecraft: Vagrant Nation and the Modern American State," *Law and Social Inquiry* 43, no. 4 (2018): 1650-1651.

movements of the sixties and seventies.[10] Alcoholism reformers also relied upon this rights-based language to demand changes in how alcoholics were handled by the American state.

Their rights framework directed what they saw as being the federal government's role in relation to alcoholics in both the positive and negative sense. As American citizens, advocates argued, alcoholics possessed constitutional rights which protected them against unjust punishment and discrimination by the state and other mainstream institutions. But they also asserted that alcoholics had the right to receive appropriate treatment for their disease and that it was the role of the federal government to ensure that these healthcare services were adequately available across the country. In making these rights claims, reformers shifted expectations around what the government owed citizens struggling to control their drinking. It was now the federal government's obligation to end discriminatory practices in the workplace and in hospitals and to bolster a rehabilitative system that would expand healthcare opportunities for alcoholics on a national scale.

The idea of citizenship was also a critical rhetorical strategy that helped build political support for the funding needed to create these treatment resources. Especially within the decriminalization effort, reformers contended that treating rather than punishing impoverished alcoholics was a worthwhile public investment precisely because it would "restore" sick people to "productive citizenship." Contributing to society through work and breadwinning were the main markers used to define what made citizenship "productive." With enough governmental aid, decriminalization supporters maintained that homeless alcoholics would be able to get sober,

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[10] As John Skrentny's *The Minority Revolution* has demonstrated, many social movements and political reform efforts in between the 1960s and 1970s modeled their protest and rhetorical strategies off of the civil rights struggle. Reformers in and out of government latched on to "the rights frame" which promoted "nondiscrimination rights" that gave "positive recognition [to] group differences." In this way, the alcoholism movement was part of a rights-based advocacy trend being utilized by groups like women, those with disabilities, Latinos, and others. John D. Skrentny, *The Minority Rights Revolution* (Cambridge: Harvard University Press, 2002), 4.

find employment, and return to their proper place in their families and communities. Such language was useful in getting lawmakers to rethink a group of people that had traditionally been stigmatized as beyond the point of help.

Though these movements relied on the same ideological and political foundations, they existed in an uneasy alliance in between the 1960s and 1970s. The decriminalization movement garnered momentum first since policymakers were more easily pressured to confront the problems associated with excessive drinking that were visible to the public eye. For those involved in the modern alcoholism movement, these efforts were useful in how they made the topic of alcoholism a significant social issue for people in positions of power. But middle-class leaders also considered the emphasis on homeless alcoholics to be damaging to their cause as they believed it fed into the stereotype that all alcohol abusers were "bums." People like Marty Mann fought to make alcoholism be seen as a more legitimate disease by highlighting that most alcoholics were in fact not worthless drunks on the street, but were decent people with stable jobs, homes, and families. These respectability politics were ultimately built into the alcoholism policies that were passed in the early 1970s. Legislative responses to alcoholics of different socioeconomic backgrounds were placed on separate tracks, ultimately resulting in a two-tiered treatment system being created in the United States.

Through exploring the sociopolitical aspects of medicalization, this work adds to the growing historiographical field on alcohol and drugs in the United States. Most of the historical scholarship on American alcoholism has focused on temperance, Prohibition and "the early alcoholism movement" led by 19th century reformers.[11] Historians of medicine, culture, and gender have offered some of the only studies that look at alcoholism in the postwar era. Trysh

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[11] See notes 3, 7, and 9.

Travis has written an important work on how Alcoholics Anonymous and modern treatment centers approach the concept of "recovery," and Michelle McClellan has surveyed how gendered assumptions of drinking affected the views and treatment of female alcoholics.[12] Books by Nancy Campbell, Caroline Acker, and William White have evaluated the development of professionalized addiction science and "expert" knowledge around sobriety from the 1940s on. They have argued that the medicalization of both drug and alcohol abuse gave scientific weight to the idea that addiction was a medical disease as opposed to a moral or criminal problem.[13] My dissertation instead examines how these developments in the world of ideas, culture, and medicine affected the political and legal handling of citizens with alcoholism.

There has been no comprehensive political history on alcoholism in the post-Prohibition period. This lack of scholarly attention can in part be attributed to how the political history of substance abuse in the postwar era has largely been dominated by works on drug addiction and drug policy. These histories have illustrated how, especially in the late 1960s and early 1970s, there was an effort to offer therapy instead of punishment to illicit drug users who often were thought to be young and white.[14] The sharp punitive turn in the 1980s epitomized by Ronald

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[12] Trysh Travis, *The Language of the Heart: A Cultural History of the Recovery Movement form Alcoholics Anonymous to Oprah Winfrey* (Chapel Hill: The University of North Carolina Press, 2009); Michelle L. McClellan, *Lady Lushes: Gender, Alcoholism, and Medicine in Modern America* (New Brunswick: Rutgers University Press, 2017). Golden offers a similar analysis of how gendered assumptions shaped the development of fetal alcohol syndrome and the mix of medical/criminal response to it towards the end of the twentieth century. Golden, *Message in a Bottle.*

[13] Caroline Acker, "Addiction and the Laboratory: The Work of the National Research Council's Committee on Drug Addiction, 1928-1939," *Isis* 86 (1995): 167-193; Caroline Acker, *Creating the American Junkie: Addiction Research in the Classic Era of Narcotics Control* (Baltimore: Johns Hopkins University Press, 2002); Caroline Jean Acker and Sarah W. Tracy, ed., *Altering American Consciousness: The History of Alcohol and Drug Use in the United States, 1800-2000 (*Amherst: University of Massachusetts Press, 2004); Nancy D. Campbell, *Discovering Addiction: The Science and Politics of Substance Abuse Research* (Ann Arbor: University of Michigan Press, 2007); and William L. White, *Slaying the Dragon: A History of Addiction Treatment in America* (Bloomington: Chestnut Health Systems/Lighthouse Institute, 1998). There has also been a study on the rise of Alcoholics Anonymous: Ernest Kurtz, *Not-God: A History of Alcoholics Anonymous* (Center City: Hazelden Educational Services,1979).

[14] Michael Javen Fortner, *Black Silent Majority: The Rockefeller Drug Laws and the Politics of Punishment* (Cambridge: Harvard University Press, 2015); Kathleen J. Frydl, *The Drug Wars in America, 1940-1973* (Cambridge: Cambridge University Press, 2013); David Musto, *The American Disease: Origins of Narcotic Control* (New York: New York University Press, 1999); Eric C. Schneider, *Smack: Heroin and the American City*

Reagan's version of the War on Drugs eroded these attempts at non-carceral rehabilitation. Historians have shown how it was this system of harsh and racially discriminatory sentences for drug users and sellers that considerably expanded the carceral state towards the end of the twentieth century.[15] It is understandable how much attention has been paid to illicit drugs, particularly since this history helps explain the current crisis of mass incarceration and its corresponding consequences for black and brown communities. But this history of anti-drug politics is incomplete without the political history of alcoholism. Decriminalization advocates sought to use their legal arguments against the penalization of alcoholics as a stepping stool for progress in other areas like drug addiction. The fact that they failed to win a national mandate from the Supreme Court to decriminalize drunkenness effectively halted this criminal justice reform effort and removed any possible constitutional and legal guardrails against the punitive approach taken against drug users in the 1980s.

Methodologically, my analysis of the politics of alcoholism is informed by the analytical lenses used by scholars of social welfare policy. Historians of programs like Medicare and Medicaid for example have argued that the American welfare state has been divided based on the target demographic of who is being served by different forms of assistance. Universal benefit programs like Social Security have historically been understood as entitlements given to worthy, tax-paying citizens. Alternatively, programs aimed at marginalized groups including the poor

(Philadelphia: University of Pennsylvania Press, 2008); Matthew D. Lassiter, "Impossible Criminals: The Suburban Imperatives of America's War on Drugs," *Journal of American History* 102, no. 1 (June 2015): 126-140; and Mical Raz, "Treating Addiction or Reducing Crime? Methadone Maintenance and Drug Policy under the Nixon Administration," *Journal of Policy History* 29, no. 1 (2017): 58-86.

[15] Michael Massing, *The Fix* (Berkeley: University of California Press, 1998); David F. Musto and Pamela Korsmeyer, *The Quest for Drug Control: Politics and Federal Policy in a Period of Increasing Substance Abuse, 1963-1981* (New Haven: Yale University Press, 2008); Dan Baum, *Smoke and Mirrors: The War on Drugs and the Politics of Failure* (Boston: Little, Brown, 1996); and Michelle Alexander, *The New Jim Crow: Mass Incarceration in the Age of Colorblindness* (New York: The New Press, 2010).

and racial minorities were stigmatized as "welfare."[16] Similarly, the rhetorical positioning of different alcoholic groups concretely impacted the quality and permanence of various rehabilitation programs. Participants in the alcoholism movement depicted what they described as "average" alcoholics as largely white, employed, and housed. As "respectable" people, these citizens deserved enduring governmental support and protection.

Advocates working for indigent alcoholics, on the other hand, consistently had to prove that these individuals were capable of being rehabilitated and therefore worthy of public assistance. When these patients failed to remain sober or achieve the lofty goals set by reformers and treatment providers, programs aimed at alcoholics who were poor were easily attacked for being a waste of governmental funds. The net result of this difference in the supposed "worthiness" and rehabilitative potential of alcoholics of varying socioeconomic circumstances ultimately shaped the trajectory of the budding alcoholism treatment system in the later decades of the 20th century. Federal dollars were used to vastly expand quality care options for those who were insured and working by the end of the 1970s. At the same time, services for the poor and uninsured remained underfunded and barely operational.

Additionally, my analysis offered in the following chapters has been inspired by recent works of historians Julily Kohler-Haussmann and Elizabeth Hinton. These scholars have discussed the importance of considering welfare and carceral policies and politics together.[17]

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[16] Alan Cohen, David C. Colby, Keith A. Wailoo, and Julian E. Zelizer, *Medicare and Medicaid at 50: America's Entitlement Programs in the Age of Affordable Care* (Oxford: Oxford University Press, 2015); Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982); Beatrix Hoffman, *Health Care for Some: Rights and Rationing in the United States Since 1930* (Chicago: University of Chicago Press, 2012); Michael B. Katz, *The Undeserving Poor: America's Enduring Confrontation with Poverty* (Oxford: Oxford University Press, 2013); and Linda Gordon, *Pitied But Not Entitled: Single Mothers and the Origins of Welfare, 1890-1935* (New York: The Free Press, 1994).

[17] Julily Kohler-Hausmann, *Getting Tough: Welfare and Imprisonment in 1970s America* (Princeton: Princeton University Press, 2017), 33. Elizabeth Hinton, *From the War on Poverty to the War on Crime: The Making of Mass Incarceration in America* (Cambridge: Harvard University Press, 2016); Julily Kohler-Hausmann, "Guns and

Traditionally, the welfare and carceral arms of the American government have been dealt with by historians as oppositional entities. Kohler-Haussmann and Hinton instead have importantly illuminated how the purposes and operations of these two supposedly diametrical institutions are in fact often overlapping and therefore cannot be examined as two separate areas of study.[18]

Similarly, I argue that there has always been a thin boundary between the health and welfare approach to alcoholism and the penal approach. It is more useful to see the punishment or treatment of problem drinkers on a spectrum. The politics of alcoholism have to be considered as a pendulum swinging between two seemingly contradictory viewpoints-- excessive drinking as a sickness or as a matter of willful misbehavior. The emphasis placed on either of these different perspectives has changed based on the political context. But which direction the pendulum has swung within the three decades discussed below determined how accessible, affordable, and voluntary treatment was for citizens battling alcoholism.

Recent works have analyzed healthcare activism in the civil rights, Black Power, and feminist movements.[19] Activists in these movements sought to substantially alter the nation's health care system, hoping to make it more equitable and responsive to the specific needs of women and people of color. Those involved in the decriminalization and modern alcoholism movements were a part of this broader trend. Their organizing took the form of test court cases and policy advocacy rather than street protests or grassroots mobilization. But their efforts were still impactful and the policies that resulted from these movements did fundamentally change the

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Butter: The Welfare State, The Carceral State, and the Politics of Exclusion in the Postwar United States," *Journal of American History* 102, no. 1 (June 2015): 87-99.

[18] Kohler-Hausmann, *Getting Tough,* 33.

[19] John Dittmer, T*he Good Doctors: The Medical Committee for Human Rights and the Struggle for Social Justice in Health Care* (New York: Bloomsbury Press, 2009); Alondra Nelson, *Body and Soul: The Black Panther and the Fight Against Medical Discrimination* (Minneapolis: University of Minnesota Press, 2011); Jennifer Nelson, *More than Medicine: A History of the Feminist Women's Health Movement* (New York: New York University Press, 2015).

healthcare landscape for alcoholics. By the end of the 1970s, hospitals and emergency rooms could no longer withhold care from individuals just for being an alcoholic. And more doctors and medical professionals were trained to diagnose and treat rather than ignore patients that exhibited signs of problem drinking. Alcoholism reformers won significant achievements in removing barriers to treatment in mainstream medical settings and in shoring up protections for alcoholic employees in the workplace. But these accomplishments were also uneven and benefited certain people more than others. Balancing an analysis of the triumphs of these efforts with an interrogation of its blind spots, this dissertation illustrates how the lives of citizens with alcoholism changed as a result of this activism in both positive and negative ways.

The following chapters trace the ideas, goals, and the resulting policies of alcoholism reform efforts. This work unfolds chronologically, tracking how decriminalization advocates first succeeded in politicizing the most obvious and public of problems associated with alcoholism. Chapter One analyzes how the movement to decriminalize public drunkenness came together throughout the 1960s. It illustrates how this effort was the result of a change in ideas around poverty, alcoholism, crime, and the role of the state in combatting all these issues. Test cases led by civil liberty lawyers altered the relationship homeless alcoholics had with law enforcement and the criminal justice system, as more federal courts recognized the rights of alcoholics to not be unduly and criminally punished for being sick. But decriminalization advocates fell short in their goals of having this legal change uplift public inebriates out of poverty and homelessness by failing to contend with the larger structural issues outside of alcohol abuse that were keeping people in poor economic circumstances.

Chapter Two uses Washington D.C. as a case study to examine the concrete effects of decriminalization. In between 1966 and 1968, the District's municipal leaders and public health

officials were charged with implementing the new court mandates that called for the incarceration of chronic alcoholics to be replaced with medical treatment. This chapter analyzes how the medicalized approach to public inebriates did not initially differ from the carceral system. The chaos that resulted from attempting to find the appropriate line between treatment and punishment put far more pressure on the federal government to come up with better answers and resources concerning those who were public alcoholics. Political pressure resulted in the passing of the District of Columbia Alcoholic Rehabilitation Act in 1968. The law was the first piece of federal legislation that officially recognized alcoholism as an illness and alcoholics as rights-bearing citizens worthy of help. It also backed the idea that it was the state's responsibility, especially in the case of the indigent, to provide detoxification and other forms medical help rather than incarceration to citizens with alcoholism.

Chapter Three analyzes how the consensus that had formed between lawmakers, city officials, and activists around support for the decriminalization of public drunkenness broke down with the rise of "law and order" politics in the late 1960s and early 1970s. As criticism mounted against the liberal progressivism of the Warren Court in the face of supposedly rising crime rates and urban disorder, lawyers failed to win a mandate from the Supreme Court in 1968 to decriminalize alcoholism on a national scale. This setback caused decriminalization reformers to instead focus on legislation that could implement their goals on a nationwide basis. The closest they got was the Uniform Alcoholism and Intoxication Treatment Act in 1971, a policy framework that all states could opt to follow to both decriminalize drunkenness and to establish a continuum of treatment for indigent alcoholics. Chapter Three argues that the tangible effects of this act were piecemeal even in areas that implemented these changes. With more calls for "law and order," city officials tended to support forcibly removing homeless alcoholics from public

view. In doing so, lawmakers reified homeless alcoholics as a deviant group less deserving of help and understanding when positioned against the needs of "the public."

Chapter Four pivots to the modern alcoholism movement and its focus on the "average alcoholic" or those who were employed, housed, and not visible to the public eye. The work of these reformers resulted in the passing of the Hughes Act at the end of 1970. This policy was significant for how it institutionalized the rights-claims being made by alcoholics in recovery. It codified the notion that alcoholics possessed the right to receive quality medical care for their disease and that alcoholics deserved protections against discriminatory practices in the workplace and in the healthcare field. The law also led to a large infusion of federal funds being directed towards alcoholism research and treatment. However, this chapter argues that the respectability politics behind the modern alcoholism movement infused the Hughes Act and led to an uneven distribution of its benefits. In drafting this federal alcoholism legislation, lawmakers intentionally differentiated employed and housed alcoholics from the "public drunk" who lacked ties to the mainstream society and economy. Separating the policy response to these different alcoholic groups allowed for treatment opportunities for those with financial resources to expand by the 1980s while help for those who were poor or uninsured often failed to survive budget cuts and attacks on welfare programs.

The last chapter further contends that the Hughes Act was limited in how it promoted a one-size-fits-all approach to alcoholism treatment. As Chapter Five illustrates, this model was largely based on the view of the "average" alcoholic as someone who was white and male. In the 1970s, a variety of social movements became more focused on how racial and gender differences impacted one's experiences with mainstream American institutions like schools or hospitals. Activists maintained that alcoholism rehabilitation programs were no different, pointing to how

treatment programs that had been designed for white patients often failed to meet the needs of those who were not. Representatives for Black and Native American alcoholics expanded the rights claims being made in the 1970s, demanding that a limited medicalized approach alone could not solve problem drinking in economically-deprived communities.

Finally, my conclusion discusses how the political pendulum swung back towards a moralistic view of alcoholism in the 1980s. Conservative scholars were once again referring to homeless alcoholics as “drunks” who the police needed to arrest for being threats to public safety. The Supreme Court endorsed the idea that alcoholism was not necessarily a disease but rather was the result of willful misbehavior and agreed that employers could therefore withhold certain benefits like paid sick leave as a result. As prominent people in recovery like Betty Ford claimed, these views re-stigmatized alcoholics and made individuals far less willing to openly seek out treatment out of fear of the consequences. While the conservative and punitive turn of the 1980s did reverse some of the accomplishments of the alcoholism reform efforts that are highlighted throughout these chapters, I contend that they were never fully set back. Instead, the ideas and rights-claims of those who believed alcoholism to be a disease were now in contention with those who saw excessive drinking as a matter of deliberate choices.

CHAPTER 1

"Law on The Assembly Line:"

The Decriminalization of Public Drunkenness

On a Saturday night in 1937, DeWitt Easter was arrested in Washington D.C. for being drunk in public. Easter, a white plasterer, often frequented the bars on Upper 14th Street after his work shifts and would make his way home to his wife undisturbed by the police. But his first arrest for public intoxication that Saturday in 1937 propelled Easter into a downward spiral. Now labeled by the police and the courts as a "drunk," he was consistently arrested and sentenced to short terms in jail. As his drinking problem grew worse, he was unable to hold onto a job, lost his home and family, and ended up living on the streets of the nation's capital. A little over 30 years old at the time of his first arrest, Easter would go on to be arrested for the same charge of public drunkenness over 60 times by the age of 59.

In the early 1960s, Easter was firmly entrenched in a system that engulfed hundreds of other men in D.C. alone and thousands throughout the nation. He was now in a "revolving door" of repeated convictions for public intoxication, the criminal justice system's chosen policy for managing indigent and homeless "chronic alcoholics."[20] The double burden of being an alcoholic and not having financial resources doomed many men like Easter to a lifetime of being in and out of jail. Easter succinctly explained the kind of hopelessness that this cycle generated: "We alcoholics are the last thought of people in the world."[21]

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[20] David Pittman and Wayne Gordon, *Revolving Door: A Study of the Chronic Police Case Inebriate* (Glencoe, Ill: Free Press and the Yale Center of Alcohol Studies, 1958), 1.
[21] Dan Morgan, "It's a Crime (Legally) the Way a Man Can Ride Skids While Society Watches," *The Washington Post,* November 8, 1964, E5.

However, at the time of Easter's 70th arrest in 1964, attitudes towards alcoholics like Easter were beginning to change. According to leading legal advocacy organizations like the American Civil Liberties Union, the medicalization of alcoholism fundamentally altered how Easter and others like him should be legally treated. The ACLU, with the support of medical professionals, judges, political commissions, and alcoholism reform groups, led the fight against the traditional method of jailing alcoholics who did not have permanent shelter or employment. They argued that homeless alcoholics needed public health and medical treatment, not incarceration. Furthermore, they claimed that penalizing sick alcoholics for a symptom of their disease (public drinking) was a violation of their constitutional rights as American citizens.

Unlike thousands of indigent alcoholics whose names we will never know, Easter became a name of notoriety and a part of the public and historical record in the 1960s. The D.C. chapter of the ACLU picked Easter as the face of a test case to overturn the laws behind his continual arrests for public drunkenness. Easter's case would go on to fundamentally alter the political conversations and approaches to alcoholism on the local, state, and federal levels. Rather than being "the last thought of people in the world," indigent alcoholics like Easter became the center of widespread debate throughout the 1960s as major cities across the United States attempted to remove chronic alcoholics out of the criminal justice system and into the realm of public health and social welfare. The primary targets of this transition were white and male alcoholics like Easter.

This chapter will examine how this effort to decriminalize public drunkenness came together. It will argue that the focus on homeless alcoholics was a culmination of new understandings of poverty, alcoholism, and crime. Though this group made up a small subsect of alcoholics, it was the public nature of alcoholism amongst the unhoused that made it a point of

political concern. Additionally, as alcoholism was being medicalized, the federal government was assuming a new role in combatting major social problems like crime and poverty. The combination of an expanding welfare state and a wave of major legal and constitutional changes that sought to protect the rights of impoverished Americans led to a natural concentration on "Skid Row alcoholics." This population was not only suffering from poverty but also was being victimized by an inefficient and inhumane legal system that criminalized their disease. Legal advocates fought for the removal of homeless alcoholics from the arms of law enforcement as well as their entitlement to health and welfare aid. Members of the decriminalization movement believed in the ability of the state, at a time of increasing scientific knowledge, to eradicate issues that had once seemed hopeless. Though chronic inebriates might be the "hardest to reach," reformers pushed for political support of the idea that modern medicine could be used to rehabilitate even the most hardened alcoholics. While this effort opened new opportunities for white, male alcoholics to be handled outside of the carceral system, the medicalized approach to chronic inebriates was also never absent of coercion.[22] Decriminalization supporters never floated the option of just leaving alcoholics alone. Instead, their public presence remained an ongoing reason for state-sponsored intervention.

The attempt to prove that impoverished alcoholics like DeWitt Easter were worthy of help raised fundamental questions about socioeconomic belonging and citizenship in 1960s America for those who were primarily white and male but also impoverished and sick. Could the alcoholics found on Skid Row be taken in as members of the American polity, society, and economy? What role should the state play towards alcoholic citizens? Should it be an enforcer of

[22] On medicalization more broadly: Conrad and Schneider, *Deviance and Medicalization*; Michael Foucault, *The Birth of Clinic: An Archeology of Medical Perception,* trans. by A.M. Sheridan Smith (New York: Viking, 1975); Starr, *The Social Transformation of American Medicine.*

public order or a provider of treatment? And did homeless alcoholics have a right to publicly subsidized rehabilitation? Proponents of decriminalization still considered chronic inebriates to be deviants whose problems were largely a result of personal pathologies rather than larger economic and structural failures. However, their deviancy could now be traced to a solvable problem: the illness of alcoholism. And with government-sponsored public health treatment and various other avenues of social assistance, these individuals could be "restored" to citizenship. Implicit in this seemingly humanitarian move was the idea that one could not be both an indigent alcoholic and a full citizen. Reformers relied upon this notion of citizenship to market the idea that "curing" Skid Row residents of their alcoholism would enable them to be reintegrated into American society.

Though the population of Skid Row was racially diverse, researchers and reformers mainly focused on white men like Easter as those who they believed to be capable of rehabilitation. This chapter will analyze how the presumed whiteness and maleness of alcoholics on Skid Row shaped who advocates found to be worthy of a second chance. After receiving treatment, these individuals would be able to regain both the responsibilities and entitlements of white male citizenship. With their disease behind them, they could become economically secure persons who could contribute to the community and provide for their families.

However, the lofty goals of reformers often failed to align with reality partially because of their tendency to not take in the viewpoints of the men they were trying to help. Their narrow emphasis on the prevalence of alcoholism amongst the homeless population resulted in a myopic view towards the problems of urban poverty, overshadowing other structural issues like unemployment or lack of affordable housing that resulted in men finding themselves on skid rows. While the focus on alcoholism failed to lift people out of poverty or even get them off the

street, the fact that Skid Row alcoholics were now considered to be sick rather than criminal had significant impacts on the lives of men like DeWitt Easter. Most significantly, the fight to decriminalize drunkenness dramatically changed their relationship with law enforcement and their standing in court as reformers worked to uphold their rights as American citizens.

The Rise of the Disease Concept

A confluence of factors led to the 1960s moment that brought national calls to decriminalize public drunkenness and institute more therapeutic approaches towards homeless alcoholics. First and foremost, a medicalized notion of alcoholism gained momentum amongst the medical community as well as the general public. After the repeal of Prohibition in 1933, the belief that drunkenness was a moral or criminal issue increasingly fell out of favor. The rise of Alcoholics Anonymous in the 1930s helped bring renewed attention to the idea that unhealthy drinking was a disease. A.A. was founded on the idea that alcoholism was a physical allergy, one which manifested itself as a total "inability to control further drinking." Leaders of A.A. argued that alcoholism was not "a vice or habit," nor was it a "hopeless illness."[23] It was a disease that could be brought under control with the guidance of A.A. fellowship and the Twelve Steps.[24] In the decades following its founding, the effectiveness of A.A. was central in relabeling alcoholics as sick persons who were capable of recovery.

The creation of the Yale Center for Alcohol Studies in the early 1940s furthered the medicalization of alcoholism by bringing scientific credence to the disease concept. Under the

[23] While agreeing with the notion of alcoholism being an allergy, Bill W. (the man primarily credited with the founding of A.A.) tended to be wary of calling alcoholism a disease. He instead favored "illness" or "malady," terms he thought better conceptualized alcoholism as an issue that often was a manifestation of many different "ailments." Kurtz, 15, 22.

[24] The 12 Steps is a process for recovery originally outlined in the *Big Book* of A.A. They involve admitting a loss of control over alcohol, examining past errors, making amends, and helping others who also suffer from alcoholism.

tutelage of leading alcoholism researcher E.M. Jellinek, Yale became the first interdisciplinary center of alcoholism studies that brought together physicians, sociologists, psychologists, social workers, and others to study alcoholism from a broad range of expertise. Jellinek was the primary medical scholar in the post-Prohibition era to label alcoholism a disease that could be treated and controlled. Breaking down alcohol addiction into different phases, Jellinek traced the development from a pre-alcoholic into a “chronic alcoholic” based on symptoms that included behaving properly in social situations, holding onto a job, and maintaining a stable home.[25] While attempting to equate habitual drinking to other illnesses like tuberculosis and heart disease, Jellinek and others at the Yale Center primarily relied on social behaviors when defining alcoholism as a physical disease (as opposed to a mental illness). Alcoholics often only exhibited physical ailments like liver cirrhosis or Delirium Tremens accompanying withdrawal in the “acute” phase of their addiction.

Though alcoholism was not easily comparable to other physical illnesses, professionals believed medicalization was a necessary step in gaining legitimacy for the alcoholism field. Yale researchers thought the popularization of the disease theory was also fundamental to moving beyond the stigma of chronic drinking being a crime or sin. Scholars recognized that “sickness [carried] with it the legitimation of claims to outside help.” John Seeley, an authority in the alcoholism field, noted in 1962 that calling alcoholism a disease was politically critical to “changing social policy [to open] the door to more humane, physician-like treatment” of alcoholics.[26] Yale scholars supposed that wide acceptance of the disease concept would lead to the funding of clinics, therapeutic developments, and further research on alcoholism. The

[25] E.M. Jellinek, “Phases of Alcohol Addiction,” Quarterly Journal of Studies on Alcohol 13 (1952): 673-684; E.M. Jellinek, *The Disease Concept of Alcoholism* (New Haven: Hillhouse Press, 1960).
[26] John R. Seeley, “Alcoholism is a Disease: Implications for Social Policy,” In *Society, Culture and Drinking Patterns* ed. David Pittman and Charles Snyder (New York: Wiley, 1962): 590, 592.

promotion of the phrase "alcoholism is a disease" therefore was a deliberate and practical choice by researchers. They believed it be easier to argue for research and rehabilitation funding if alcoholism was positioned as a medical disease rather than some other kind of psychological, behavioral, or criminal problem.

While those involved in alcoholism research tended to agree that alcoholism was a disease, there was little consensus on what kind of disease it was. Some agreed with the A.A. view that alcoholism was an allergy. Others saw it as a personality disorder, a biological or genetic defect, or a side effect of undersocialization. All these different theories were loosely tied together by the understanding that to be diagnosed as an "alcoholic" required that a person had "lost control" over their drinking behavior. This notion of a loss of willpower was of the utmost importance in the conversations surrounding how alcoholics should be handled by the law.

The disease concept received its biggest boost in 1956 when the American Medical Association officially stated that alcoholism should be considered a sickness and therefore be under the responsibility of medical practitioners. The AMA further acknowledged medicine's culpability in historically rejecting alcoholics as patients based on the stereotype that "these people [were] intractable, uncooperative and difficult to handle." But the fact that alcoholism was now broadly considered an illness meant that hospitals and doctors were obligated to take on these individuals as patients. Their statement also recognized medicine's role in overturning the stigma assigned to problem drinkers, arguing that hospital administrators and physicians were in a "unique position" to increase public "acceptance of these sick people."[27] This declaration in 1956 was a watershed moment for alcoholism awareness and treatment. The AMA's statement did not immediately trickle down to individual doctors or hospitals who continued to refuse to

[27] "Report of Officers," *Journal of American Medical Association* 162 (Oct 1956): 750.

admit alcoholics as patients. However, persons struggling with alcoholism and their families could now point to this broader order from the AMA and make demands on medical professionals for access to treatment. And legal and political reformers who were advocating for more humane treatment of alcoholic individuals now had a clear directive from the highest medical organization that alcoholics should be handled by the health professionals rather than law enforcement.

The War on Crime and The War on Poverty

Around the same time that alcoholism was being medicalized, reformers and politicians were setting their sights on improving the criminal justice system. As historian Risa Goluboff has examined in her work on vagrancy laws, legal professionals in the 1960s began to "question the fundamental basis of the criminal law" especially as it related to the poor and marginalized. The combination of an "expanding welfare state that deemed the poor worthy of support" with social movements that were "claiming constitutional protection for the rights of racial minorities and the poor" propelled lawyers, judges, politicians, and citizens to raise substantial questions about the function of the criminal justice system and the role of law enforcement.[28] What should be considered a crime? Were there areas in which the courts and the police were being used that could be replaced with social welfare and public health mechanisms? The attempt to decriminalize poverty as well as the effort to expand the rights of racial minorities and indigent Americans required a deep questioning of the criminal justice system in a way that would have ramifications for many American citizens, including homeless alcoholics.

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[28] Risa Goluboff, *Vagrant Nation: Police Power, Constitutional Change and the Making of the 1960s* (Oxford: Oxford University Press, 2016), 6.

This new analysis of the criminal justice system was reflected in the establishment of a national commission as part of President Johnson's "War on Crime" in 1966. While the commission was established "to study crime in America," its work resulted in an examination not only into the kinds of crimes being committed by American citizens but also a broader inquiry into the fairness and efficacy of the criminal justice system. The commission's final report broke down the various layers of law enforcement (the police, courts, and corrections) and offered recommendations for how these different facets could be improved. Members of the commission saw the War on Crime as intertwined with President Johnson's War on Poverty effort. As historian Elizabeth Hinton has argued, these "twinned goals of social welfare and social control" were problematic. Especially regarding Black Americans, the tactics and goals of crime control tended to "outpace" those that would enhance socioeconomic opportunities.[29] The recommendations proposed by the presidential crime commission and the resulting reforms they helped to inspire would remain mired in this tension between welfare and control, between seeing poverty versus criminality as the main issue that needed to be tackled.

While the commission might have been blinded to the flaws in their merger of crime control with social welfare goals, they did attempt in some areas to differentiate between what they saw as a social service issue versus a criminal justice or law enforcement problem. The commission argued that the police, courts, and corrections were being forced to deal with difficulties that were not particularly amenable to a punitive approach. This claim in no way meant to reduce the scope of the criminal justice system or the amount of funding being devoted to law enforcement. Removing certain areas that were currently "burdening police, lower courts, and penal institutions" from the jurisdiction of the criminal justice system would allow for more

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[29] Hinton, *From the War on Poverty to the War on Crime,* 14.

time and energy to be focused on "legitimate crimes and criminals."[30] Particularly in the areas of juvenile offenses, narcotics addiction, and public drunkenness, the commission believed that the time, energy, and resources of the criminal justice system were being wasted. Instead, individuals engaging in these kinds of behaviors would be better served by a community-based "treatment approach."[31] While not necessarily removing law enforcement entirely, offenses like drug use and drunkenness would be better handled through social welfare and public health means. Figuring out the extent of the role of the police in relation to these acts and trying to find the line between a treatment and punitive approach would be a major source of debate particularly in relation to Skid Row alcoholics throughout the 1960s.

Another dimension of the commission's report that would inform the discussions surrounding public drunkenness was a concern over inequities in the criminal justice system. This emphasis on fairness reflected the broader social movements of the 1960s centered on lessening racial and class discrimination in American social, economic, and legal systems. Legal reformers in the 1960s saw the elimination of injustices in the criminal justice system as essential to promoting the constitutional rights of citizens who had historically been disenfranchised. Goluboff writes that the discriminatory impact of the criminal law on "the visibly poor and underemployed" was increasingly questioned throughout the 1960s. Historically, the criminalization of vagrancy, idleness, and drunkenness had been used in urban areas to "make any form of unemployment whether willful or involuntary legally unacceptable."[32] In light of an

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[30] *The Challenge of Crime in a Free Society: A Report by the President's Commission on Law Enforcement and the Administration of Justice* (Washington D.C: US Government Printing Office, 1967), viii.
Like Elizabeth Hinton has shown, "legitimate crime" during the Johnson administration was consistently a synonym for a seeming uptick of crimes in urban areas. Johnson's "War on Crime" and the resulting "significant expansion" in law enforcement mechanisms tended to undermine the administration's other progressive aims by increasing "supervision and control in low-income urban communities," disproportionately impacting "an entire generation of young men of color." Hinton, *From the War on Poverty to the War on Crime,* 2-3.
[31] *The Challenge of Crime in a Free Society,* vii.
[32] Goluboff, *Vagrant Nation,* 16.

expanding welfare state and a renewed emphasis on the rights of indigent Americans, this criminalization of poverty no longer made any sense to those interested in reform. While the punishment of those who were "idle, indigent or itinerant" had traditionally been used to "persuade unemployed persons to seek work," they could be now be replaced by growing job training and employment services.[33] As the American Civil Liberties Union and other legal aid groups began taking on indigent citizens as clients, individuals now had the representation to make these claims around due process and their constitutional rights in court.

These arguments altered the legal standing of impoverished Americans and led to an ongoing debate over the proper response of government to poverty. Removing class biases from the criminal justice system, decriminalizing poverty and difference, and protecting the due process and constitutional rights of American citizens would all become key arguments in why alcoholics should be taken out of the legal system and placed into the hands of social services. These claims could not have been made without President Johnson's War on Poverty. In an era of postwar economic prosperity, the dire poverty of millions of citizens in both rural and urban America seemed particularly jarring. As President Johnson declared in his speech announcing the War on Poverty effort: "We are citizens of the richest and most fortunate nation in the history of the world…. Yet there are millions of Americans- one fifth of our people- who have not shared in the abundance which has been granted to most of us." Reflecting his faith in the federal government's ability to tackle society's most complex problems, Johnson promised "total victory" against national poverty and an assurance of "an America in which every citizen shares

[33]Due process "requires that every exercise of the criminal sanction have sufficient rational relationship to a legitimate public objective." With this definition, vagrancy and drunkenness no longer were seen as meriting criminal sanction. Robin Yeamans, "Constitutional Attacks on Vagrancy Laws," *Stanford Law Review* 20, no. 4 (April 1968): 784; *Fenster v. Leary,* New York, July 7, 1967, 316; Forrest W. Lacey, "Vagrancy and Other Crimes of Personal Condition," *Harvard Law Review* 66, no. 7 (May 1950): 1203-1226; Caleb Foote, "Vagrancy Law and Its Administration," *University of Pennsylvania Law Review* 104, no. 5 (March 1956): 603-650.

all the opportunities of his society."[34] Johnson and his advisors envisioned a comprehensive expansion of social welfare legislation that could take on both the causes and consequences of poverty with a focus on families, jobs, education, and health.

The War on Poverty was designed to fix the fault lines of the New Deal, bringing into the fold those who had been left out on account of racial discrimination. As a number of historians have documented, War on Poverty programs often failed to meet their lofty goal of eliminating poverty. Scholar Jill Quadagno has pointed out that, in part due to the continuation of racial biases amongst legislators, the focus always remained on changing the "the character of the individual rather than the character of the economy."[35] Exemplified in the focus on job training as opposed to job creation, War on Poverty programs dealt more with trying to increase socioeconomic opportunities rather than intervening in social or economic structures. Within this individualistic framework, alcoholism and drug addiction became sources of great concern. An individual's misuse of substances, not systems-level issues, became targeted as one of the main causes of economic deprivation in anti-poverty politics. Though both drug and alcohol addiction were being reframed as health rather than criminal problems, they remained sources of individual pathology and thus fit neatly into a program that made changing individual character defects central to alleviating poverty.[36] The emphasis on alcoholism amongst the homeless and impoverished was politically useful, giving reformers a clear issue that could be targeted through War on Poverty funds for detoxification and rehabilitation.

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[34] *Public Papers of the Presidents of the United States: Lyndon Johnson, 1965* (Washington D.C.: Government Printing Office, 1966).
[35] Jill Quadagno, *The Color of Welfare: How Racism Undermined the War on Poverty* (Oxford: Oxford University Press, 1996), 30.
[36] Kohler-Hausmann, "Guns and Butter," 94-95.

Skid Row and The "Alcoholic Poor"

An overlapping emphasis on alcoholism and poverty by the 1960s led reformers to focus their attention on a specific urban place where both of these were believed to be most prevalent: Skid Row. Experts believed white male homelessness to be quarantined to geographical areas of American cities termed "Skid Rows."[37] These districts were often marked by the presence of cheap lodging houses, restaurants, bars/taverns, employment agencies, and Christian missions. Located near factories, waterfronts, and freight yards, skid rows throughout the United States developed alongside migratory labor markets in the late 19th century. Most residents of Skid Row were young males following the work offered by railroad, shipyard, and lumber industries. Histories of Skid Row have shown how these spaces were racially diverse consisting of white Americans, Mexican Americans, African Americans, and American Indians. But those studying "Skid Row" before the late twentieth century tended to rarely count non-white persons or women among the homeless.[38]

By the 1960s, the economic circumstances outside of Skid Row districts had changed. The postwar GI bill helped to fund mass suburban homeownership for white males and their families throughout the 1940s and 1950s. This legislation, according to historian Todd DePastino, effectively "[transformed] demobilized men into breadwinning husbands and fathers." However, as more citizens enjoyed an increase in socioeconomic mobility, "the men of Skid Row appeared to be stagnating."[39] Because the impoverished Skid Row man seemed like an aberration in a time of postwar economic prosperity, they became the center of interest and

[37] The term "skid row" originated in the 19th century, being used to describe the skidways loggers and lumberjacks in the Pacific Northwest used to transport lumber to sawmills in cities like Seattle and Spokane. Todd DePastino, *Citizen Hobo: How a Century of Homelessness Shaped America* (Chicago: University of Chicago Press, 2003), 227.
[38] Ibid., 231-232. Donald J. Bogue, *Skid Row in American Cities* (Chicago: Community and Family Study Center, 1963), 1.
[39] DePastino, *Citizen Hobo*, 227.

study. Politicians, scholars, and reformers turned their attention to the continuation of poverty in urban spaces and debated the best ways to end the indigency and homelessness of Skid Row.

In between the 1940s and 1960s, skid rows were equated with problem drinking in popular representation and scholarly works. Michael Harrington in his seminal work on poverty *The Other America* labeled Skid Row residents "the alcoholic poor" whose poverty he believed to be "the bitterest, most physical and obvious." Harrington's branding of Skid Row residents made their alcoholism inseparable from their poverty. To be poor and on Skid Row was to be an alcoholic and vice versa.[40] What Harrington and others struggled to determine was which of these problems was a cause and which was an effect. Did alcoholism lead to poverty? Or was problem drinking a consequence of being poor? Harrington seemed to favor the latter option, arguing: "Though their spiritual torment is well known by most Americans, what is not understood is the grim, terrible, physically debilitating life of the alcoholic: the fact that these people are poor." Harrington was one of the few who emphasized the poverty aspect. The conflation of the alcoholism with Skid Row poverty led to a focus on the excessive drinking part, overshadowing the fact that these individuals were economically marginalized. "Alcoholic poverty" therefore remained particularly stigmatized, attached to the traditional belief that chronic drunkenness and its consequences resulted from personal choices. Or as Harrington put it plainly: "People get moral when they talk about the alcoholic."[41]

[40] Alcoholic advocacy groups like the National Council on Alcoholism, A.A. and the Yale Center consistently fought against this association between alcoholism and Skid Row, arguing that alcoholics were not "worthless, weak-willed skid row derelicts" but were "worthwhile persons suffering from an illness which can be successfully arrested." They walked a fine line between claiming that derelict alcoholics existed and were deserving of help while maintaining that these individuals were not the "average" alcoholic. Ordinary alcoholics were far more respectable and fully worthy of being seen and treated as sick citizens in need of help. Ruth Fox, "Alcoholism in 1966," *American Journal of Psychiatry* 123 (Sept. 1966): 337.

[41] Michael Harrington, *The Other America: Poverty in the United States* (New York: Macmillan Publishing, 1962), 82; 94-95.

Press reports published in between the 1940s and 1960s represented Skid Row residents with a mix of pity, fascination, and frustration. Many major newspapers continually published articles on Skid Row, often written by journalists who had supposedly lived on skid rows for a few days to provide personal accounts of life there. The public seemed hyper-interested in these stories. One Chicago newspaper's readership jumped to 20,000 copies a day when it offered "an inside story" of "drunks on the street."[42] Most of these stories included images of men passed out on the street with piles of liquor bottles alongside them. They dwelled on the physical appearance of these individuals as being both off-putting and sympathy-inducing. To *The New York Times,* alcoholics were "grimy unfortunates" who had been drawn "to the Bowery's deep shadow with the same instinct that makes hurt wild things seek the cave or forest darkness to lick their wounds."[43] This theme of Skid Row men as being hurt or broken was reflected in a variety of stories. But journalists also emphasized that these men had not been capable of living up to the realities and demands of mainstream society. They had chosen Skid Row because it was the only place "where [security] is unchallengeable- at the bottom of the heap, where no man can fall."[44] These men had not been failed by American social or economic structures but had failed to fully participate in them. And their habitual drinking and fall to Skid Row was often depicted as a result of this inadequacy.

However, many of these stories also perpetuated the view of Skid Row men as pitiful creatures in need of help. One of the most vivid depictions of this characterization came from a *Boston Globe* reporter, Ray Richard, who described the Skid Row scene in 1969:

> Drunks hang out there. You can see them day or night. There's hundreds of them slumped in doorways, shuffling along sidewalks, crowding the crummy taverns, staggering into the streets,

[42] "Land of the Living Dead," *Time Magazine*, August 29, 1949, 48.
[43] Meyer Berger, "The Bowery Blinks in the Sunlight," *The New York Times,* May 20, 1956, 228.
[44] Elmer Bendiner, "Immovable Obstacle in the Way of a New Bowery," *The New York Times,* January 21, 1962, 187.

> their bodies tired, their faces sad, their hands outstretched for donation. It's all unshaved faces- expressions of despair- second hand clothing, outdated styles, unmatched and too big- badly worn shoes or sneakers over stockingless feet. These are the bums. The winos. The rejects. The quitters. In the city where they live in clusters, it's called Skid Row… these are lonely desperate people- rarely evil. They have done terrible harm but only to their own lives. These are misunderstood people. They collapse every day from hunger, malnutrition, exhaustion, pneumonia. For hours they lay where they fell, ignored by the haughty and healthy. These are the weary, the harmless. They don't want trouble and seldom cause it. They have enough just trying to survive.[45]

Richard's portrayal picked up on a number of themes common in most renditions of Skid Row. It conflates the area with homelessness, poverty, and alcoholism with the main descriptor of the residents being "drunks," "winos," or "bums." He harps on the physical appearance as a way to document the supposed misery and sadness of Skid Row poverty. While not fully discarding the moralistic view of homeless alcoholics, he argues that they do not represent a threat to the public. And he is trying to depict them as something other than criminal, characterizing them as sick and harmless rather than dangerous and fear-inducing. These kinds of descriptions set the tone for how the public as well as government officials understood the "alcoholic poor."

The large body of social scientists studying this population also tended to offer a similar welfarist take, claiming that homeless alcoholics would respond to rehabilitation if it was offered. However, their understanding of what led these individuals onto a path of poverty and excessive drinking influenced their proposed therapy recommendations. Two primary views regarding Skid Row residents emerged. One camp argued that Skid Row men had a distinct subculture. These group culture theorists claimed that no matter how cut off Skid Rowers were from mainstream society, they formulated their own community.[46] The prevalence of drinking, while problematic, might not necessarily be tied to alcoholism. Instead, heavy drinking was a

[45] Ray Richard, "Skid Row: Lonely Bums and Desperate Winos," *The Boston Globe,* February 3, 1969, 1.
[46] W. Jack Peterson and Milton A. Maxwell, "The Skid Row 'Wino,'" *Social Problems* 5, no. 4 (Spring 1958): 308-316; Joan K. Jackson and Ralph Connor, "The Skid Road Alcoholic," *Quarterly Journal of Studies on Alcohol* 14 (1953): 468-486; Earl Rubington, "The Chronic Drunkenness Offender," *The Annals of the American Academy of Political and Social Science* 315 (Jan 1958): 65-72; and Samuel E. Wallace, "The Road to Skid Row," *Social Problems* 16 (1968): 92-105.

way to find companionship and acceptance within the Skid Row subculture. Social scientists in this camp tended to believe that aid for these individuals had to come in the form of replacing this support system with one that was healthier and more tied to mainstream societal norms. In this sense, Skid Rowers could be rehabilitated by replacing their drinking subculture with Alcoholics Anonymous, group therapy, and sober halfway houses.

The other social science camp issued findings, which would become more influential in public policy debates, contending that people ended up on Skid Row and began excessively drinking because they were undersocialized. Similar to the images espoused in the press, undersocialization theory claimed that individuals came to Skid Row in light of their rejection to mainstream norms. These individuals were "deprived of the opportunity of sharing experiences with others" whether this was through marriage, schooling, employment, or community life. This lack of social ties made them "insecure" in "normal society" and caused them to "choose a way of life which avoids associations."[47] One predominant Skid Row researcher, Howard Behr, went so far as to define "homelessness" as a "condition of detachment from society." Behr claimed that the defining feature of "the Skid Row man" was his "powerlessness," but this powerlessness was rooted in his "disaffiliation or lack of social ties."[48] With this conceptualization, lacking social connections was the most important facet in being considered homeless, more so than even the fact that one was without a permanent home or shelter. Furthermore, this lack of attachment removed any social pressures that might have prevented one from drinking excessively. And though life on Skid Row may allow for an escape from social norms, it also could drive people into a pattern of heavy drinking. As one popular study of Skid Row alcoholics

[47] Robert Straus, "Alcohol and the Homeless Man," *Quarterly Journal of Studies on Alcohol* 7 (December 1946): 363.
[48] Howard M. Behr, *Skid Row: An Introduction to Disaffiliation* (Oxford: Oxford University Press, 1973), 17.

argued, these men were "isolated, uprooted, unattached, disorganized, demoralized and homeless and it is in this context that he drinks to excess."[49] Undersocialization theorists toggled between seeing a descent onto Skid Row as a conscious choice to reject social norms or as a failure of American social and economic structures to integrate these individuals. But no matter the causes of undersocialization, this theory still buttressed an individualistic approach to the problems of urban poverty and homelessness.

The medicalization of alcoholism, the efforts to make the criminal justice system more humane, and anti-poverty measures led to a natural focus on the plight of Skid Rowers. The scholars and officials who tried to eliminate the homelessness and poverty of Skid Row districts approached these problems with the individualistic analysis common in all War on Poverty programs. Instead of dealing with the larger social and economic reasons that could lead an American citizen into a cycle of poverty and homelessness, the political solutions offered emphasized individual behaviors and pathologies. Skid Row men's alcoholism and excessive drinking became the main issue that seemed to be preventing them from being the productive job holders, homeowners, and breadwinners expected in an era of postwar abundance. As the disease concept of substance abuse took hold and the rights of the poor expanded, homeless alcoholics were now seen as sick people who deserved publicly subsidized treatment as opposed to incarceration. While this focus on curing Skid Rowers of their alcoholism might have done little to end urban poverty, it did alter how these individuals were treated by local law enforcement and it did change the political conversations around the rights and entitlements of alcoholic citizens. These discussions began in earnest with a national debate over the fairness of public drunkenness laws and their effects on homeless alcoholics in American cities.

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[49] Pittman and Gordon, *Revolving Door,* 145.

Decriminalizing Public Drunkenness

The origins of drunkenness laws in the United States were tied to a traditional moralistic view of excessive drinking. English common law first made public drunkenness a criminal offense in 1606 with a statute entitled "An Act for Repressing the Odious and Loathsome Sin of Drunkenness."[50] As outlined in the title of the law, these statutes were designed to police certain behaviors that were considered immoral in nature. Colonial leaders instituted similar codes throughout early America. By the 1960s, statutes criminalizing drunkenness remained on the books although they varied by state and by locality. In some areas, intoxication had to be accompanied by disorderly conduct or a breach of peace to warrant an arrest. But most states and localities had laws that criminalized solely the act of "being drunk in a public place," without clearly defining what accounted for "being drunk" or "drunkenness."[51] While the kind of statute criminalizing the act of public intoxication varied by locality, all of them remained holdovers from a time of biblical and moralistic disapproval of heavy drinking. In the second half of the 20th century, legal reformers and researchers in the developing alcoholism field began to view these laws as anachronistic relics of Temperance and Prohibition that were not reflective of a modern society.

Critics of public drunkenness laws also pointed to how they disproportionately affected the homeless and the poor in American cities. Studies commissioned throughout the 1960s found that approximately 2 million arrests for drunkenness occurred each year across the United States.

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[50] Peter Barton Hutt, "Perspectives on the Report of the President's Crime Commission- The Problem of Drunkenness," *Notre Dame Law Review* 43, no. 6 (January 1968): 859.
[51] President's Commission on Law Enforcement and Administration of Justice, *Task Force Report: Drunkenness-Annotations, Consultants' Papers, and Related Materials* (Washington DC: US Government Printing Office, 1967), 1.

While the corresponding punishment varied by state, most resulted in a fine ranging from 10 to 50 dollars. If someone was unable to pay the fine, they would be held in a jail cell until they could be seen in "drunk court" where judges would mete out sentences to correctional facilities ranging between 5 days and 6 months (the most common being 30 days). As the President's Crime Commission reported, persons arrested for drunkenness consisted of different "offenders," including "rowdy college boys, the weekend inebriate… unemployed and single men."[52] But homeless individuals were overrepresented in this group, often showing up in drunk court as "repeat offenders." On the surface, the reason for this uneven representation made sense. While individuals with homes had a safe place to either drink in or return to after drinking, for unsheltered citizens drinking and drunkenness happened in public and therefore was likely to come to the attention of the police and result in an arrest. Furthermore, these citizens did not have the financial resources to pay the fines to avoid incarceration. Those involved in the decriminalization movement termed these individuals "chronic public inebriates," defined as "one who is repeatedly drunk in public, has frequent contact with the police, often resulting in incarceration and has limited financial and other resources."[53]

Criticisms of drunkenness laws and their effects on the indigent came from five different corners: social scientists, municipal judges, legal advocacy organizations, government crime commissions, and the "chronic public inebriates" themselves. Each of these groups had different concerns about the inhumanity, inefficiency, and injustice of public drunkenness laws. But all of them were united in their belief that drunkenness should no longer be considered a crime. Additionally, they all agreed that many amongst the homeless population were struggling with

[52] President's Commission, *Task Force Report,* 1.
[53] National Conference on the Public Inebriate, *The Public Inebriate: Overview and Alternatives to Jail* (Madison: Wisconsin Clearinghouse, 1981), 3.

excessive drinking and should not just be left alone. Instead, they deserved to be seen as sick citizens who should be provided with publicly subsidized medical treatment and social welfare supports to help them get back on their feet. In order to justify the use of taxpayer dollars to fund these efforts, they argued that homeless alcoholics were capable of fully participating in American society and economy if their alcoholism was cured.

The most ardent scholarly support for this transition from a penal to a therapeutic approach came from sociologists David Pittman and Wayne Gordon. They were commissioned by the Yale Center of Alcohol Studies to examine how many chronic alcoholics were caught in the punitive institutions of Rochester, New York and to see whether these individuals might respond to rehabilitation. Their final product, entitled *Revolving Door: A Study of the Chronic Police Case Inebriate,* was published and widely distributed in 1958. The study was one of the first to utilize the disease concept of alcoholism to explain the troubles facing homeless individuals. It is important to analyze their findings in full as their study would initiate a whole branch of social science research beyond the Rochester case that supported the need to decriminalize public drunkenness. Their proposed solutions would be taken on by political officials across the country as the most viable methods for dealing with homeless alcoholics.

According to Pittman and Gordon, the majority of the homeless population in American cities were either alcoholics or people who had problems with habitual drinking. This was a group who had been failed by every aspect of American society- by social organizations that failed to fully integrate them into their communities, by families who failed to love them, by employers who failed to see them as people, and by hospitals that refused to treat them. But by far the biggest failure was the way in which the criminal justice system engulfed Skid Row alcoholics in a repetitive cycle of punishment and dehumanization. Pittman and Gordon labeled

this penal process a “revolving door” for the way in which homeless individuals were caught in a series of arrests, incarcerations, releases and rearrests for the act of being drunk in public. They claimed confidently that the results of their study “negated completely the assumption that incarceration acts as a deterrent to the chronic public inebriate.” The futility of the system could be seen by the high rates of recidivism. In Rochester, for example, 82% of the population jailed for public drunkenness at the time of their study had already been in jail for the same crime.[54] Some were arrested between 100 to 200 times and ended up serving 10 to 20 years in jail on short term sentences.[55] Clearly, arrests and jail time did not prevent these men from being drunk in public. And this method of punishment would continue to fail precisely because it did nothing to address the underlying reasons that were causing these men to drink excessively.

The *Revolving Door* report claimed that a significant proportion of the homeless population became “chronic police cases” not because they were willfully breaking the law, but because they were struggling with the disease of alcoholism. If drunkenness was an action attributable to sickness rather than criminality, then a new approach needed to be developed to handle those who were consistently being punished for nothing other than publicly manifesting a symptom of their disease. This new system would need to be “built on the concept of treatment and rehabilitation instead of punishment and custodial care.” While the criminal justice approach provided perhaps temporary shelter and food, it did little to stop men from drinking. If anything, the penal approach increased a person’s problem drinking behavior as consecutive arrests and jail sentences led to a “loss of self-respect and self-esteem” that could further incentivize drinking as a method of coping.[56] Instead, Pittman and Gordon envisioned a comprehensive

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[54] Pittman and Gordon, *Revolving Door*; 1,3, 139.
[55] David Pittman, “Public Intoxication and the Alcoholic Offender in American Society,” in *Task Force Report: Drunkenness* (Washington DC: US Government Printing Office, 1967), 7.
[56] Pittman and Gordon, *Revolving Door,* 145.

treatment approach. Medical treatment would be provided for detoxification and increasing physical health; individual and group therapy to improve mental health; and social rehabilitation for job, housing, and financial help. While these solutions seemed to be wide-ranging in approach, the main thrust remained on curing individuals of their alcoholism and dealt less with their unemployment, homelessness, or poverty.

Pittman and Gordon contended that this kind of holistic system had the potential of providing a long-term solution for Skid Row alcoholics. Propelling the undersocialization theory, Pittman and Gordon saw this multifaceted therapeutic regimen as being the best way to restore a sense of human dignity to men who had been demoralized by their time on Skid Row. By increasing these men's self-respect, homeless alcoholics would be far more willing to re-engage with mainstream society. The aim of this rehabilitation regime would be not only to halt Skid Rower's alcoholism but "enable them to function in productive roles in the community" by providing them with the tools needed to "adjust to becoming a responsible member of society" again.[57]

Perhaps because Skid Row individuals had long been considered by city officials as well as the bulk of the general public as bums or criminals deserving of punishment, those who argued for a more therapeutic approach swung heavily in the other direction. Setting lofty expectations, rehabilitation advocates claimed that some of the most downtrodden could change their drinking behavior, be uplifted out of dire poverty, and become active community members. These large goals were impractical for multiple reasons. Most problematic was misconstruing alcoholism as the main issue keeping individuals in a cycle of homelessness and assuming that this population could be "restored" through a temporary therapy program rather than providing

[57] Pittman, "Public Intoxication and the Alcoholic Offender," 18.

them with ongoing institutional supports. As will be discussed in the next chapter, advocates also mistakenly assumed that the public will and government investment would continue to support rehabilitation projects when these lofty goals failed to align with reality.

Despite the flaws in this approach, Skid Row researchers as well as the politicians and press reporters who picked up on their studies consistently utilized a language of usefulness, productivity, and responsibility when discussing the need for a different approach towards chronic inebriates. The individuals who were living on skid rows were written about as "wasting years of their lives," as their alcoholism and poverty were preventing them from fully engaging in American life. Social scientists, journalists, and politicians often tied this lack of participation in social and economic institutions to national citizenship. They marketed the therapeutic programs discussed by Pittman and Gordon as a way to "turn Skid Row alcoholics into useful citizens again" or to restore them to "a normal functioning, productive role in society."[58] Implicit in this terminology of useful or productive citizenship was the idea that homeless alcoholics were not currently behaving like full citizens. To be an American citizen was to have a permanent home, to be employed, to be self-sufficient, to provide for one's family, and to engage in the broader community.

For a Skid Row alcoholic to return to "useful citizenship," he needed to be sober, employed, and tied to mainstream society. Witnesses who testified before Congress in 1967 in order to receive public funds for alcoholism rehabilitation claimed that these programs would allow for "the sick alcoholic to be wisely reintegrated into the community, home, [and] taken off

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[58] Examples include: Stuart Auerbach, "Hospital Replaces The Drunk Tank in St. Louis Alcoholism Program," *The Washington Post,* October 23, 1966, A25; *Congressional Record-Senate*, April 27, 1966; *Congressional Record House,* May 1, 1967, 11335; "Reclaiming Alcoholics," *The Atlanta Constitution,* October 5, 1969, 18A; Charles Sutton, "Skid Row's Alcoholics Get Rebuilding Chance," *The Los Angeles Times,* April 24, 1960, E1; and Austin MacCormick, "Correctional Views on Alcohol, Alcoholism, and Crime," *Crime and Delinquency* 9 no. 1 (Jan 1963): 26.

relief." He would then "become a useful citizen to society, family, and the business community."[59] Reformers marketed sobriety as the main tool that would "restore" Skid Rowers to mainstream American life, therefore making their rehabilitation worthy of public investment.

The calls for rehabilitation funding hinged on a narrow understanding of the average homeless alcoholic being white and male, a demographic who reformers saw as future "useful citizens" and working breadwinners with the help of public investment. Howard Behr, one of the most prominent Skid Row researchers, claimed that most "Skid Row men are white men."[60] Yet, while the demographics of Skid Row populations varied by locality, they were never only made up of white individuals. Native Americans were a "visible minority" in Seattle as well as Los Angeles and San Francisco, Chicanos were represented in Sacramento, and African Americans supposedly made up 29% of New York's Bowery area. Despite the presence of racial diversity, researchers still tended to identify Skid Row alcoholics as predominately white. The supposed whiteness of Skid Row was a product of both the racial bias of those studying these areas and the racial discrimination that occurred there. African Americans and other non-white individuals were often barred from or assigned to separate lodging houses and Christian missions on the row.[61] Most Skid Row researchers throughout the 1960s, who tended to be white and male themselves, failed to address this racial dynamic at all beyond documenting that the majority of the population they studied were white.

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[59] *Alcoholism- Hearings Before the House for Control of Drunkenness and Treatment of Alcoholism in D.C.,* April 11, 1967, 88.
[60] Behr, *Skid Row: An Introduction to Disaffiliation,* 105. A sample of other works who claimed that the issues of homeless alcoholism in Skid Row areas was primarily a white problem: Raymond T. Nimmer, *Two Million Unnecessary Arrests: Removing a Social Service Concern from the Criminal Justice System* (Chicago: American Bar Foundation, 1971), 19; Donald Bogue, *Skid Row in American Cities* (Chicago: Community and Family Center, 1963), 161; Gerald S. Newman, *The Homeless Man on Skid Row* (Chicago: Chicago Tenants Relocation Bureau, 1961), 15; and Jacqueline Wiseman, *Stations of the Lost: The Treatment of Skid Row Alcoholics* (Chicago: University of Chicago Press, 1970).
[61] Howard, *Homeless,* 166.

Even by the end of the 1970s when the presumed whiteness of homelessness was brought into question, the reasons offered to explain this bias were limited. Leonard Blumberg, a sociologist who set out to study "invisible Skid Row populations," argued that "homeless Black workingmen" had been left out of previous research because they had been "less stigmatized," "hidden in the Black slum." Blumberg tried to explain the oversight of Black homelessness by stating simply that white social scientists and the "white population" in general "simply did not expect anything else from Black people."[62] The erroneous view of Black life somehow being synonymous with poverty became a justification for not seeing Black homelessness as anything in need of particular study or amelioration. In doing so, social scientists and the policy makers who utilized their findings failed to examine their own biases or the racial discrimination occurring within Skid Row institutions that had resulted in white-washed representations of urban homelessness.

This racial prejudice also pervaded how researchers understood the problem of alcoholism amongst the homeless population. Those examining chronic public inebriates were more likely to label those who were white as suffering from the disease of alcoholism. Public intoxication amongst individuals of color was identified instead as a consequence of non-white cultural norms. Pittman and Gordon's study found that there was an uneven representation of young Black men in their sample of drunkenness offenders in Rochester, representing 18% of incarceration numbers while making up only 2% of the population. However, unlike the older, white males who made up bulk of their study, Pittman and Gordon considered Black men "nonaddictive excessive drinkers" rather than alcoholics. Their drinking behavior and subsequent arrests were supposedly "a manifestation of the tendency of the lower-class Negro to indulge in

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[62] Leonard Blumberg, *Liquor and Poverty: Skid Row as a Human Condition* (New Brunswick: Rutgers Center of Alcohol Studies, 1978, 138.

aggressive disorderly behavior when drinking."[63] Other researchers similarly tied drunkenness amongst Black individuals to their assumptions about Black culture, which they believed exhibited "a greater tolerance for aggressive or sensual behavior" that allowed for the permission of "excessive ingestion of intoxicants." Thus, rather than seeing the public drunkenness arrests of Black men as an unfair handling of a disease symptom, Black men's drinking remained mired in prejudiced understandings of blackness as either pathological or criminal.

Police officers also demonstrated a prejudicial approach to non-white drunkenness offenders. People of color tended to be overrepresented in the arrest and incarceration statistics associated with typical "Skid Row offenses" such as public drunkenness, disorderly conduct, and vagrancy.[64] In the case of drunkenness, these arrests were tied to racially biased understandings of drinking behavior. For example, studies found that white officers believed that "all Indians who drink [were] drunks" and that "Indians [were] racially unable to drink moderately."[65] This stereotype influenced how often police arrested Native Americans who were visibly intoxicated. The same was true for Black Americans. After coming to the attention of law enforcement, as one African-American journalist A.M. Riviera noted, white folks were likely to be considered "problem drinkers" in need of help while "Negro tipsters [were] just plain drunks." Particularly in the South, racial discrimination pervaded both alcoholism knowledge and treatment. The director of a treatment center in North Carolina believed there to be "less alcohol addiction among Negroes because they take care of one another so much better."[66] Similar to how

[63] Pittman and Gordon, *Revolving Door,* 133. Pittman and Gordon also acknowledged that this over-representation of Black men in their sample was "a reflection partly of the higher vulnerability of the Negro to police and court action." But they focused less on this discrimination to explain these high arrest numbers, instead relying more on a stereotype of "aggressive" drinking behavior amongst Black men.
[64] Blumberg, 123.
[65] John Stratton, "Cops and Drunks: Police Attitudes and Actions in Dealing with Indian Drunks," *International Journal of the Addictions* 8 (1973): 618.
[66] AM Riviera, "North Carolina Considers Negro Tipsters Plain Drunks, White Alcoholics Receive Bulk of Funds for Rehab," *Pittsburgh Courier,* February 27, 1954, A3.

Blumberg claimed that Black homeless persons were just subsumed within the larger Black population of the city, Black individuals with drinking problems supposedly could be taken care of on their own and were less in need of public funds for treatment.

Studies also tended to assume that homelessness was primarily a male problem, overlooking the presence of women in Skid Row areas. This oversight was in part due to a lack of visibility as Skid Row women were far more likely to reside in shelters than to be found sleeping or congregating outdoors.[67] However, homeless women existed and often were represented in drunkenness arrest numbers as well (making up 3-20% of the total arrest numbers depending on the city). The few articles in the 1960s that focused on Skid Row women tended to be primarily concerned with their respectability, focusing on whether women engaged in prostitution to support their drinking. Researchers wrote that homeless women's "unrespectability while in a drunken condition" was "more grievous than a man's unrespectability" because her drinking was often linked to being "sexually promiscuous."[68] This focus on women's sexual behavior influenced how likely they were to be labeled as an alcoholic deserving of care. As one alcoholism counselor in Boston explained, "On skid row even more than in straight society, a male alcoholic is 'ill' and a female alcoholic is a slut."[69]

For the most part, however, women of the nation's skid rows tended to be ignored. The failure to account for these women might be because both homelessness and alcoholism were seen as male issues. Women also did not fit easily into the reasons heralded for helping Skid

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[67] Howard, *Homeless,* 169.
[68] Blumberg, *Liquor and Poverty,* 137; Mary Jane Cramer and Edward Blacker, "Social Class and Drinking Experience of Female Drunkenness Offenders," *Journal of Health and Human Behavior* 7, no. 4 (Winter 1966): 283.
Despite this focus on Skid Row women's sexuality, little attention was paid to the prevalence of sexual assault occurring in these areas. Memoirs of the gender dynamics amongst Skid Row alcoholics have detailed how women were often subjected to rape and other forms of violence. For example, see: Robert Sundance with Marc Gaede, *Sundance: The Robert Sundance Story* (La Canada: Chaco Press, 1994), 79; 116.
[69] Anita Harris, "Women Derelicts: To Be Old, Homeless, and Drunk," *The Real Paper,* July 25, 1973, 4.

Row residents. They were not male workers or family heads who could be restored to "useful citizenship" once their alcoholism was cured. Ann Geracimos, a writer for New York's *Village Voice,* pointed out this confusion over how women fit into the changes being proposed for the homeless and urban poor. She wrote: "Now that the ACLU is defending the rights of vagrants to be vagrants… and the Welfare Department is trying to cure Bowery bums instead of letting police take them to jail, now that minority rights are the just concern of the age, female bums and drifters are the least noticed, least upheld minority around."[70] While modifications were being proposed to handle homeless alcoholics differently, the fact that these problems were seen as white and male left out those who were not members of either category. When reforms were put in place, the lack of attention paid to the female homeless and alcoholic population would come under scrutiny with women protesting their right to be given both shelter and treatment.

"I've Got Rights Like Any Other Citizen:" Life on Skid Row

White men of Skid Row, particularly those who had frequent run-ins with law enforcement, were perhaps one of the most researched groups in the United States throughout the 1960s. In most of these studies, observers were far more interested in their own point of view concerning the reasons for a Skid Row existence rather than hearing from the men themselves. This bias led to a conceptualization of Skid Row individuals as mainly suffering from alcoholism. But the personal views of Skid Row residents complicate this narrow understanding. While most sources from this time period exclude the voices of Skid Row men, a few newspaper profiles and anthropological studies offer first-hand descriptions of their lives within Skid Row districts. Their voices help to sketch out their experiences with public drunkenness laws as well

[70] Ann Geracimos, "Where Do the Ladies Go? Distaff on Skid Row," *The Village Voice,* June 15, 1967, 17.

as their views on rehabilitation programs. Social scientists, legal scholars, and the politicians who debated about what to do with homeless alcoholics tended to depict this group as passive people who "[accepted] their fate" and were too broken to be able to change their circumstances.[71] In reality, many of these individuals were resourceful and were active in making the choices needed to survive in their circumstances.

While most social scientists pedaled the "undersocialization" theory, few men described the reasons behind why they currently resided on Skid Row in the same way. Instead, most men tied their move to Skid Row to a major change in their social or economic circumstances. Many Skid Row men traditionally worked physically demanding jobs like iron work, farming, or construction. Several reported a debilitating injury or a bout with a major illness like TB that prevented them from continuing to work. They found themselves on Skid Row as the only affordable place to live or were sent there by welfare offices. While many of the men sprinkled their drinking history throughout these narratives, they described economic insecurity as a large reason for being on Skid Row.[72] Heavy drinking could also be pointed to as a cause of one's "fall" into homelessness, but it was rarely talked about as the whole story. Skid Row men agreed with observers that living "on the Row" meant that one had reached "the bottom of the barrel."[73] But most of the men did not necessarily see their excessive drinking as the main obstacle keeping them in the area.

No matter their reasons for remaining on Skid Row, the men whose voices can be found in the historical record emphasize the prevalence of law enforcement in their lives. This level of police involvement was reflected in how older residents would teach "newcomers" strategies for

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[71] Kleiboemer and Schneider, "The Law on Skid Row," 37; Behr, "Skid Row," 199.
[72] Pittman and Gordon, *Revolving Door,* 55; 89; 122-123.
[73] Wiseman, *Stations of The Lost,* 5 and 45.

avoiding the police.[74] Despite these lessons, most Skid Row men had run-ins with the police on a routine basis. Weekly round-ups by "bum wagons" often led the police to make fairly subjective choices about who to arrest. A Chicago resident explained: "The Wagon circles around those alleys and streets, and if you're standing there with a couple of fellows, you're picked up. One day just after I got out of the house of corrections… I got picked up… without even a drink. In the first precinct, they have four paddy wagons alone. I guess those fellows have to pick us up to keep their jobs."[75] As this man described, the mere presence of someone who had been labeled a "drunk" by the police or had a similar appearance was liable to be arrested for public intoxication even if they were sober at the time. One man in California described it this way: "Arrest for drunkenness depends on where you are, who you are, what you look like, and if they need you to fill the wagon." In some cases, these arrests were used to shore up local law enforcement's arrest and prosecution statistics to illustrate to the community that the police were doing their jobs.[76] Skid Row men felt that they were specifically targeted to boost these numbers because they did not have the legal defenses to fight against unjust arrests.

Race also factored into how individual Skid Row men interacted with police. Native Americans in particular noted that stereotypes of the "drunken Indian" held by white officers made them targets for intoxication arrests. An anthropologist wrote that Indian Skid Rowers felt that they were "carefully watched" because they had been "suspected and labeled as drinkers"

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[74] Jackson and Connor, "The Skid Row Alcoholic," 476.
[75] Gerald Stern, "Public Drunkenness: Crime or Health Problem?" *Annals of the American Academy of Political and Social Science* 374 (Nov. 1967): 151.
[76] Wiseman, *Stations of the Lost,* 78.
The decision to arrest indigent men for drunkenness tended to correlate in each city to how much work a policeman had to do after booking. In New York City, for example, drunkenness arrests were remarkably lower than other cities' despite the larger population size because judges forced police officers to stay through booking and to be there to testify in court proceedings. In other cities, the policing of crimes like drunkenness were "politically useful" ways to show that law enforcement was waging a successful "war on crime." Nimmer, *Two Million Unnecessary Arrests,* 64; Morris, "The Law is a Busybody," 11.

and therefore any "sign of intoxication frequently resulted in arrest."[77] Additionally, Native residents of Skid Row described how white policemen treated them with racial animus and abuse. "If there is something going on where [the police] can beat an Indian's head in," a Native man in Minneapolis stated, "they will come right away for sure." Native Americans caught up in the carceral revolving door system argued that their arrests were because of unfair police treatment, not criminal behavior. The same Minneapolis resident explained: "The police hang out, stake out these bars, and I believe stop an Indian person driving or walking down the street on much less than probable cause or reasonable grounds than they do with white people."[78] It was this bias that had resulted in a disproportionate number of American Indians being arrested and incarcerated for drunkenness.[79]

Various individuals described a sense of indignation over the supposed "crime" they were committing. One man living on the Bowery in New York explained to a newspaper reporter: "I didn't commit no crime. What I did I did only to myself, see?"[80] He claimed that he could not be penalized for something that did not threaten the safety of another person. Another in Seattle queried: "Isn't it a man's personal business to live the way he wants? He's got a right to live and enjoy life like that- that should be his privilege as an American to live that way. Who the hell is the law to tell you that you can't drink?"[81] Many of the men questioned whether drunkenness

[77] Philip A. May, "Arrests, Alcohol, and Alcohol Legalization Among an American Indian Tribe," *Plains Anthropologist* 20 (May 1975): 133.
[78] Minnesota Advisory Committee to the US Commission on Civil Rights, *Bridging the Gap: The Twin Cities Native American Community* (Washington D.C.: US Government Printing Office, 1975), 68.
[79] An Indian Health Service report in the late 1960s agreed with this summation. They found that an "Indian [ran] a far greater risk of being arrested and locked up for drunkenness." This was why Native Americans were 12.2. times as frequently arrested for alcohol-related offenses than the general U.S. population and drunkenness alone accounted for 71% of Indian arrests. Indian Health Service Task Force on Alcoholism, *Alcoholism: A High Priority Health Problem* (Washington, D.C.: US Department of Health, Education, and Welfare, 1969), 5.
[80] Bendiner, "Immovable Obstacle," 187. Another man phrased it as: "Of course I had really been drinking pretty heavily. I won't deny that. But I wasn't making any trouble for anyone." Wiseman, *Stations,* 81.
[81] James Spradley, *You Owe Yourself a Drunk: An Ethnography of Urban Nomads* (Boston: Little, Brown and Company, 1970), 119.

even if it was in public should be counted as criminal. Not only was this considered an infringement on their personal rights, but they also did not see their behavior as "criminal" because they were not being threatening or violent. Though they found these arrests unfair, they did not feel like they were able to prevent them from happening. As one individual described: "There's no use complaining… you are outnumbered anyways. Besides, if you complain too much, [the police] will wait for you next time and really get you."[82] A number of Skid Rowers instead developed strategies to use arrests to their advantage. If they needed a source of food or if it was a particularly cold night, men would deliberately position themselves where they knew they would be picked up by the "bum wagon" so they could spend time sheltered in jail. Rather than the social scientist's depiction of these consistent pick-ups being an example of the men's passivity, some were exerting their own agency by manipulating the system to fulfill their own basic needs.

Skid Rowers also described experiences of degradation and unfairness after being processed on a drunk charge. Once booked at a local precinct, drunkenness offenders would be placed in a small, cement cell referred to as "the drunk tank." These rooms were described by reformers as overcrowded spaces where "there [was] no room to sit or lie down, where sanitary facilities and ventilation [were] inadequate and a stench of vomit and urine [was] prevalent." The men often referred to this area as the "barbeque rack" because there were no beds or blankets, only "steel slabs to sleep on." While most drunk tanks on average could hold around 40 persons, weekly round ups often resulted in far more individuals being packed into a small space. The men described the overcrowded nature of the tank as feeling "like a bunch of cattle,"

[82] Most Skid Rowers did not view the police as particularly violent or hostile. Some even described the police as "benevolent." But the general consensus was a sense of helplessness in the face of the policeman's decision whether that was being given the chance to "take a walk" or being taken to the precinct. Wiseman, *Stations of the Lost,* 80.

surrounded by "shit and piss all over the floor and guys who are diseased and sick."[83] A main concern from both the men and their allies was the lack of medical treatment. Some people placed in drunk tanks were severe alcoholics who suffered from Delirium Tremens (the DTs) because of alcohol withdrawal. DTs caused physical effects including shaking, tremors, irregular heartbeats, and occasionally severe hallucinations. No correctional officer was trained to deal with these kinds of health problems. Numerous cases were reported throughout the 1960s of men dying (primarily due to heart failure) in the drunk tank without ever having received medical attention.[84]

Chronic public inebriates were perhaps most angered by the complete lack of justice being served in American "drunk courts." Skid Rowers knew better than anyone that the drunk court proceedings were designed for expediency rather than actual justice, trampling on their legal rights in the process. Drunkenness offenders often were pressured into pleading not guilty, even if they were sober when picked up, because pleading innocent tended to result in a longer wait time in jail. They mocked the idea that drunk courts followed the rule of law. As one man in California explained, "It's law on the assembly line. I mean there's no concept on the part of anybody that goes into drunk court that this is a court of law… [judges are] handling 50 guys in a period of an hour or so… Each individual in the court of the United States is entitled to an individual and separate trial. But you go into [drunk] courts, 30 or 40 at a time, and they sentence

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[83] President's Commission, *Task Force: Drunkenness,* 2. Diane Stepp, "Help for 60,000 Drunks Questioned," *Atlanta Constitution,* July 10, 1968, 1; and Spradley, *You Owe Yourself a Drunk,* 159.

[84] Between 1964 and 1964, 16 people died while in police custody. "US Accused of Neglecting Its Alcoholics," *Atlanta Constitution,* October 1, 1967, 3B; President's Commission, *Task Force: Drunkenness,* 69; "Meeting the DC Problem," *Congressional Record- Senate,* May 10, 1967, 12225; James Yenckel, "Long Record of Chronic Alcoholic Ends Quietly In a District Cellblock," *The Washington Post*, April 10, 1966, B6; James Yenckel, "Need of Drunk Facility Cited After Jail Death," *The Washington Post,* September 8, 1967, C2; and William Reivogel, "Police Neglect Found in Alcoholic's Death," *St. Louis Post-Dispatch,* May 3, 1979, 10.

you accordingly."[85] The pressure to plead guilty on top of a lack of representation and mass sentencing did not follow along with any of these men's understandings of how the criminal justice system should operate.

Furthermore, the intensity of the punishment did not seem in line with the "crime." Some officials argued against decriminalization because jailing Skid Row alcoholics for 10 to 30 days allowed them to sober up and receive temporary food and shelter. Fighting against the argument that they were being locked up for their own good, one man stated: "As far as jails go, all jails are the same. Nobody likes to be in 'em regardless of whether they give you steak or whatever. Like any place, it's a place of detention… We're just taken away from the public. And as far as getting here, it's for [being] drunk, and as far as the sentence goes, I believe that's quite a price to pay. Taking 10 days away from your life for getting drunk."[86] Skid Rowers felt they were being incarcerated not for their own welfare but because they were seen as a public nuisance. The understanding that this punishment was only happening because they could not afford the fines to avoid jail was also particularly jarring to the drunkenness offenders. One man who had been on many skid rows across the country cited this disparity: "There is a tremendous hiatus between 20 dollars and six months in jail… Are you a landowner or a peon? That's about what it amounts to. It's completely unfair."[87] Similar to the arrest process, though, men who had been on the nation's skid rows for a long time knew how to work the process to their advantage. They would offer to leave town to avoid jail or ask to be sent to the state mental hospital for medical attention rather than being incarcerated. While this illustrates the Skid Rowers' cleverness and

[85] Others described the drunk court system as a "travesty of the American justice system" or as being treated "like an animal" where you are made to feel "look and feel like a bum whether you are or not." Wiseman, *Stations of the Lost,* 100. Spradley, *You Owe Yourself a Drunk,* 192.
[86] Wiseman, *Stations of the Lost,* 104-105.
[87] Spradley, *You Owe Yourself a Drunk,* 158.

agency within a rigged system, it also shows how subjective the drunk court proceedings were. Judges were willing to meet these requests because they knew that incarceration was rarely necessary for the charges on which the men were brought.

The experience of being in jail further heightened the sense amongst individuals incarcerated for public intoxication that they were being treated as something they were not: criminals. Drunkenness offenders differentiated themselves from what they considered "real criminals," namely those who committed violent crimes like armed robbery. As one man described, "All the way through admission, you are treated just like a criminal- and we're really not criminal."[88] This belief that they had not done anything worthy of being treated like convicts was coupled with a sense that there was a hierarchy that favored those who were serving longer sentences. Individuals convicted of petty theft or larceny for example whose incarceration timetable was much longer than 30 or 60 days were able to do more "high-status" work like kitchen or office jobs. Drunkenness offenders did not receive other privileges like getting visits or mail precisely because they served a comparatively short amount of time. One person described this feeling of being discriminated against within the jail: "The drunk, in general, is not really a criminal type and I don't know why a bank robber should be fed better than he is… the drunk is made to feel that he is on the lowest rung of society and he's treated as such."[89]

In addition to being cut off from the outside world despite not feeling like a "real criminal," drunkenness offenders also felt particularly exploited by the jail for their labor. Similar to the notion that needing to fill arrest quotas was leading to their pickup by the police, chronic inebriates felt that they were used specifically as a cheap labor force for penal institutions. One man described a partnership between the courts and the jails: "What a lot of

[88] Wiseman, *Stations of the Lost,* 118.
[89] Spradley, *You Owe Yourself a Drunk,* 213.

people don't realize is that this institution and most jails need labor and the alcoholic furnishes that. When I was a trusty in Minneapolis, I'd hear the superintendent call the judge and say we are short 150 men here and in 3 days the courts would send 150 men."[90] Another individual from California claimed that all the groups involved in the drunk court system knew that alcoholics were an expendable labor source. He stated: "Listen, any police, any guard at the jail, any judge can tell you what's going on with the drunks. It doesn't help to send them to jail. They all know that. But they are in it for the money and the graft. They aren't going to upset a good deal. As a man who has spent 20 years in and out of jail for drinking, I know what I'm talking about. They use us." Correctional officers indeed did view Skid Row alcoholics as reliable maintenance providers for the jail. They would be used and rarely paid to work on farms tied to the prison, keeping up the lawn, or helping with roofing and other construction work.[91] To those who found themselves in and out of jail on drunkenness charges, they understood the enforcement of drunkenness laws to have little to do with "justice" or penalizing criminal behavior. Instead, it was more about manipulating and exploiting defenseless individuals for economic gain.

While reformers often discussed the need to "restore" Skid Row alcoholics to "useful citizenship," some of the men themselves rarely saw their situation in similar terms. When asked by one anthropologist to pick a label that they most identified with, most picked the term "citizen" with "reference to their rights under the law and indicated their membership in American society."[92] These men did not feel like they should not be considered full citizens just because they happened to be either homeless or struggling with drinking. As one main explained, "Some say an alky is a non-taxpayer. I submit that our fraternity contributes considerably in

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[90] Wiseman, *Stations of the Lost,* 150.
[91] Ibid., 124.
[92] Spradley, *You Owe Yourself a Drunk* 83.

blood, labor, sweat, fines, bails, bonds, provides for cops, judges, attorneys."[93] Statements like these countered the notion being offered by reformers that homeless alcoholics needed to be returned to productive citizenship. For some living on Skid Row, they already were fulfilling their roles as citizens and were contributing to society.

However, others embraced the same vision of citizenship put forth by decriminalization advocates. Many referenced their hope to "no longer be leading a useless life," "make it in the outside world," "get back on their feet" or get "back into society."[94] This desire to no longer be on skid rows or consistently brought in on drunkenness charges was reflected in many men's calls for being provided something that would help alleviate either their drinking problem or their socioeconomic circumstances. One man in DC claimed: "I don't think jail has done me any good. Perhaps with social rehab or hospitalization I can get the incentive [to stop drinking.]"[95] Others like Robert Sundance in California described how he came to view his penal treatment as unlawful because he had the disease of alcoholism. He explained: "In the early years of my walk through the alcoholic world, I figured I was breaking the law because it was against the law to be habitually drunk in society. As time went by, I realized I didn't drink because I wanted to… I later heard the word 'disease' mentioned in relation to alcohol, and I figured, hell yes, I must have a goddam disease… The law was wrong to jail [me for] suffering from a disease."[96] While the majority of homeless alcoholics' stories are lost in the historical record, the few whose voices we can hear clearly articulate their understanding of being unlawfully penalized by the criminal justice system. Furthermore, many expressed a desire to be provided with medical help and other

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[93] Spradley, *You Owe Yourself a Drunk,* 30.
[94] Wiseman, *Station of the Lost,* 227.
[95] Rasa Gustaitis and Dan Morgan, "Alcoholism: Revolving Door Affliction," *The Washington Post,* July 26, 1964, E2.
[96] Sundance, *The Sundance Story,* 273. Sundance's case halted the incarceration of homeless alcoholics in California, following the logic that jailing sick citizens was a violation of their 8th Amendment rights.

forms of treatment in helping them to get back on their feet. Skid Row alcoholics utilized the language of citizenship in different ways. But many put forth the idea that they deserved, as American citizens, to be treated fairly under the law and were entitled to public aid. This sentiment was perhaps wrapped up most succinctly by one man struggling with alcoholism who had been in and out of jail for decades and was hoping to start receiving medical help: "I've got rights like any other citizen."[97]

Rethinking the Legal Approach to The Chronic Public Inebriate

In order for Skid Row alcoholics to receive the rehabilitation that researchers and Skid Row men themselves deemed necessary to treat their illness, the "revolving door" process of arrest and incarceration had to be legally reevaluated. Many judges presiding over metropolitan "drunk courts" became early supporters for decriminalizing public drunkenness because they personally witnessed the inhumanity homeless alcoholics were experiencing at the hands of the law. Judge John Murtagh of New York City described a typical scene within an urban courtroom: "I looked at the tragic figures lined up before the bench- unshaved, drunken, dirty, down and out. Notwithstanding the impressive judicial setting, one was aware only of a compound of smell, noise, dirt, drunkenness, and sweating people packed into a big, but crowded courtroom."[98] By the early 1960s, several judges like Murtagh could see that these "down and out" individuals were not dangerous threats to society. Instead, drunk court judges across the country began to see the Skid Row men who violated public drunkenness statutes to be in their courtrooms largely as a result of their struggles to control their drinking. Throughout the 1950s and 60s, the Yale School offered conferences specifically for judges to think through how the

[97] Wiseman, *Stations of the Lost,* 250.
[98] John M. Murtagh, "The Derelicts of Skid Row," *The Atlantic Monthly,* March 1962, 77-78.

medicalization of alcoholism might change the legal methods for handling excessive drinkers.[99] Most of these judges walked away with a sense that the disease-concept required a transition from a penal to a welfarist system for the homeless alcoholics currently wrapped in the "revolving door" process.

In 1960, a group founded the National Association of Municipal Judges to provide a professional forum where judges could rethink the relationship between chronic inebriates and the criminal justice system. This collection of over 800 lower court judges contended that "no single problem causes greater concern or constitutes a greater enigma than that of alcoholism," especially since this issue went beyond their judicial training. According to their statement of objectives, one of their ultimate goals was "relieving courts of the responsibility of administering to the health needs of citizens who require medical rather than legal treatment, such as alcoholics and drug addicts."[100] Their calls for removing alcoholics from the criminal process was not just because the judges were ill-equipped to handle them, but also was related to the idea that penalizing alcoholics was forcing them to make choices that flew in the face of a fair judicial process. When dealing with drunkenness offenders, judges had to take into consideration their knowledge of alcoholism as a medical illness while also being bound to the criminal codes they were supposed to be enforcing. Or as one observer put it, judges had to deal with the "implied inhumanity of sentencing a man who may be ill to jail."[101] While the criminalization of drunkenness remained in place, judges tried to deal with this possibly inhumane application of the law by finding a line between enforcing the criminal code and administering to the human needs of the sick men in front of them. Some judges would sentence the men to jail as a way to

[99] Judge Murtagh was often quoted as saying: "I got my law at Harvard, my alcohol at Yale." Ibid., 79.
[100] *Alcoholism- Hearings,* 11; "Statement of Objectives," *Municipal Court Review* 1 (1961): 19; "NAJA Joins Amicus Curiae on *Powell*," *Municipal Court Review* 7 (1967): 8.
[101] Wiseman, *Stations of the Lost,* 87.

get them off the street, forcibly dry them out, and provide them temporary food and shelter. Others let drunkenness offenders off with a warning or a suspended sentence.

Certain judges came up with more therapeutic ways that the court system could treat chronic alcoholics while drunkenness remained criminalized. These court-sponsored programs were forms of enforced medicalization, offering mandatory help as an alternative to carceral punishment. For example, Judge Ray Harrison of Iowa began a "court class" for police-case inebriates in the late 1950s. He would suspend sentences for drunkenness if offenders agreed to attend alcoholism awareness courses. Harrison's court classes operated similar to AA, utilizing the fellowship of former Skid Row alcoholics to show others that they could be "released from the chains of addiction into liberty and sane, sober citizenship."[102] While still wrapped up in the criminal justice system, Harrison's "court classes" were considered an alternative to punishing alcoholics. The success of Harrison's classes (the rate of arrests for drunkenness in Des Moines was supposedly down by over 30%) led to similar operations being started in Chicago, Denver, Omaha, San Francisco, Miami, and D.C. Another model program was set up in Atlanta by Judges TC Little and James Webb who allowed drunkenness offenders to go to a clinic instead of serving time in jail. Individuals who chose this option were required to take Antabuse, a pill that caused violent reactions to drinking in order to force an adjustment "to life without alcohol." The judges contended that the amount of drunkenness offenders who specifically asked to be put on "them pills" illustrated their desire to be helped and countered the traditional view that these

[102] Ray Harrison, "Drunks Become Amicus Curiae," *Municipal Court Review* 1 (1961): 9; Ray Harrison, "A Court Program for the Chronic Inebriate," *The Court and the Chronic Inebriate: Conference Proceedings* (Washington D.C.: US Government Printing Office, 1965), 20. Most of the recovery numbers seem self-reported by Harrison. However, a few news stories included quotes from individuals who had found help through the court classes. One man, Marvin, had been arrested over 300 times for drunkenness until Judge Harrison gave him the opportunity to attend court class. He then got sober and now held a steady job. Gordon Gammach, "The Judge Who Saves Alcoholics," *Look* 21 (February 1957): 78; Gerald S. Levin, "The San Francisco Court School for Alcoholism Prevention," *American Bar Association Journal* 53, no. 11 (November 1967): 1045.

individuals were too far gone to be aided in any substantial way.[103] NAJA marketed the achievements of these court programs as proof that alternative, therapeutic methods could be more productive in leading chronic drunkenness offenders out of a cycle of addiction, arrest, and incarceration.

These judge-initiated attempts at providing some form of humanitarian aid before decriminalization was put in place were obviously always limited in scope because they still operated within a punitive structure. If the ultimate goal of the North American Association of Judges was to remove chronic inebriates from the courts, then alcoholism education classes and Antabuse programming failed to achieve this. However, these programs served as examples of how chronic public inebriates could be handled more therapeutically. The faith that highly regarded judges put in the ability of homeless alcoholics to be placed on a path of "sober citizenship" was extremely influential in building political support at the local and federal levels for removing chronic alcoholics from the legal system and into the health and social welfare realm. Their role in these discussions was cemented early on with a federally sponsored conference in 1965 on "The Court and the Alcoholic Offender." President Johnson welcomed "the distinguished judges," whose knowledge he believed would be essential in implementing the removal of alcoholics from the penal system in order that "they may resume a role in our society of dignity and positive contribution."[104] Judges utilized their position to bolster support for the idea that alcoholics were sick individuals who deserved health and social service help rather than incarceration. The fact that a number of judges served as advisors on the presidential

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[103] Celestine Sibley, "The Comic Drunk Isn't Funny Anymore," *The Atlanta Constitution,* December 8, 1963, SM22; John Pennington, "The Judge is Trying to Rescue Alcoholics," *The Atlanta Constitution,* March 17, 1963, 1C.

[104] "Statement by President Lyndon B. Johnson," *The Court and the Chronic Inebriate: Conference Proceedings* (Washington, D.C.: US Government Printing Office, 1965), iv.

commissions' drunkenness task force in the late 1960s reflected the degree of their involvement in the move to decriminalize alcoholism and its public symptoms.

But perhaps, no other group was more influential in the fight for decriminalization than the lawyers working to reform the criminal justice system. Unlike social scientists and others who argued for a therapeutic approach to chronic inebriates, lawyers were primarily focused on ending a system that was violating the rights of the alcoholic poor. First and foremost, they argued that the enforcement of drunkenness laws inherently failed to comply with the due process safeguards expected in all criminal cases. Municipal drunk courts operated on a "mass production model" or "assembly line" basis where the prerogative was speed and efficiency to the detriment of the legal rights of drunkenness offenders. Men charged with violating public drunkenness statutes would appear before the drunk court judge often in groups of 15 or 20. There, legal scholars claimed, defendants were not "permitted even the most basic rights."[105] Unable to pay for counsel, they often pled guilty en masse. The few who pleaded not guilty would be given one-minute trials where the judge would serve as prosecutor, meting out sentences that tended to be subjective rather than based on sound legal grounds. Reformers contended that this "mass production" form of law harmed the integrity of the entire criminal justice system. As one legal scholar, Sanford Kadish claimed, "the whole criminal justice system is denigrated by the need to process massive numbers of empathetic and impoverished people through clumsy and inappropriate procedures."[106]

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[105] Stern, "Public Drunkenness: Crime or Health Problem?" 152; Kleiboemer and Schneider, "The Law on Skid Row," 36-37; Nimmer, *Two Million Unnecessary Arrests,* 2; and Yeamans, "Constitutional Attacks on Vagrancy Laws," 784.
[106] Sanford H. Kadish, "The Crisis of Overcriminalization," *Annals of the American Academy of Political and Social Science* 364 (Nov. 1967): 166.

Many advocates for criminal justice reform argued that legal rights of chronic inebriates were violated at the time of arrest. On account of the fact that "drunkenness" was not necessarily defined in most city's criminal codes, it was up to the police to decide for themselves who was exhibiting drunken behavior that justified an arrest. Unlike in drunk driving arrests, policemen relied on their own observations rather than breath or blood tests to determine intoxication levels. Policemen utilized certain signs of intoxication like bloodshot eyes, unsteady walking, slurred speech, or the smell of alcohol to justify a drunkenness arrest. Homeless individuals were vulnerable to being arrested just for being "drunk types," capable of being taken in if they were sober but had a disheveled appearance.

Some policemen would even arrest individuals based solely on the basis that they had previous convictions for drunkenness. As one police officer was quoted, "Why not arrest them now especially if the patrol wagon is on the scene and half empty?"[107] Most of the policemen who worked the "drunk beat" were assigned to patrol Skid Row areas on semi-permanent basis, allowing them to become acquainted with the residents of the area. Policemen on Skid Row initiated arrests to either remove certain individuals from public view (what legal scholars termed "peacekeeping") or to get the most down and out off the street for their own welfare and protection (paternalism). No matter their reasons, police intervention often was rarely "in the interest of law enforcement" but instead was in "the interest of producing relative tranquility and order on the street." This discretionary use of arrests was seen by police departments as the most appropriate approach to Skid Row citizens, despite the fact that their legal rights were often being violated in the process. As one police sergeant claimed, "A good man has things worked

[107] Stern, "Public Drunkenness," 150.

out in his own ways on his beat and he doesn't need anybody to tell him what to do."[108] Maintaining a relative sense of order within Skid Row districts was articulated as the most important goal for police officers working in these areas, even if this meant an inconsistent enforcement of the law.

However, this peacekeeping approach tended to discriminate against the poor. Homeless inebriates were far more likely to be arrested for drunkenness than drinkers of a higher socioeconomic status because their inability to return to a home could lead to public disturbances. For most legal reformers, this fact alone enough was proof enough that public drunkenness laws "inherently discriminated against the homeless and the poor."[109] Drunkenness laws also unevenly impacted people of color. Reports showed that drunkenness arrests were "far more frequent in Negro areas, especially during the weekends."[110] In most cities, the ratio of Black chronic police inebriates exceeded their population numbers, reflecting the vulnerability of Black Americans to unfair and discriminatory treatment by law enforcement. This racial and socioeconomic discrimination carried over into the courtroom as judges tended to make their rulings based on a subjective view of the physical appearance of the defendant, whether or not he had a job, or his arrest record. The results of this subjective sentencing were highly prejudicial

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[108] Bittner, "The Police on Skid Row," 710; 713; 714. A number of studies in the 1960s focused on how the policemen on Skid Row understood their role. Some saw Skid Row patrols as vital work in protecting the safety of the homeless and protecting the public order. Others believed this peacekeeping role to be a denigration to police work, as something that was taking manpower away from hunting down "real criminals" and that the "bums and drunks" would be better handled by social welfare agencies. David Arronson, C. Thomas Dienes, Michael C. Musheno, *Public Policy and Police Discretion: Processes of Decriminalization* (New York: Clark Boardman Company, 1984), 62.
In terms of drunkenness arrests, police officers rarely justified them as necessary in punishing for public intoxication. They occasionally said these arrests were necessary to get Skid Row residents temporary shelter and assistance. But the main reasoning for arrests was making "the men of the Row less visible to 'normal' citizens." Nimmer, "Public Drunkenness," 91.
[109] Presidential Commission, "Task Force Report: Drunkenness," 3.
[110] Nimmer, "Public Drunkenness," 89; Presidential Commission, "Task Force Report," 9; and Jerome H. Skolnick, "A Study of the Relation of Ethnic Background to Arrests for Inebriety," *Quarterly Journal of Studies on Alcohol* 15, no. 4 (December 1954): 624.

with the disheveled, unemployed, and previously incarcerated far more likely to get the maximum sentence of months in jail. On the rare occasions those with financial means got arrested for drunkenness, they were able to pay the small fines to avoid criminal processing. But, as one advocate argued, "poor drunks" were "compelled to endure the indignity of a perverted trial procedure and a jail sentence solely because of a lack of funds."[111] During a time in which reformers were focused on eliminating legal inequities, public drunkenness laws and their disproportionate impact on racial minorities and the poor became another area that needed to undergo significant changes to protect the rights of the most vulnerable.

Other legal scholars argued that drunkenness laws reflected a broader problem within the criminal justice system: overcriminalization. The true function of criminal law was to protect citizen's personal safety and property. But in a number of areas, American citizens were being policed for "victimless crimes" that made up over half of the nation's arrest records. Leading legal proponents of this theory, namely Norval Morris and Sanford Kadish, claimed that abortion, homosexuality, narcotics use, prostitution, drunkenness, and gambling were all examples of areas where people were being prosecuted for behaviors that impacted nobody but themselves.[112] Prosecuting these kinds of behaviors was based on a traditional and more "primitive" view of the criminal justice system where the law was used to "not only to protect persons and property but to lead men away from vices and sin, sins that injure only the sinner."[113] This policing of morality led to an overreach of the law into Americans' personal lives and hampered the functionality of the criminal justice system. Policing of victimless actions

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[111] Stern, "Public Drunkenness," 152.
[112] For more on the broader move to halt morality policing: H.L.A. Hart and Patrick Devlin, *The Enforcement of Morals* (Oxford: Oxford University Press, 1965); H.L.A. Hart, *Law, Liberty, and Morality* (Palo Alto: Stanford University Press, 1963); Edwin M. Schur, *Crimes Without Victims* (Englewood Cliffs: Prentice-Hall, 1965); and Louis B. Schwartz, "Morals Offenses and the Model Penal Code, *Columbia Law Review* 63, no. 4 (1963).
[113] Norval Morris, "The Law is A Busybody: Crimes Without Victims," *New York Times Magazine,* April 1, 1973, 11.

overloaded the system and removed resources from where it was really needed: violent crimes. According to Kadish, “no single experience so dramatically [exemplified] the misuse of criminal law” than the “staggering number of drunks fed into the criminal machinery daily.[114]” Homeless alcoholics were consistently being criminally prosecuted for behaviors that may have been unseemly but did not impact the health and safety of others. As Judge Murtagh queried, “Are they hurting you? Are you being threatened? When they overindulge, who are the losers, except themselves?”[115] Unlike the other “victimless crimes,” there was general agreement around the futility and inhumanity of drunkenness laws. Legal scholars concerned with victimless crimes firmly believed that the criminal handling of other forms of morality policing would “undoubtedly be exposed to public ridicule at some time in the future.”[116] They hoped that successfully decriminalizing drunkenness would provide a pathway to end criminalization in other areas like homosexuality and marijuana use once the public will was there to do so.

Public drunkenness laws touched on all the areas that criminal justice reformers were concerned about in the 1960s: violating the rights of the nation’s most vulnerable, discriminating on the basis of race and class, subjectively utilizing law enforcement, and misapplying criminal sanctions.[117] The combination of judges and legal advocates fighting for the need to remove chronic alcoholics from the penal system would lead to significant transformations for those caught up in a revolving door of arrests and incarcerations. Armed with these legal arguments for the need to decriminalize public drunkenness, local chapters of the ACLU beginning in 1964 set out to instigate test cases across the country that would force these changes to take place. ACLU

[114] Kadish, “The Crisis of Overcriminalization,” 166.
[115] Murtagh, “The Derelicts of Skid Row,” 81.
[116] Hutt, “Perspectives on The Report of The President’s Crime Commission,” 860.
[117] Mark Tushnet, ed., *The Warren Court in Historical and Political Perspective* (Charlottesville: University of Virginia Press, 1993); Michael R. Belknap, *The Supreme Court and Criminal Procedure: The Warren Court Revolution* (Washington: CQ Press, 2010); Geoffrey R. Stone and Davis A. Strauss, *Democracy and Equality: The Enduring Constitutional Vision of the Warren Court* (Oxford: Oxford University Press, 2020).

lawyers relied on the disease concept of alcoholism to explain why the criminal approach to public intoxication was unlawful. If alcoholism was to be understood as a "loss of control over drinking," then alcoholics (especially those without homes) who were drunk in public were doing so involuntarily. And if alcoholics did not have the ability to willfully participate in their behavior, then they lacked the *mens rea* or criminal intent required to be convicted of a crime.[118] The ACLU relied on the constitutional implications of this, arguing that to punish an ill alcoholic for publicly manifesting an unwilled symptom of his disease was in violation of his 8th Amendment protections against cruel and unusual punishment.

This line of reasoning was not without precedent. In 1962, the Supreme Court took up the case of Walter Robinson, a 25-year-old heroin addict who had been convicted in California of the crime of "using, being under the influence of, and being addicted to narcotics." Robinson's lawyers called on the Supreme Court to rule whether or not the jailing of a drug addict was constitutional if addiction was universally accepted as a compulsive disease. In a 6-2 decision, the Supreme Court sided with Robinson stating that "criminal penalties may not be inflicted upon a person for being in a condition that he is powerless to change."[119] This decision was substantial for a number of reasons. It put the weight of the Supreme Court behind the idea that drug addiction (not the sale of narcotics) was an illness and not a crime. Additionally, it was the

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[118] These legal arguments against the criminalization of drunkenness were not unprecedented. Peter Barton Hutt, the most prominent ACLU lawyer fighting for decriminalization in the 1960s, often pointed to the 1869 New Hampshire case of State *v. Pike* for a historical example of the disease defense. The court found that the defendant could not be held criminally responsible for murder if he could prove both that his alcoholism was a disease and that his behavior was a by-product of it. But this case "stood alone for almost a century" and it was not until the 1960s that the disease concept of alcoholism and its ramifications on the law gained real momentum. Peter Barton Hutt, "The Recent Court Decisions on Alcoholism: A Challenge to the North American Judges Association and Its Members," in *Task Force Report Appendix,* 1966, 110.

[119] *Robinson V. California,* 370 U.S. 660 (1962); Erik Luna, "The Story of Robinson: From Revolutionary Constitutional Doctrine to Modest Ban on Status Crimes," in *Criminal Law Stories,* ed. Donna Coker and Robert Weisberg (New York: Foundation Press, 2013), 53; and Raymond T. Nimmer, "Public Drunkenness: Criminal Law Reform," *Valparaiso University Law Review* 4 (1969): 85.

first time that the Court relied upon an 8th Amendment claim and intentionally applied it through the 14th Amendment to all the states. Their decision also had implications for other disease-based defenses based on the fact that the justices broadly conceptualized what counted as cruel and unusual in relation to sick individuals. As Justice Stewart claimed, "Even one day in prison would be cruel and unusual punishment for the 'crime' of having a common cold."[120] The ACLU seized upon the *Robinson* ruling since chronic alcoholism was similar to narcotics addiction. If drug addicts could not be incarcerated because they were ill, then it could be reasonably argued that jailing alcoholics was also unconstitutional on the grounds that punishing them for their illness was a violation of their 8th Amendment rights.

To test this theory in court, ACLU lawyers sought individuals who fit a specific profile. They needed to be unemployed, without financial resources, and homeless. Also, they should have a high number of arrests for public intoxication, be a proven alcoholic, be able to explain the unfairness of the system, and articulate a desire for rehabilitation. While the success of these test cases varied, they did not happen in a vacuum. The majority of them relied on testimony from medical and health experts who put their weight behind seeing alcoholics as ill and capable of receiving help. ACLU legal teams also formed partnerships with representatives from Congress, individuals from the Department of Health, Education and Welfare, as well as local public health officials to ready cities for a transition away from relying on penal institutions to deal with chronic alcoholics. These legal advocacy groups also knew that they had the support of judges and could rely on receiving favorable rulings on behalf of alcoholic defendants. Peter

[120] *Robinson v. CA.* The Supreme Court traditionally steered clear of 8th Amendment arguments, as it curtailed the states' power to define crimes and punishments. The Warren Court was often divided over whether criminal responsibility was inherently a constitutional question. They were more willing to side with due process claims that could bring about changes in the criminal process but did not impede the ability of state legislatures to define criminal intent. Mike E. Stevenson, "Chronic Alcoholism and Criminal Responsibility," *Gonzaga Law Review* 4 (1969): 342.

Barton Hutt, an ACLU lawyer from the DC chapter who took on a number of these test cases, summarized their main argument: "An alcoholic drinks involuntarily, as a result of his disease, and therefore cannot be criminally punished for his drunkenness…. Public intoxication is merely a symptom of a disease- chronic alcoholism- and under long accepted common law and constitutional principles neither a disease or its symptoms maybe be punished as criminal."[121]

In 1964, Hutt chose DeWitt Easter as the model defendant to implement a test case in Washington D.C. The lawyers intentionally zeroed in on the District of Columbia to test the legality of criminalizing chronic inebriates because the police rigidly enforced public drunkenness laws there. The District "recorded nearly half as many arrests for drunkenness as Los Angeles, a city three times as large as the District, and almost one and one-half times as many arrests as New York, a city with nearly ten times its population." Furthermore, the city had only one alcoholism treatment center that was run on an outpatient basis and was extremely underfunded. The D.C. branch of the ACLU as well as the Washington D.C. Area Council on Alcoholism hoped that a ruling proving the unconstitutionality of punishing alcoholics would not only prevent alcoholic citizens from being arrested for drunkenness but would also spur more investment in public health treatment and rehabilitation. Easter checked all the boxes for which the ACLU lawyers were looking. Alongside a long history of arrests, "Easter was an alcoholic, he had no home or family, he drank involuntarily, and could not stop drinking once he began."[122] At the urging of the ACLU lawyers, Easter pleaded not guilty to his 70th arrest for public intoxication. A trial judge sentenced him to serve 90 days in jail but the ACLU lawyers challenged this ruling until it was heard before the United State Court of Appeals in 1965. Easter's lawyers argued that he was "innocent of the

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[121] Peter Barton Hutt, "The Changing Legal Approach to Public Intoxication," *Federal Probation* 31 (March 1967): 41-42.
[122] Richard A. Merrill, "Drunkenness and Reform of the Criminal Law," *Virginia Law Review* 54, no. 6 (Oct. 1968): 1139; 1142.

intoxication charge on the ground that his alcoholic condition afforded a complete defense because it negatived the *mens rea* or the necessary criminal intent to commit the offense."[123] Hutt additionally brought in experts to testify that Easter could be helped by a program that would bring his compulsive drinking other control.

In March of 1966, United States Court of Appeals unanimously sided with Easter and ruled that chronic alcoholics were sick persons who had lost control over their drinking and were therefore not responsible for public drunkenness. Judge Charles Fahy surmised: "An essential element of criminal responsibility is the ability to avoid the conduct specified in the definition of the crime. To be guilty of the crime, a person must engage responsibly in the action. Chronic alcoholism is a defense to a charge of public intoxication and therefore is not a crime."[124] The *Easter* decision became a crown jewel in the decriminalization movement, reflecting a culmination of years of work. Newspapers widely reported on the case as being a "landmark ruling," effectively ruling that chronic alcoholics "were sick and therefore couldn't be jailed as criminals."[125] While the outcomes of this case will be further discussed in the next chapter, the news stories were right in predicting that *Easter* would have far-reaching consequences for the city of D.C. with officials now having to implement alternatives for handling homeless alcoholics.

A few months later in 1966, a similar case was brought before the Court of Appeals for the Fourth Circuit. Similar to Easter, Joe Driver was a 59-year-old, diagnosed alcoholic from North

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[123] *Easter v. District of Columbia* 209 A.2d (1965).
[124] Ibid.
[125] Don Morgan, "Easter Still Fighting His Battle," *The Washington Post,* April 1, 1966, A6; Paul W. Valentine, "Court Rules Alcoholics Here Cannot Be Jailed, *The Washington Post,* April 1, 1966, A1; "The Alcoholism Void," *The Washington Post,* April 3, 1966, E6; Jon Mclaughlin, "Alcoholic Hospitalized in First "Easter' Case," *The Washington Post,* April 2, 1966, B1; George Getze, "Alcoholism Called Illness: Chaos Feared Over New Court Policy on Drunks," *The Los Angeles Times,* December 26, 1967, B6; "False Arrests Suits Possible In Seizure of Public Drunks, *St. Louis Post-Dispatch,* October 18, 1966, 12; Sid Ross, "Man who May Rescue Alcoholics From Jail," *The Boston Globe,* July 25, 1966, B13; Joseph Harvey, "Alcoholism- If It's a Legal Illness," *The Boston Globe,* January 21, 1968, A3; and Fred P. Graham, "Alcoholics Win Key Court Case: Judges Rule They Cannot be Convicted of Drunkenness," *The New York Times,* April 1, 1966, 31.

Carolina who had been arrested over 200 times for public drunkenness. By the time of his case, he had served more than 25 years in jail for drunkenness. Driver's lawyers relied more heavily than Easter's on the *Robinson* precedent. They argued not only that chronic alcoholism should be seen as a viable defense against public intoxication but also that convicting and sentencing an alcoholic for drunkenness constituted cruel and unusual punishment. The appellate court judges ruled in Driver's favor and agreed that his arrests and incarcerations were a violation of his 8th Amendment rights. Judge Albert Bryan explained that the court's decision was based primarily on the fact that "chronic alcoholism [was] now almost universally accepted medically as a disease." When a symptom of that disease included being "unwillingly" drunk in public, then "no judgment of criminal conviction" could be given because "to do so would affront the Eighth Amendment, as cruel and unusual punishment in branding him a criminal."[126] Like the *Easter* case, the *Driver* ruling had wide implications as it applied to North Carolina, Maryland, Virginia, West Virginia, and South Carolina.

The ACLU lawyers were effective in these test cases precisely because they brought together the core arguments that had been winning broader acceptance amongst those in medicine, law, and politics. They successfully claimed that alcoholism was a disease and that alcoholic citizens, especially those without financial resources, were being unfairly and unlawfully imprisoned for being sick in public view. Their legal arguments were sound and they had enough support amongst the judicial community to receive favorable rulings. But perhaps the most effective aspect of their cases was that the men they picked for the test cases were capable of generating a level of public sympathy that decriminalization advocates had been working to solidify for years. As one legal scholar explained succinctly, "The most important reason for

[126] *Driver v. Hinnant,* 356 F.2d 761 (4th Circ. 1966).

success in each court case has been simply the sympathetic appeal of the defendants' basic position. It is difficult to dispute the argument that people who are sick should be imprisoned for exhibiting their symptoms in public."[127] While test cases were tried in other parts of the country between 1966 and 1967, *Easter* and *Driver* were the most significant because they were the first to effectively rule that chronic alcoholics could not legally be punished for public drunkenness.[128]

As ACLU lawyers looked for the right test case to bring before the United States Supreme Court, all cities (even those beyond the jurisdiction of the *Easter* and *Driver* rulings) were being forced to have conversations about what changes might need to happen to comply with a ruling that would make incarcerating chronic public inebriates unconstitutional on a national level. Officials on all government levels officials began working on legislation to fund rehabilitative alternatives, relying on the scholarly recommendations for how these programs could restore alcoholics to "useful citizenship." The resulting chaos that ensued upon the implementation of the *Easter* ruling illustrated that this transition from a penal to a welfare approach was not going to be simple or easy. It was hard to create a distinct boundary between punishment and rehabilitation. In determining this line, the rights and entitlements of homeless alcoholic citizens remained up in the air as well.

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[127] Merril, *Drunkenness and Reform,* 1164.

[128] ACLU lawyers in Georgia won a case for 57 year old Jack Dunlap in Atlanta. Judge Etheridge ruled that "chronic alcoholism was a legal defense" because alcoholics lacked "the intent" to commit a crime. Judge Etheridge argued that alcoholics should be dealt with like "mental patients" who were taken to health facilities rather than to city prisons. Unlike in the other test cases, however, Etheridge's ruling sought to differentiate the alcoholic from "the ordinary drunk" who did not have a medical problem. Two other cases were not successful. *Hill v. Seattle* claimed that decriminalization was a process that should happen through the legislature rather than through the courts in order to make sure that treatment programs were ready to handle alcoholics. The Supreme Court of Michigan was one of the only courts that articulated a reasoning for continuing to incarcerate alcoholics because it did have a certain "deterrent" effect and was necessary in removing "drunks who were a threat to the public."
Dick Herbert, "Imprisoning of Alcoholics Ruled Illegal by Etheridge," *The Atlanta Constitution,* July 15, 1967, 1.
Merril, "Drunkenness and Reform*,"* 1145-1147.

CHAPTER 2

"The Line Between Penal and Treatment Care is Far from Clear:"
Altering the State's Relationship to Alcoholics

In April 1968, NBC aired a special called "The American Alcoholic." The show opens with a voiceover by the actor James Daly: "We are the richest nation in the world. Our medicine is the most advanced. But for all our money and all our skill, the alcoholics among us are shamefully and consistently shortchanged. We prefer to ignore them, neglect them, reject them… We question their character. We'd rather preach to them than respond to their plight." As Daly speaks, video of businessmen walking along the skyscraper-lined streets of New York City is juxtaposed with footage of various men passed out in plain sight on the side of the street. A second video then plays depicting two police officers picking up one of these men off the street. After asking if he has had too much to drink that night, they place him in the back of their cop car. Daly narrates that "this is the alcoholic that everyone knows… he's dirty, unshaven, reeking from cheap wine. We think of him as a worthless bum. A public nuisance. A legal headache. But there is also a human side. One which we tend to ignore." To illustrate this human side, the special highlights an older, white "derelict alcoholic" named Willie. Emphasizing his sad condition, the camera focuses on Willie's face as he is brought to tears explaining how drinking led him to a lonely life on Skid Row. From the outset, the TV special questions how the tragic lives of alcoholics like Willie could occur in a country full of wealth and knowledge.

While most "Skid Row alcoholics" like Willie end up in jail on public drunkenness charges, the show presents another option for these men. In St. Louis, Harry has been picked up "in a desperate state" on the streets of downtown. Rather than going to the precinct's drunk tank,

the police bring him to a medical detoxification facility. One of the first in the nation, the St. Louis Detoxification Center offers Harry a "clean bed" and he receives "expert medical attention minutes after arrival." 10 hours later, Harry is sober and declaring to the cameramen, "[this place] helps me get sense enough to help myself." Daly narrates that men like Harry "are the most difficult to rehabilitate," but they are also the "most neglected."[129] The special was designed to make the case that if more men like Harry were provided something besides jailtime, perhaps they could successfully be rehabilitated. As the NBC program demonstrates, support for removing indigent alcoholics from the carceral system and into the realm of public health and social welfare had reached the level of mainstream media towards the end of the 1960s. National newspapers and popular TV channels were covering the challenges facing alcoholics like Willie and Harry and were doing so from the vantage point that these were sick people in need of help.

In addition to publicity, the aims of the decriminalization movement were gaining political traction at the federal government level. President Johnson openly endorsed the disease concept in a 1966 presidential address. The Department of Health and Welfare Services published reports on how alcoholism could be tackled on a national scale. And two significant presidential crime commissions called for public drunkenness to no longer be considered a crime in any American city. Federal attention towards alcoholism increased as Washington D.C. became the first major urban area to deal with the effects of decriminalization. Sheer chaos unfolded as D.C. municipal judges started to implement the *Easter* and *Driver* decisions in 1966. This emergency situation forced reformers in the decriminalization effort as well as city officials to confront the practical realities of their proposals, especially how ill-prepared public health and medical facilities were to assume the responsibility of treating alcoholic patients. As a result,

[129] "The American Alcoholic," *NBC,* 51.53, April 1968, https://www.youtube.com/watch?v=CAUh81LiSpA&t=416s.

D.C. became the primary site of contestation over the handling of indigent alcoholics. Those in charge of trying to remove chronic alcoholics from penal institutions struggled to determine the difference between what was considered "punishment" and what counted as "treatment."

Attempts by lawyers, judges, social scientists, and city officials to decide how alcoholism and drunkenness could be fully removed from the criminal justice system raised significant questions concerning the responsibility of state, local, and federal governments towards alcoholics who lacked financial resources. If it was now unconstitutional to jail chronic inebriates for a symptom of their alcoholic disease, what was to be done with the large number of homeless alcoholics in cities across the United States? Could these individuals just be left on the street or did local governments have an obligation to provide them with treatment? Did citizens struggling with alcoholism have a right to publicly subsidized treatment? Was it acceptable to mandate treatment, even if the sick individual himself did not voluntarily seek help? If so, what was the line between confinement and rehabilitation?

Those involved in the decriminalization process throughout the late 1960s tended to answer these questions in binary terms, positioning the "treatment" and the "punishment" of homeless alcoholics as opposites. Yet as D.C. judges and officials attempted to enforce the *Easter* decision, the boundary between these two supposedly diametrical poles became hard to define. Historian Julily Kohler-Hausmann has written about how scholars too have fallen into this binary trap when analyzing the histories of the American carceral and welfare states, often viewing these as "oppositional pairings" rather than "historically intertwined phenomena." "Rehabilitation and punishment were neither mutually exclusive nor opposite," Kohler-Hausmann writes, "instead they were contiguous and at times intertwined."[130] This chapter will

[130] Kohler-Hausmann, "Guns and Butter," 88; 91.

deploy this analytical framing to examine how the political conversations around the state's treatment of alcoholics also reveal an "intertwined" history of "rehabilitation and punishment." Though the historical actors described below were trying to differentiate between these two forms of state intervention, the ways in which they put the medicalization of drunkenness into practice were not inherently distinguishable from the criminal approach. Forcing the legal recognition of alcoholics as sick persons might have led to a more humane treatment of chronic inebriates. However, public alcoholism was still considered an individual pathology that necessitated governmental intervention. It was just the kind of state involvement and the level of coercion required that were the primary considerations up for debate.

Tracing the fallout of the 1966 *Easter* decision through to the passing of federal rehabilitative legislation in 1968, this chapter will analyze how civil liberty lawyers transitioned from fighting to end the punishment of chronic, indigent alcoholics to asserting the rights these citizens had to publicly subsidized medical treatment and social welfare supports. By making these rights claims, decriminalization advocates joined a larger trend that historian Paul Starr has labeled the "generalization of rights" occurring within healthcare policy and politics in the 1960s. Entitlement programs like Medicare created "a specific set of rights to medical care" for

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In her book length study on the topic, Kohler-Hausmann utilizes the politics of drug addiction as an example of how medicalized "treatment" especially when it relied on state coercion was not functionally different than imprisoning narcotics users. While there are a number of similarities between the politics of drug addiction and alcoholism in the late 1960s, there are also significant differences. First, the fact that one substance was legal led to major differences in the handling of drug and alcohol abusers. As Kohler-Hausmann illustrates, though both drug and alcohol addiction were being medicalized at the same time, the continued criminalization of narcotics bifurcated drug addiction politics between penalizing "pushers" or sellers of drugs and providing therapy to "users." Support for the "law and order" approach to both pushers and users quickly outpaced the seemingly failing and under-funded therapeutic options in the early 1970s.
Second, by the 1970s, drug addiction was being represented largely as a problem for "urban spaces of color" and "poor areas" while alcoholism and the abuse of prescription pills was largely attributed to white individuals and the affluent. The presumed whiteness of alcoholism allowed for a political rhetoric of therapeutics, worthiness, rights, and entitlements towards alcoholic citizens that the racial coding of drug addiction did not.
Kohler-Hausmann, *Getting Tough,* 63; 80.

citizens who were eligible.[131] Those interested in expanding access to healthcare services for alcoholics also relied on the rhetoric of rights. Though the law did not officially recognize any right to health care, legal scholars and others posited that healthcare was more than a privilege. Like other sick people, decriminalization advocates argued that alcoholics possessed the right to adequate medical care for their disease. These health rights claims formed the basis of "The District of Columbia Alcoholic Rehabilitation Act" which was signed into law in 1968.

The successful passing of this law marked the first time that the federal government placed its legislative weight behind recognizing alcoholism as an illness and that alcoholics no matter their economic circumstances were rights-bearing citizens deserving and worthy of help. In anticipation of a Supreme Court decision that would make the punishment of indigent alcoholics unconstitutional nationally, policymakers designed a rehabilitation program for D.C. that could serve as a model for the rest of the nation on how to stop the arrests and incarcerations of chronic public inebriates as well as how to uphold their right to publicly subsidized treatment. Fear that the confusion experienced in D.C. would be unleashed in other urban areas led to a significant amount of political support for funds to be directed toward a medicalized framework regarding alcoholism. By the end of the 1960s, a general consensus had formed among politicians, city officials, and reformers that it was the state's responsibility to ensure that one of groups most neglected by society, homeless alcoholics, received the medical and psychological treatment needed to treat their disease.

My analysis around this shifting relationship between indigent alcoholics and the state relies on the work of sociologist Loïc Wacquant. He has delineated three strategies that modern societies utilize "to treat conditions and conducts of those they deem undesirable, offensive, or

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[131] Starr, *The Social Transformation,* 388-389.

threatening." One is penalization where the state effectively reduces "a delinquent to a noncitizen" through imprisonment or other punishment thereby "invisibilizing social problems" like homelessness or substance abuse. The second strategy is medicalization where individual pathologies like "alcohol dependency, drug addiction or mental illness" can be treated by health professionals. As Wacquant explains, medicalization can serve "as a conduit to criminalization" especially for those "at the bottom of the class structure as it introduces a logic of individual treatment." The third method is socialization in which the state acts "at the level of collective structures and mechanisms."[132] Examples of this would include guaranteed jobs and income, or the building and subsidizing of housing for persons experiencing homelessness. Those involved in the debates around homeless alcoholics examined in this chapter wavered between the first two strategies but rarely touched on the third. Decriminalization advocates often failed to contend with the possible underlying structural reasons for why a Skid Row alcoholic ended up in his position. The primary issue remained his individual and pathological drinking behavior which could now be solved through medical treatment.

This chapter contends that medicalization did alter the role of the state in the lives of homeless alcoholics, especially as reformers' goals moved beyond halting punishment to fighting for the right that alcoholics had to quality health treatment. However, there were limits to what an individualized medical approach that did not take into account broader socioeconomic structures could do for homeless alcoholics. Members of the decriminalization effort continued to uphold the idea that that ending the "revolving door" cycle of arrests and incarcerations by replacing jail with medical aid would restore chronic inebriates to "full citizens." But a comprehensive alcoholism treatment program that remained focused on ending men's problem

[132] Loïc Wacquant, *Punishing the Poor: The Neoliberal Government of Social Insecurity* (Durham: Duke University Press, 2009), xxi-xxii.

drinking and dealt less with their economic or housing status meant that most Skid Row alcoholics were rarely reintegrated into mainstream society. Furthermore, decriminalization advocates remained torn between protecting the health and legal rights of chronic inebriates and continuing to see them as a public nuisance. Because of this, there was never any question that something had to be done with indigent alcoholics either for their individual well-being or for the sake of public order. Acceptance of the need for some kind of governmental intervention resulted in a continued reliance on the police to remove Skid Row alcoholics from public view. Even if this did not result in an arrest or prison sentence, it allowed for a continual blend of a penal and welfarist/medicalized approach towards alcoholic citizens like Harry and Willie.

Reactions to *Easter*

For the people working to change the treatment of public inebriates in the nation's capital, the *Easter* ruling was a long time coming. In 1946, a series of jailbreaks led to a city-wide investigation that found alcoholism to be the primary reason behind overcrowding in the District's jails. The result was a local statute passed in 1947 that directed the D.C. government to establish a diagnostic and rehabilitation clinic for alcoholics. Unlike twenty years later, however, there was no judicial ruling that made the continual jailing of chronic alcoholics unlawful. As the District government failed to fund the type of clinic called for in the statute, D.C. judges had no place to send drunkenness offenders who continued to experience the "revolving door" cycle of arrests, incarcerations, and rearrests found in most American cities. The Washington D.C. Area Council on Alcoholism (WACA), a voluntary health organization, attempted to force a change in 1960 by training and educating the community leaders who would be in charge of implementing

a public health approach for indigent alcoholics.[133] When both the educational and legislative campaigns failed to make a difference, WACA shifted tactics and partnered with the ACLU to bring DeWitt Easter's case to court. By the mid-1960s, WACA had learned that they could not rely on local statutes alone to create more humane treatment of alcoholics. A court decision that would make the penalization of homeless alcoholics unconstitutional was now seen as necessary to force the funding of the therapeutic programming that had been called for in D.C. since 1947.

Decriminalization advocates as well as the popular press heralded the *Easter* ruling that resulted from WACA and the ACLU's work as being a watershed moment for alcoholics. A *Washington Post* editorial claimed that both the *Easter* and *Driver* decisions heralded a time when the law "[appeared] to be catching up with scientific fact that alcoholism is a disease," finally following one of the most "basic concepts of law that a person cannot be punished for chronic alcoholism anymore than he could be punished for tuberculosis or insanity."[134] While reporters covering *Easter* did not necessarily anticipate an easy road ahead, they articulated similar sentiments of ACLU lawyers who believed that this judicial action was required to place pressure on community leaders to provide medical treatment for the alcoholics who needed it.

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[133] "Alcoholism in the District of Columbia: Hearing Before the Subcommittee on the Judiciary of the Committee on the District of Columbia," *Congressional Record- Senate, 90th Congress- 2nd Session,* March 26, 1968, 110.
The Washington D.C. Area Council on Alcoholism was a voluntary community organization made up of citizens concerned with popularizing the disease concept and transitioning to a medical approach to chronic alcoholics. The group was formed in 1947 in response to the finding that alcoholism was behind most arrests and incarcerations in the District. According to Maryland Senator Joseph Tydings, "the accomplishments of the Washington D.C. Area Council on Alcoholism [would] go down in history as one of the truly great contributions to criminal justice and to humane welfare ever made by a voluntary health organization." Joseph Tydings, "The Chronic Alcoholic: A Challenge to the Efficient Administration of Justice," *Congressional Record- House,* May 23, 1967, 13654.
Citizen groups like these were common between the 1940s and 1960s. The first was formed earlier in 1947 in Connecticut at the behest of the Yale Center for Alcohol Studies, to independently fund and study the kinds of services offered by the state to Connecticut alcoholics. By the end of the 1960s, 40 states had these kinds of commissions that waged public education campaigns around the disease concept.
Archer Tongue, "What the State Does About Alcohol and Alcoholism: An International Survey," in *Society, Culture and Drinking Patterns* ed. David Pittman and Charles Snyder (New York: Wiley, 1962), 595.

[134] "Alcoholism- A Disease," *The Washington Post,* January 26, 1966, A20; Fred P. Graham, "Alcoholics Win Key Court Case: Judges Rule They Cannot be Convicted of Drunkenness," *The New York Times,* April 1, 1966, 31.

Other journalists and members of the decriminalization movement agreed with the significance of the decision but predicted that D.C. officials were far too dependent on the traditional law enforcement methods to be able to quickly transition to providing public health supports for homeless alcoholics. The decision did not prohibit the police from continuing to make public drunkenness arrests, meaning that chronic public inebriates were still being brought before drunk court judges. But the *Easter* ruling now meant that all alcoholics could raise the "chronic alcoholism defense" against intoxication charges. Lawyers claimed that this meant all public inebriates now required an attorney present to argue the alcoholism defense for their clients, a change which would radically alter the mechanisms and typical efficiency of drunk court proceedings. Someone would then have to be present to use arrest records or psychiatric evidence to determine whether or not the defendant was a "diagnosable" alcoholic.[135] For drunkenness offenders who were classified as alcoholics, D.C. judges had to decide whether to release the men or send them to some kind of treatment facility.

But the fact remained that there was very little in the way of rehabilitation institutions in D.C. to send those who might agree to get help. It was this hole in the equation that many reporters claimed "raised serious administrative problems for court and city officials who now [had] to set up procedures and facilities to handle chronic drunks differently." If this was not done successfully, one journalist mused, then the *Easter* decision would result in alcoholics being sent to "treatment" that "was little better than sending them to jail."[136] The idea that those determined to be chronic alcoholics could just be let go without either a sentence of punishment or of treatment was never raised as a possible option. Decriminalization advocates as well as

[135] Paul W. Valentine, "Court Rules Alcoholics Here Cannot be Jailed," *The Washington Post,* April 1, 1966, A1; and Leonard Downie Jr., "Arrest of Drunks Continue," *The Washington Post,* April 1, 1966, A6.
[136] "Treatment for Alcoholics," *The Washington Post,* March 17, 1966, A20.

those reporting on the process argued that it would be just as inhumane to leave homeless alcoholics on the street without any treatment than it would be to continue to arrest and incarcerate them. Opening publicly subsidized facilities for rehabilitation was seen as the only step forward after *Easter.* While this decision was proclaimed as being in the best interest of the alcoholic, it also illustrates how the medicalization and penalization approaches towards Skid Row alcoholics relied on similar foundations. Reformers still considered public alcoholism to be a pathology that necessitated state intervention. Especially for substance abusers who happened to be homeless, they were still considered a visible nuisance that should be removed from public view. But now it was the local government's responsibility to provide therapeutic institutions where the goals centered around curing the individual through medicine and therapy, not punishing him for criminal behavior through detention and forced labor.

Anticipating this outcome, the District government had organized a task force in February of 1966 to study how prepared the city would be to provide rehabilitation for those normally handled by the courts and jails. At this time, D.C. public health operated one outpatient clinic, one ward at D.C. General Hospital, and a mental health center that could care for approximately 75 alcoholic patients. The task force did not recommend expanding these services despite the likelihood that they would not be able to handle an influx of new patients. In response to the sharp criticism this lack of preparation generated in the months after *Easter,* the directors of the public health department defended their decision since "no one could know in advance the wording of the decision or the reaction of local judges." The health department therefore could not know how many new alcoholic patients would be their responsibility.[137] However, seemingly from all other corners, there was no question that the health facilities that existed in 1966 would

[137] Murray Grant and Richard J. Tatham, "The District of Columbia's Experiences with the Alcoholic," *Journal of the American Medical Association* 22, no. 10 (Dec. 1967): 931.

be insufficient to handle the number of drunkenness offenders who were normally housed in D.C. jails and workhouses. As one *Washington Post* reporter commented immediately after the *Easter* decision, an indigent alcoholic had no place to go "if he [needed] something more than outpatient help" and "D.C. General [was] already overloaded with arrested drunks who turned out to be physically ill."[138] The defenses given by public health directors and other city officials for their refusal to expand treatment services in anticipation of court-mandated decriminalization turned out to be less about their supposed belief that the already available facilities would be enough. They were counting on local judges to not truly implement the decision and for legislators to not force the issue as they had done twenty years earlier.

But a lot had changed since 1947. As the previous chapter showed, the general understanding around how homeless alcoholics should be treated had completely shifted. Whether it was from media reports or claims in court, Skid Row alcoholics were now considered non-threatening individuals who needed medical help rather than criminal punishment. The combination of the medicalization of alcoholism, the push to reform the criminal justice system in protection of the poor, and an expanding welfare state had altered the landscape on which homeless alcoholics and their advocates were standing. Perhaps D.C. government officials were unaware of the full extent of this change. No matter the reason, they did not put the steps into place that ACLU lawyers, social scientists like David Pittman, and groups like WACA were calling for to ready the city for a transition into a medicalized approach towards its homeless alcoholic population. This failure to prepare left the city completely unable to provide rehabilitative supports for drunkenness offenders as political pressure grew to do so. Though legal advocates had won support for decriminalization in courts, their claims around sober

[138] Downie, "Arrest of Drunks," A6.

citizenship were not as easily accepted by the city officials now in charge of funding and providing medical care to indigent alcoholics.

Capital Chaos: Effects of *Easter*

In the nation's capital, the Court of General Sessions handled about 20,000 public intoxication cases each year which accounted for about a fourth of its calendar.[139] Although it was thought that the *Easter* ruling would ease the court's drunkenness caseload, it initially resulted in few changes as judges continued to mandate jail time for individuals brought in on public intoxication charges. This inaction began to change in May of 1966 when Judge George Nielson was assigned to the D.C. Branch of the Court of General Sessions. Like many other judges across the country, Nielson agreed with the fundamental premise of the *Easter* decision that alcoholics should be treated as sick individuals rather than criminals. But since police were allowed to continue arresting persons found drunk in public, thousands of indigent men still found themselves in D.C.'s court system.

Concerned District judges like Nielson now had to contend with a number of questions about how to uphold the constitutional protections laid out in the *Easter* decision. Who was to raise the chronic alcoholism defense against public drunkenness charges for individuals who did not have a lawyer? Was that the judge's responsibility? How was chronic alcoholism to be defined? Was there a difference between being a "plain drunk" and being a medically diagnosed alcoholic? Who should make that determination- a social worker, a psychiatrist, a physician, or the judge? If one was diagnosed as an alcoholic, could they just be released or did they have to be provided with treatment? How much responsibility did the judge have in ensuring that

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[139] Leonard Downie Jr., "Facility Sought to Treat Alcoholics as Sickness Victims, Not Criminals," *The Washington Post,* March 16, 1966, A1.

homeless alcoholics were offered treatment and who decided what quality care entailed? Unlike his predecessors, Judge Nielson was intent on trying to provide a modicum of answers to these questions.

Beginning in May, he outlined some formal procedures that other judges could follow in regards to indigent alcoholics. Individuals could raise the chronic alcoholism defense themselves or through a lawyer. If someone who was unrepresented did not raise the defense and the judge believed him to have a drinking problem, he had an "obligation" to bring up the alcoholism defense on the defendant's behalf.[140] Dr. Sanford Billet, the chief director of the city's one outpatient rehab clinic, would attend drunk court twice a week to determine whether drunkenness offenders were chronic alcoholics. His decision would be based on their arrest record as well as the individual's willingness to accept treatment for his excessive drinking. If someone was given an alcoholism diagnosis, he would be sent to the outpatient clinic for further diagnosis and treatment.[141] Mandated therapy allowed for judges to uphold the *Easter* decision that made imprisoning an alcoholic for a symptom of their disease unlawful. Yet drunkenness offenders were still not being given the option to refuse this treatment, maintaining a level of coercion and forced removal that reformers and chronic inebriates had critiqued of the revolving door system. Judge Nielson additionally suggested up to 90 days of compulsory medical therapy. This timeline was significantly higher than the 30-day jail sentences to which drunkenness offenders were accustomed. Nielson told chronic inebriates that they were being sent to a place where they would be receiving help for their drinking problem. Since the rehabilitation was compulsory, indigent alcoholics had no choice but to agree to this longer timetable that would be spent in facilities whose rules and procedures remained unclear.

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[140] *District of Columbia v. Richard Walters,* Printed in *Congressional Record- Senate,* September 1966, 23658.
[141] "Judge Clears D.C. Alcoholic Haze," *The Washington Post,* May 3, 1966, B1.

Following Nielson's guidelines forced District officials to begin facing the complicated reality of trying to medically and socially support homeless alcoholics. By the end of the first week of this procedure, the District's three different treatment centers were completely overwhelmed. Furthermore, the combination of the outpatient clinic, hospital ward, and mental health center provided nothing more than emergency care even though Judge Neilson was mandating that alcoholic defendants agree to long-term treatment. The rapid filling of the District's meager clinic options for court-ordered alcoholic patients led to a complicated dance that played out on the front pages of newspapers among the D.C. commissioners, municipal judges, public health officials, ACLU lawyers, and chronic inebriates themselves.

Judge Nielson utilized his position to continue to place pressure on the District government to establish and fund a comprehensive alcoholism rehabilitation program. He told reporters: "If this program [to have chronic alcoholics not be treated as criminals] falters, the responsibility will be on those who don't cooperate. We can't carry out the mandate from the Court of Appeals with the present facilities and manpower."[142] When DeWitt Easter reappeared in the city's drunk court having received little to no treatment for his drinking, Peter Barton Hutt represented him again and called the District's supposed treatment program for chronic alcoholics "a hoax on the people and the public." Similar to Judge Neilson, Hutt laid the blame on the District government commissioners' unwillingness to follow through on funding promises to provide "immediate and adequate facilities for the keeping, care, and treatment" of alcoholics.[143] In response, District officials agreed to make the health department fully responsible for "an expanded alcoholic rehabilitation program" that would be backed "by the

[142] Jim Hoagland, "33 Alcoholics Get 90 Days in Clinic Here," *The Washington Post,* May 6, 1966, C1 and Stuart Auerbach, "Flow of Alcoholics Almost Overloads Rehabilitation Center," *The Washington Post,* May 10, 1966, B1.
[143] Stuart Auerbach, "City's Programs to Care for Alcoholics Called a 'Hoax' When 70-Time Violator Reappears in Drunk Court," *The Washington Post,* May 24, 1966, B1.

total resources of the District Government."[144] This plan would include a 100-bed residential hospital for homeless alcoholics, enlarged treatment staff, and a commitment to generating a permanent regimen of therapy for indigent alcoholics.

The District commissioners were unable to establish a timetable for this proposal and did little to solve the immediacy of the situation. This inaction spoke to a larger problem within the fight to medicalize the governmental approach to chronic alcoholics. Decades of funding had gone into the establishment of a highly efficient carceral system for individuals convicted of public intoxication charges. In most jails and workhouses in D.C. and across the country, drunkenness offenders made up over half of the prisoner population. Their presence helped to keep these institutions running and their labor was consistently utilized to support other projects for the city. Judges, lawyers, and other decriminalization supporters were calling for a complete overhaul of this system. What they were asking for would require vast sums of money to be spent on building, staffing, and maintaining entirely new facilities outside of the already well-established carceral infrastructure. As the commissioners' stubbornness to offer this kind of budgetary backing illustrates, the political willpower to start from scratch and fully medicalize the D.C. government's relationship to its homeless alcoholic population was not always there.[145]

By June of 1966, the District had entered a phase of sheer confusion with various camps contributing widely different solutions to the problem. The chief of the D.C. police department, for example, argued that alcoholics should continue to be arrested and jailed in order for them to have a place to eat, sleep, and dry out. Captain Dials explained, "It's not a question of

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[144] Jim Hoagland, "25 Alcoholics Freed, Clinic Overcrowded," *The Washington Post,* May 27, 1966, A1.

[145] In June of 1966, the District Commissioners stated that they would seek a special appropriation of $300,000 from Congress to provide treatment facilities. They later withdrew this request without a publicly stated reason. This occurred in the same month that an Ad Hoc Advisory Committee, made up of doctors and attorneys, stated that at least $1 million would be needed from Congress to meet the "crisis" situation that had been created by the Commissioners' lack of preparation and their handling the issue "as a public relations problem rather than a health matter." "$1 Million Plan Advised for Care of Alcoholics," *The Washington Post,* June 26, 1966, B1.

punishment, they've got to have a place where they can be taken care of."[146] Certain municipal judges had similar concerns. When faced with the choice over whether to just let alcoholic defendants back on the street because there was no room at the rehabilitation clinics, some judges would select to instead order jail sentences of up to 90 days. These judges understood that this choice violated the *Easter* ruling but they justified continuing to mandate punishment as the only way to allow individuals "to get [themselves] straightened out and to get fed properly."[147]

Others who chose to just let indigent alcoholics go did so on the basis that this would force the city to build public treatment facilities.[148] This tension between providing for the basic welfare of homeless alcoholics versus protecting their legal rights against undue punishment raised fundamental questions about the extent of responsibility local governments had towards homeless alcoholics. Was prohibiting their convictions for drunkenness sufficient or were they entitled to receive publicly subsidized aid? Did this help need to just focus on treating their alcoholism or was there additional responsibility to help securing more permanent access to things like food and shelter? These questions remained unanswered as the political debates centered primarily around the immediacy of finding viable medicalized replacements to the revolving door system. But the attention to the basic welfare of indigent alcoholics brought in the possibility that public institutions had responsibilities beyond just removing them from the criminal justice system.

Legal advocates for decriminalization as well as their allies in the press refused to let this situation go unnoticed by public. As the directors of the public health department remarked a

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[146] Alfred E. Lewis, "Police Say Drunks Fare Better in Jail," *The Washington Post,* June 10, 1966, C1.
[147] Jim Hoagland, "Answer Needed on Alcoholics' Sentences," *The Washington Post,* June 14, 1966, B1.
[148] Willard Clopton Jr, "Alcoholic's Return Irks City Judge," *The Washington post,* June 19, 1966, B1; "Judge Stops His Jailing of Alcoholics," *The Washington Post,* July 7, 1966, H8; Jim Hoagland, "Court Again Releases Alcoholics Because of Overcrowded Facilities," *The Washington Post,* July 20, 1966, C1.

year later, "considerable newspaper, radio and TV publicity resulted" out of the arguments between the D.C. government and the court system over the adequacy of treatment facilities.[149] In the four months since the *Easter* decision, *The Washington Post* continued to run news stories that called the confusion around homeless alcoholics "an emergency," "a crisis," "a grave problem," and a "flagrant failure of the city's government."[150] While members of the public who were reading these stories might have assumed that this situation was out of step with the original goals of the reformers behind Easter's case, decriminalization advocates were intent on generating this sense of urgency around the plight of homeless alcoholics. Peter Barton Hutt, for example, contended that jails had long been "used to hide the problem." Once public inebriates could no longer be incarcerated, communities like D.C. would be "awakened" to the need for medical supports for alcoholics.[151] Though Hutt could not have anticipated how dogged D.C. journalists would be in reporting on the issue, the sympathetic portraits of homeless alcoholics found in the news set against the seeming obstinacy of the District government played well for the lawyers and judges attempting to move alcoholics out of the criminal justice system. In the wake of the *Easter* decision, newspapers as well as local politicians now declared alcoholism to be "the number 1 public health problem in Washington."[152]

Of course, the people who were supposed be helped by the *Easter* ruling were the ones most affected by this ongoing confusion. As one journalist reported, drunkenness offenders did not know when they were arrested whether they were being picked up "for being sick or for being suspected of a crime, whether they would end up in jail for 90 days or be let out on the

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[149] Grant and Tatham, "The District of Columbia's Experiences," 933.
[150] Ibid,; "Alcoholic Emergency," *The Washington Post,* May 30, 1966, A16; "Alcohol Unit Charges City Shirks Duty," *The Washington Post,* June 9, 1966, A35; "1 Million Plan Advised for Care of Alcoholics," *The Washington Post,* June 26, 1966; "Law on Alcoholism," *The Washington Post,* July 8, 1966, A16; and "Alcoholic Muddle," *The Washington Post,* July 21, 1966, A2.
[151] *Powell v. Texas-* Oral Argument, *Oyez,* March 1968, 36.
[152] Willard Clopton, "100,000 Drunks Tax Our Clinics," *The Washington Post,* May 22, 1966, E1.

streets."[153] While sources that reveal their actual perspectives on the situation are sparce, a few newspaper profiles illustrate how a select few experienced this muddled time. Particularly in the immediate aftermath of the *Easter* decision, homeless alcoholics expressed hope that this change would be a beneficial one. DeWitt Easter, for example, told a reporter that he was "proud" that his test case was the reason "he and others couldn't be jailed as criminals." He agreed with his trial lawyers that alcoholics like himself did not deserve incarceration but instead should be given "the right kind of psychiatry, medication and counseling" to help them stop drinking.[154] Joseph Smith, the first individual who was hospitalized rather than imprisoned after raising the chronic alcoholism defense against his public intoxication charge, articulated a similar kind of optimism at the prospect of treatment. He said in an interview, "I just can't stop drinking. I need help badly and I hope they can do something for me at this hospital."[155] As the previous chapter showed, many of these men had figured out ways to work the current penal system to meet their basic needs. But in the wake of the *Easter* decision, they were also willing to adapt to this new promise of therapy whether as a way to escape more time in jail, receive temporary shelter and food at the clinic, or in the hopes of finding help for their drinking problem.

However, homeless alcoholics' willingness to receive rehabilitation diminished as they realized what was considered "treatment" by the city government. In response to the concern from judges and lawyers over a lack of adequate clinic space, the District Commissioners decided to set up an "overflow dormitory for alcoholics" at the Occoquan Workhouse in June of 1966. Occoquan was a short-term, minimum security facility located about 24 miles outside of D.C. Prior to the *Easter* decision, 80% of the workhouse population was drunkenness offenders

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[153] Ibid.
[154] Dan Morgan, "Easter Still Fighting His Battle," *The Washington Post,* April 1, 1966, A6; Morgan, "It's a Crime," E5.
[155] Jon McLaughlin, "Alcoholic Hospitalized in First 'Easter' Case," *The Washington Post,* April 2, 1966, B1.

who worked off their 30 day sentences by participating in farming or prison maintenance labor.[156] The fact that District officials were trying to now utilize this same penal institution as a "treatment center" was flawed from the outset.

Alcoholic patients reported that the facility itself did not feel like any significant departure from the repetitive cycle of arrest and imprisonment they were already used to experiencing. James Boyd, an alcoholic who was called to testify in court about Occoquan as a rehab clinic, stated that "he had done time before in the same dormitory and that the only difference this time was that he wore a white uniform, rather than the customary blue one."[157] While alcoholic patients did not have to work, they often were locked in the dormitory and were not given the opportunity for exercise or recreation. Furthermore, they were not given the promised medical supports. Robert Brown testified that "during his 31-day stay at the center he saw a psychiatrist once- for five minutes." Richard Walters, another patient who was a resident at Occoquan for 41 days, said his "total contact with a psychiatrist consisted of one 10-minute interview." In general, alcoholic patients reported conditions of "overcrowding, lack of medical attention, uncertainty, unsanitary conditions, and confusion." Perhaps most importantly, "treatment" at Occoquan was provided on the same "grounds with which many, if not most, of the patients" had been on as prisoners.[158] The decision to utilize Occoquan rather than a more neutral location provides a stark example of how the penalization and medicalization strategies were not inherently dissimilar.

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[156] *Report of the President's Commission on Crime in the District of Columbia* (D.C.: US Government Printing Office, 1966), 482.
55% of these drunkenness offenders were African-American men. It is important to note that while Black men made up the bulk of the "revolving door" population in D.C., lawyers picked white Skid Row alcoholics to be the faces of their test cases and the press primarily highlighted white alcoholics in their stories. Though the political conversations around decriminalization were race neutral on the surface, the presumed whiteness of "chronic inebriates" might have been an influential factor in the effort to assert the "worthiness" of these men to public aid.
[157] "Care for Alcoholics Scarce, Court Told," *The Washington Post,* June 22, 1966, C1.
[158] "The Courts and Alcoholism as a Disease," *Congressional Record-Senate*, September 22, 1966, 23658.

The alcoholic individuals caught up in this system were the key players in determining the boundary between what counted as punishment and what could be considered treatment. They used the attention from lawyers, judges, and the press to explain their experiences as both prisoner and patient. When asked by a journalist about the Occoquan facility that was now designated by the health department as the "Chronic Alcoholic Overflow Unit," John Carroll, a 48-year-old painter, stated plainly that he was "better off in jail" where he could at least "walk around and go outside." Carroll acted as a spokesman for the other 87 Occoquan "patients" since he had sent a handwritten petition for his release to the U.S. District Court of Appeals.[159] In his petition, Carroll argued that his mandated time at Occoquan was "unconstitutional" because he was denied the right to an attorney during his trial, was not given the opportunity to plead not guilty, and was being treated as a criminal rather than a sick person. Carroll castigated the supposed "medical help" he was supposed to be receiving from the city. "It's a mere sham, and I am not stupid enough to go along with it," he said, "I'll go along with anything that will help me, but this isn't."[160] In the context of a supportive judiciary and press, alcoholic citizens utilized the spotlight to assert their legal rights to not be criminally prosecuted. They also consistently highlighted their willingness to receive medical help but only if it was provided in a place where they were actually treated as patients, not prisoners. This prisoner/patient differentiation was primarily defined by the ability to move about freely within the institution as well as being able to leave on their own recognizance.

While there were various complaints about the food and lack of recreation, the main issue posed by the alcoholic patients was that they were not receiving the kind of treatment they felt they had been promised. According to the men, there was nothing offered at Occoquan that

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[159] Stuart Auerbach, "Visit to Alcoholics as Occoquan," *The Washington Post,* July 11, 1966, A8.
[160] "Alcoholic, Held at Occoquan, Asks Court to Rule Commitment Illegal," *The Washington Post,* July 8, 1966, C3.

would help them stop their drinking or aid them in not having to return to Skid Row. As one patient surmised succinctly, "I would rather be a prisoner. I don't see where any public health is down there. Like them boys say, there is nothing down there [at Occoquan] to treat you."[161] Having been caught in the middle of a chaotic attempt at decriminalization, these alcoholic individuals asserted both their right to not be punished for a symptom of their disease and their entitlement to public health treatment. Since alcoholic rehabilitation was still ill-defined, the alcoholic men themselves were vital in articulating what worked and what did not. In court testimonies as well as press reports, alcoholic citizens consistently fought for far more than what the city was trying to pass off as "adequate" treatment. As a result, the political conversation around governmental responsibility towards indigent alcoholics began to increasingly shift away from offering temporary and emergency rehab centers housed in correctional institutions to building distinct medicalized spaces that relied less on the penal infrastructure of the criminal justice system.

These declarations from alcoholic "patients" in D.C.'s "treatment" facilities were consistently backed up by staff members, adding additional fuel to claims that the District was failing to truly deal with alcoholic citizens through a public health framework. According to one staffer, the clinic options were doing nothing to help alcoholics "beat the habit." She went on, "I thought the point of calling them sick people instead of criminals was that now somebody would treat their sickness. [All we have done is] change the sign we put on them."[162] Simply turning a part of a jail into an "alcoholic center" and relabeling drunkenness offenders "patients" rather than "prisoners" meant nothing without proper follow-through in terms of funding, manpower,

[161] "The Courts and Alcoholism," 23658.
[162] Leonard Downie Jr., "Problem of Dealing with Alcoholism Unsolved Despite Numerous Studies," *The Washington Post,* March 18, 1966, D1.

and expertise. Other staff ended up resigning over their belief that the clinics were being run "without sufficient medical and nursing staff and equipment." Additionally, in memos to the leaders of the D.C. Health Department, nurses and others blamed the department's "lack of clear administrative structure and support."[163] The failure to provide enough guidance meant that there was no holistic program being offered to alcoholic patients who could leave the outpatient clinic without the follow-up care needed to make any difference in their drinking behavior. These staff grievances buttressed the arguments made by alcoholics and their lawyers who called the public health operations a "sham" or "hoax" since they were "health programs" in name only.

In the face of these staff complaints and most importantly the testimonies of alcoholic patients, D.C. municipal judges were forced to decide how best to move forward. One judge explained that they were "faced with the awful dilemma of whether to let the homeless derelict die under bridges and doorways, or whether to bring the power of the judicial branch down upon legislative and executive agencies who fail to provide humane and decent medical and treatment facilities."[164] Throughout 1966, judges chose the second option and consistently subpoenaed health and other city officials to testify to the adequacy of the alcoholic treatment options they were providing. Especially due to the remarkable amount of media coverage concerning the bungled handling of homeless alcoholics, judges were increasingly willing to assail the city government for these failures. Judge Harold Greene, for example, rebuked the D.C. Commissioners and the Health Department for "damaging and jeopardizing the administration of justice by creating unnecessary confusion in the treatment of alcoholics."[165] Judge Greene

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[163] Stuart Auerbach, "4th Health Official Hits City's Care of Alcoholics," *The Washington Post,* January 12, 1967, D20. Also see: Stuart Auerbach, "Alcoholism Program Bungled, Official Says," *The Washington Post,* January 7, 1967; Stuart Auerbach, "Dr. Grant, Staff, Differ on Alcoholism," *The Washington Post,* November 25, 1966, B1.
[164] "Hearing Before the Subcommittee, No. 3- Alcoholism," 90th. Cong., 1st. sess., April 11, 1967, 75.
[165] Jim Hoagland, "Judge Green Charges Health Dept. Perils Justice in Case of Alcoholics," *The Washington Post,* August 10, 1966, A24.

posited that this decriminalization effort was supposed to improve the integrity of the criminal justice system, but continuing to treat alcoholics as criminals and not providing even a modicum of medical or psychiatric help was hampering respect for the law. Additionally, "the lackadaisical" approach of the city government towards medicalization was causing the initial "applause" and "promise" of the *Easter* decision to "fade away."[166] Samuel Dash of Georgetown's Institute of Criminal Law and Procedure similarly argued that it would be "difficult to maintain political and community support for efforts that [did] not offer early dramatic and visible results."[167] Judges and other criminal justice reformers who wanted decriminalization to be successful were aware that if these failures continued the public would lose faith in this rehabilitative project and alcoholics would be left to suffer the consequences.

But the conversations that resulted out of this emergency situation in D.C. helped to start outlining the differences between penalization and medicalization that would inform the decriminalization effort moving forward. At the behest of alcoholic "patients" and their allies, it was now known that treatment centers should not be housed in carceral spaces. Additionally, to be a patient and not a prisoner meant to have the freedom of movement in which leaving on one's own could not be construed as "escape." And finally, state-provided rehabilitation had to align with what was promised, meaning facilities had to have trained professionals who had the time and expertise to offer patients real help in combatting their alcoholism. Though the transition to a medicalized relationship between the state and alcoholic citizens had obvious limitations in terms of failing to address their broader socioeconomic circumstances, it did open a space for homeless alcoholics to have a stronger voice in dictating the terms of their treatment.

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[166] "Alcoholic Muddle," *The Washington Post,* July 21, 1966, A2.
[167] Leonard Downie Jr., "Why Crime Reports Gather Dust: Public Concern Fades into Apathy," *The Washington Post,* March 16, 1967, H1.

They worked to mobilize these new therapeutic interventions of the state to their advantage, articulating their right to be treated as sick persons and fighting for medical help that would be effective in addressing their needs.

These standards helped to ease some of the confusion regarding the line between penal and treatment care of Skid Row alcoholics. Yet there remained a lot of unanswered questions from all parties involved in the decriminalization process about what needed to happen after chronic inebriates were taken out of the arms of law enforcement. Just as it was seen as inhumane to lock up alcoholics for a symptom of their disease, was it unlawful to mandate months of treatment? In other words, were "clinics" or hospitals just replacing the revolving door of jailtime that decriminalization advocates were trying to halt? While these issues remained unsolved throughout 1966, the attention generated after the implementation of the *Easter* ruling set the stage for how other cities approached decriminalization as they sought to avoid the chaos experienced in the District.

"Notice I Said When, Not If:" The Success of Model Rehab Programs

While D.C. showed what not to do, other examples from St. Louis and New York City showcased a different and perhaps more successful path for cities looking to decriminalize public drunkenness. Unlike in D.C., the efforts to end the revolving door cycle of arrest and imprisonment in St. Louis and New York were not undertaken in response to a court case. Instead, they were spearheaded by social scientists and other researchers who sought to create "model" rehabilitative programs that could be replicated elsewhere. These projects were funded by President Johnson's Department of Justice with the specific goal to prove that Skid Row alcoholics would respond to treatment measures and had the capacity to be "restored" to "useful

citizenship" as a result. The press widely reported on both the St. Louis Detoxification Center and New York's Bowery Project as being the gold standard for the future handling of chronic inebriates. They helped to answer some of the problems that continued to plague the D.C. government and in doing so advanced the political conversation around the line between punishment and rehabilitation of chronic alcoholics.

Beginning in early 1966, the St. Louis Police Department (SLPD) decided to start their own detoxification center that could serve as a replacement for the city's drunk tank. The police department took on this project under the advisement of Dr. David Pittman who had written the seminal work on the "revolving door" approach to Skid Row alcoholics. St. Louis' Detoxification Center (SLDC) was initially funded through a Law Enforcement Assistance Administration (LEAA) grant. Johnson's Department of Justice stated that the purpose of these grants was to help local governments operate more effective and fair law enforcement departments. In a hearing on the 1965 LEAA Act, Attorney General Nicholas Katzenbach specified that a part of this funding should be directed towards finding "better ways to handle drunks than tossing them in jail." He especially wanted the money to be used to build "sobering-up stations" like those found in other countries and other "related social agencies that might be used to keep [alcoholics] separate from the criminal process."[168]

Most European countries did not consider drunkenness to be a crime. Unlike in the United States, European law enforcement would take "public alcoholics" to "civilian detoxification centers for sobering up, instead of arrest."[169] Modeled on this international

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[168] St. Louis Police Department*, LEAA Project Report: The St. Louis Detoxication Center and Diagnostic Evaluation Center* (Washington, D.C.: U.S. Department of Justice, 1968), 35.

[169] Stuart Auerbach, "Sobering Up, Instead of Arrests, Proposed in Handling Alcoholics," *The Washington Post,* December 24, 1966, A1.

Dr. Pittman and other leading alcoholism scholars attended international conferences throughout the 1950s and 60s, collaborating on best research and rehabilitative practices towards alcoholic patients. Pittman was particularly

example, the St. Louis detox unit became the first such center in the United States that was founded on the basis that alcoholism was a disease and that providing medical care was a much more useful approach to public intoxicants than jailtime. The police department stated that the primary purposes of their demonstration detox project was to determine if this effort would save the police and courts time as well as to illustrate the rehabilitative potential of chronic inebriates. St. Louis' project was unique for a number of reasons. It was one of the only efforts within the broader decriminalization movement that had been initiated by the police department. Unlike in the District of Columbia, the police department had the full support of various other camps within the municipal government including the mayor, the health department, and social services. This support allowed St. Louis city officials to have the detox center up and running within a month of receiving the LEAA funding.

Despite the fact that the detox center was designed to offer mainly temporary services, various players involved in the project claimed that their ultimate goal was to "restore" alcoholics to "useful citizenship." Police Chief Edward Dowd stated that "[the police] feel certain that through this important project many persons who would have wasted years of their lives will become productive, normal citizens again."[170] Dr. Kendis, the medical director, wanted to use the clinic to show that homeless alcoholics were "salvageable and able to lead a life without alcohol through reeducation and treatment." Consistently refuting the notion that Skid Row alcoholics were hopeless cases, Kendis believed that "when these men are shown that someone cares about them" they "could become whole human beings again." As he declared

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interested in Switzerland's use of tranquilizers to ameliorate drunkenness. Stuart Auerbach, "Delegates Probe Cause of Alcoholism," *The Washington Post,* September 17, 1968, B2; Congressional Record- June 25, 1965, 14779.

[170] "Police to Open Sobering Clinic for Alcoholic," *The St. Louis Post-Dispatch,* October 7, 1966, 12.

confidently, "notice I said *when* not *if*" in describing the rehabilitative potential of chronic inebriates.[171]

These lofty goals were supposedly going to be met by a center that was structured primarily to provide emergency and short-term medical aid where chronic alcoholics could safely sober up and start building up their physical health. After being taken to the detox clinic by the police, a patient was showered by a nurse, given new clothes, medically examined and provided with tranquilizing drugs that would alleviate the symptoms of the withdrawal process. Once detoxification was completed after normally about 10 or 12 hours, a patient then participated in "task therapy." The directors of the clinic thought that patients having "duties" like cleaning the halls or washing dishes would "help him to assume responsibility so he will be better able to meet his own needs when he begins his life in the community as a participating citizen again."[172] A patient also would participate in individual and group therapy as well as attend classes designed to teach him about the disease of alcoholism. An average stay at the detox center was 7 days. The optimistic aims publicly given by the leaders of the St. Louis project generally outpaced the reality of what the center's staff were able to offer alcoholic patients. While the clinic was able to provide a non-penal and safe space for indigent alcoholics to dry out under medical supervision, the notion that this would be enough for individuals to get off the street and back into mainstream society was far-fetched at best.

In measuring the success of the detox unit after two years of operation, the SLPD utilized a number of different metrics that influenced the political discussions around what counted as adequate treatment for chronic public inebriates. For the directors reporting back to the DOJ on

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[171] Stuart Auerbach, "Hospital Replaces the Drunk Tank in St. Louis Alcoholism Program," *The Washington Post,* October 23, 1966, A25; SLPD, *LEAA Project Report,* 92. Auerbach was quick to point out how quickly St. Louis was able to get this clinic up in running, in complete opposition to the lethargy found in D.C.
[172] SLPD, *LEAA Report,* 92-94.

how well alcoholic patients were doing after leaving the detox program, they took into account five factors: drinking status, employment, income, health, and housing. The thousands of individuals who completed the 7 days at detox improved the most in their physical health (49%) and in their ability to stay sober (47%). Leaders of the pilot program considered these numbers to be much higher than what they were initially expecting, once again illustrating the responsiveness of even the most "hardcore" alcoholics to compassionate medical treatment. SLDC directors also attempted to outline how "success" should be defined when dealing with alcoholic patients. Unlike some other diseases with a certain cure, the SLDC directors argued, alcoholism was a chronic illness and relapses should be expected. "Success" therefore might not mean full sobriety but rather someone staying "dry longer than he had been before," in the hopes that his "positive experience" at the center might lead him eventually to "come to a meaningful decision that total sobriety for him is the preferable way of life."[173] The fact that only 9% of alcoholic clients refused to stay for the entire time also was viewed as a marker of achievement. As Dr. Kendis had predicted, this low number represented the willingness of homeless alcoholics to receive help.

However, the numbers for the other success standards were significantly lower. Only 15-18% of detoxification patients showed improvement in their employment, income, or housing situation. While the center had social worker staff members who worked on setting up referrals to other agencies, most of these did not lead to any major changes in the patients' financial or shelter circumstances. SLDC directors advised that a "wide range of aftercare services and facilities" including halfway houses, outpatient services, and domiciliary care were necessary in advancing indigent alcoholics' employment and housing status.[174] It remained unclear at the time

[173] Ibid., 28.
[174] Ibid., 68.

of the project whether the government's responsibility toward chronic inebriates extended beyond replacing penal infrastructure with medicalized therapy for pathological drinking. According to the SLDC report, if decriminalization supporters wanted the goal of these projects to be turning alcoholics into citizens, then there had to be other services besides temporary detox and therapy that could aid chronic inebriates in securing more stable employment and housing.

By documenting the effectiveness of emergency detox centers as well as its shortcomings, the St. Louis demonstration project offered an example for other cities to follow. It was now known that detoxification was a potential replacement to the drunk tank system. Not only did a center like this keep indigent alcoholics out of the penal system and help them rebuild their physical health, it also reduced the amount of time police and courts were spending on drunkenness offenders. No longer having to put these men through the booking system supposedly cut down how long police officers were spending on these individuals by over 50%. Yet, the fact that many of the men who finished detox struggled to stay sober and still returned to Skid Row illuminated the need to have a more comprehensive system that included detox, inpatient therapy, and aftercare services.

Despite these limitations, St. Louis' detox program was widely reported on as being the way forward in transitioning drunkenness offenders out of the criminal justice system. TV shows like "The American Alcoholic" as well as newspaper stories pointed to St. Louis as being the "best city in the nation for treating alcoholics."[175] Many of these articles quoted one detox patient as saying that his stay at the clinic was the "first time in years that [he] felt someone cared."[176]

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[175] Auerbach, "Hospital Replaces Drunk Tank," A25.

[176] Judson Calkins, "Many Drunkards Receive First Treatment at Center," *The St. Louis Post-Dispatch,* July 10, 1968, 42. Donald Apperson, "How New Treatment Center Helps Alcoholics Break Habit," *The St. Louis Post-Dispatch,* Aug 6, 1967, 99; "Treating Alcoholics," *The St. Louis Post-Dispatch,* May 21, 1967, 327; SLPD, *LEAA Report,* 50.

Unlike in D.C., men taken to the city-run “treatment center” were actually provided with something that felt significantly different than what they received in the prison system. Furthermore, the elimination of the drunk court appearance and the intentionally short stays at the center reduced the level of coercion involved in this version of medicalization. Because of this, reformers and their supporters in the press began discussing publicly subsidized detoxification as one of the most viable alternatives to the traditional law enforcement approach to Skid Row alcoholics. A similar sentiment was felt on the federal level, with the DOJ calling for the center’s report to be widely distributed and claiming that it was one of the most successful LEAA-funded projects ever undertaken.[177] The feeling that detoxification worked and that chronic alcoholics who had often been deemed “hopeless” were in fact capable of being helped was most strongly expressed by the leaders of the program. Even if their public statements were hyperbolic, they did increase support for the idea that spending public dollars on rehabilitation programs were worthwhile political investments. Hear this sense of optimism: “How much ‘return on the investment’ accrues to the community as individual public intoxicants become contributing members of society- assets rather than liabilities- is an imponderable that we cannot document. But it is there- we have witnessed it- and it is substantial!”[178]

Between 1965 and 1968, The Vera Institute initiated another model program that was designed to develop more effective and humane strategies for aiding homeless alcoholics in New York City. The Ford Foundation funded this “Manhattan Bowery Project” alongside partnerships with Mayor John Lindsay’s Criminal Justice Council and NYC’s social services, police, and public health departments. Similar to the St. Louis initiative, the directors of the Bowery Project traced the origins of this effort to the new understanding that Skid Row alcoholics were “sick,

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[177] “St. Louis Treatment of Drunks Praised,” *The St. Louis Post-Dispatch,* June 5, 1969, 48.
[178] SLPD, *LEAA Report,* xvii.

desperate people" who deserved medical help rather than arrest and criminal prosecution.[179] In determining whether this project should be focused on developing long-term rehabilitation or short-term emergency services, Vera decided to prioritize temporary detoxification. Like other demonstration projects, the Vera Institute believed medicalized detox was the necessary first step in setting up a viable "substitute for the present revolving door policy of police, courts and jails."[180] Leaders of the Bowery Project also had the goals of reducing the amount of time police spent arresting drunkenness offenders, cleaning up the streets of the Bowery by removing public alcoholics, improving the physical health of these men, and putting them on a path to sobriety.

However, the Vera Institute also sought to minimize the level of law enforcement involvement with public inebriates. Their logic went that as long as the police and courts were still relied upon to handle chronic alcoholics, then decriminalization would not be fully effective. Therefore, they piloted the first "medically oriented system for removing drunken men from the street."[181] Unlike in St. Louis, a rescue civilian team would pick up homeless alcoholics off the street and bring them to a medicalized detox center rather than to the drunk tank. In this way, Skid Row alcoholics never had to interface with the police in any official capacity and instead were being handled humanely and medically from the time they were approached on the street. These rescue team patrols included a "rescue aide" who himself was a recovered alcoholic and a plain-clothes police officer. Teams were told to find the most "hardcore alcoholics," the ones "lying down in the gutter, passed out in the doorway or collapsed over a garbage can." The two men would approach one of these individuals on the street and offer him the chance to

[179] The Vera Institute of Justice, "First Annual Report of the Manhattan Bowery Project," April 1969, 5.
[180] "Proposal for the Manhattan Bowery Project," in *Task Force Report: Drunkenness* (Washington D.C.: Government Printing Office, 1967), 58.
[181] Vera, "First Annual Report," 10.

voluntarily “see a doctor” and “have a place to stay.”[182] If the patient accepted, he then was brought in an ambulance or unmarked police car to the detox center where he underwent a medical evaluation and was given medicine to help with alcohol withdrawal symptoms. Here is an example of one of these interactions:

> George was shaking from the cold, or maybe from the cheap wine he had been drinking all morning. As he sat, shivering in the pale sunlight, two men got out of an unmarked panel truck and walked up to him. John Rogan, a former alcoholic, approached George: ‘How do you feel?’ ‘I don’t feel so good,’ was the reply. ‘You feel like coming up to the project?’ ‘Yeah. I gotta do something, I’m freezing.’[183]

As this instance shows, individuals like George were willing to accept the Bowery Project’s help often as a way to meet their basic needs whether this was to receive medical treatment, a warm meal, or a place to stay. After George went through detox, he could agree to stay for a few more days where he would be given a “hotel-type bed” and the option to participate in “crafts and recreation.” His stay would end with seeing a caseworker who established an aftercare plan that consisted of AA meetings, outpatient clinics, the city’s welfare shelter, and psychiatric hospitals. According to project’s report, this completely voluntary approach was effective about 67% of the time with about 2,000 out of 2,996 men accepting help from the street patrols.[184] The Vera Institute as well as the news stories and political reports concerning their initiative pointed to this number as proof that Skid Row alcoholics would respond to treatment if it was provided. Most significantly, this project also proved that police coercion did not have to be involved. If enough money and energy was there, civilian individuals could be utilized to get indigent alcoholics off the street and voluntarily checked into a place where they could get help.

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[182] Edward C. Burks, “Daily Search for Broken Men,” *The New York Times,* Feb 16, 1968, 39.
[183] Rudy Johnson, “Bowery Project: Warm Bed and 2nd Chance,” *The New York Times,* Feb 7, 1970, 31.
[184] Vera, “First Annual Report,” 29, 55.

One major factor that determined whether or not a man on the street was willing to accept the help of the project's rescue team was their racial identity. The project's report stated that "for reasons not altogether clear, Negro Bowery men refused the assistance of the street patrol more frequently than did Caucasians." However, a rescue aide's diary entry points to the fairly obvious reason why African-American men would be more wary about accepting this help. After being approached and asked if he wanted "a place to stay," one Black homeless individual reportedly refused saying "I ain't going to no jail."[185] Despite the fact that the Bowery team tried to deliberately distance themselves from operating as an official police presence, it is clear from this statement that especially individuals of color would be cautious about going with the rescue team and would assume that this would result in further jailtime or punishment.

Unlike in the St. Louis example, leaders of the Bowery Project emphasized having tempered expectations around what counted as successful treatment of homeless alcoholics. Herbert Sturz, the architect of the project, stated that success should not be determined by how many men quit drinking but whether or not the program resulted in a "civilized alternative to the expensive and wasteful cycle of arrest, trial, and jail."[186] According to the project's final report, rehabilitation for Bowery men could not "be measured in absolute terms of permanent sobriety and of acquisition of jobs, families, property, and other social ties." Rather than determining effectiveness on the basis of restoration to full citizenship, rehabilitation was bettered understood "on a less absolute scale" that considered increased "time between benders from a few weeks to months," holding on to jobs longer, and making better use of New York's health and welfare resources barometers of success.[187] Their willingness to be open about what they were trying to

[185] Vera, "First Annual Report," 60.
[186] David Burnham, "Two Man Teams to Offer Help to Bowery Derelicts," *The New York Times,* October 7, 1967, 31.
[187] Ibid., 40.

do, safely getting individuals off the street and providing them with a medicalized space for withdrawal, allowed the project to continue to be funded for years. Instead of trying to prove that their clients were no longer homeless or completely sober, Vera could remain focused on the fact that their program was a successful non-criminalized way to handle chronic public inebriates.

Both the St. Louis Detoxification Center and the Manhattan Bowery Project helped advance the conversations around decriminalization and model different ways to think about how to find the line between punishment and rehabilitation. Reformers and politicians pointed to St. Louis and detoxification in general as the most humane and efficient replacement to the traditional drunk tank. Vera's Bowery Project rounded out one other piece of the puzzle, illustrating how civilian teams could be used to either minimize or eliminate the use of police when handling chronic public inebriates. These two demonstration projects also aided in determining what should count as adequate medical treatment for alcoholic citizens who did not have financial resources, accounting for factors like relapses rather than saying they were offering holistic "cures" to either the men's drinking problem or the socioeconomic and housing situations. Operating as a counterweight to the chaos D.C. experienced after *Easter,* New York City and St. Louis provided more successful examples for other cities to follow. For politicians and reformers seeking to decriminalize on a national scale, they also proved that with enough dedication and funding non-criminal approaches to indigent alcoholics could be implemented.

The Right to Treatment and The Right to Freedom

The visibility of the District's failures to appropriately treat the public inebriate population turned drunkenness and alcoholism into urgent and significant political problems in the late 1960s. Since these events were unfolding in the nation's capital, it was an issue not only

for D.C. officials but also for the federal government. Intense media scrutiny coupled with continued pressure from decriminalization advocates left politicians with little choice but to deal with alcoholism especially as it related to the homeless population. While the emergency occurring in the capital was being written about as a national embarrassment, lawmakers started to view it as an opportunity. If Congress could find ways to actually decriminalize drunkenness and medically treat homeless alcoholics in the city through federal legislation, they could not only improve the District's image but also provide a model for the rest of the country. Pressure for this national standard increased in November of 1967 when the Supreme Court agreed to hear a case concerning the criminal punishment of public drunkenness.[188] In anticipation of a ruling that would make the criminalization of alcoholics unconstitutional country-wide, pressure mounted on Congress to act. A number of officials began working on legislation that would support the process of transitioning the state out of being an arm of law enforcement and into a provider of rehabilitation for alcoholic citizens.

One of these calls for legislative action came from the head of the federal government. Between 1966 and 1967, President Johnson utilized his bully pulpit platform to demand changes around the political handing of alcoholics. Addressing Congress on "Domestic Health and Education" in March of 1966, Johnson said: "The alcoholic suffers from a disease which will yield eventually to scientific research and adequate treatment. Much can be done to reduce the untold suffering and uncounted waste caused by this affliction."[189] For the first time, the president of the United States was using his platform to amplify the disease concept of alcoholism. Furthermore, by directing the arms of the federal government to devise and

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[188] John P. Mackenzie, "Court Asked to Bar Drunk Penalty for Chronic Alcoholics," *The Washington Post,* November 25, 1967, A3.

[189] Lyndon B. Johnson, "Special Message to the Congress on Domestic Health and Education," The American Presidency Project, March 1966, https://www.presidency.ucsb.edu/node/238089.

implement a public system of alcoholism treatment, Johnson also became the first president to accept the idea that alcoholics were capable of responding to treatment and that it was the state's responsibility to provide this aid.

In the aftermath of the *Easter* decision in early 1967, Johnson also urged Congress to support decriminalization. He stated plainly: "Alcoholism is not a criminal problem. It is a health problem. Alcoholics should not be arrested. They should be treated." According to Johnson, the nation's capital needed to start serving as a leader that other cities could follow in the implementation of this new approach especially towards poor alcoholics or those experiencing homelessness. He explained that D.C. should be "a living expression of the highest ideals of democratic government," a city "of beauty and inspiration, of equal justice and opportunity."[190] An essential aspect of these ideals, Johnson claimed, had to be revolutionizing the District's approach to indigent alcoholics by removing them from the criminal justice system and instead providing them with quality health care. In his address, Johnson amplified the ideas that decriminalization advocates had been articulating for years: that alcoholics were sick people who deserved help rather than punishment and who were worthy of public investment.

Another pressure point for political action came from the findings of two major federal crime commissions. President Johnson's "Commission on Law Enforcement and the Administration of Justice" in its final report published in February of 1967 included the criminalization of public drunkenness as one of the primary places in which the American criminal justice system was failing. Members of the commission highlighted three main issues raised by the decriminalization movement. One, drunkenness arrests were inherently discriminatory for the way they targeted the poor. Two, the amount of time, manpower, and

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[190] Lyndon B. Johnson, "The Nation's Capital- Message from the President of the United States," *Congressional Record- House*, February 27, 1967, 4483; 4486.

money spent between the courts and the police on drunkenness offenders resulted in a tremendous waste of criminal justice resources. Finally, the penal approach to chronic alcoholics had been proven time and again as ineffective and inhumane. The commission summarized its recommendations as follows: "Drunkenness should not in itself be a criminal offense. Communities should establish detoxification units as part of comprehensive treatment programs. Communities should coordinate and extend aftercare resources, including supportive residential housing."[191] Upholding the promise of public health programs like the detoxification center in St. Louis and the treatment facility in New York, the commission suggested that these medicalized approaches to chronic inebriates be undertaken on a national scale.

These recommendations were in no way designed to eliminate or even lessen the funding for and presence of law enforcement in local communities. The commission was only questioning where and how the resources of the criminal justice system should be directed. Commission members agreed with legal scholars who considered public drunkenness alone to a "victimless" behavior that did not deserve to be handled through criminal sanctions. Illustrating the intertwined nature of the welfare and carceral modes of state intervention, the idea that removing alcoholics from the criminal justice system would free law enforcement to deal with more "legitimate crimes and criminals" was essential to the commission's arguments for decriminalizing drunkenness.[192] They argued that medicalizing alcoholism would not only better protect the health, welfare, and legal rights of indigent alcoholics, but it would also free up

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[191] President's Commission on Law Enforcement and the Administration of Justice, *The Challenge of Crime in a Free Society* (Washington D.C., United States Government Printing Office), 236-237.

[192] Ibid. This continued emphasis on "legitimate crimes" and the fear over a supposedly rising crime rate in the late 1960s would easily lead into the political rhetoric around "law and order" that would become dominant by the early 1970s. As Kohler-Hausmann has written, "therapeutic options often became political liabilities." For narcotics addicts, the "delicate balance" struck between penalization and medicalization quickly tilted towards the more politically expedient methods of removal and punishment, especially towards men of color.
Kohler-Hausmann, *Getting Tough,* 80; Hinton, *From the War on Poverty to the War on Crime.*

individuals and institutions of the criminal justice system to focus on "serious criminal offenses" like homicide, rape, and armed robbery.

Another report, coming from the President's Commission on Crime in the District of Columbia, was even more explicit in its condemnation of current practices concerning the arrest and incarceration of chronic inebriates. The report stated: "Substantial resources have been devoted to apprehending, convicting and punishing the estimated 6,000 skid-row chronic alcoholics in the District. The resort to criminal sanctions has completely failed [to] meet either the alcoholic's immediate health needs or the more basic problems underlying his illness. This reliance on short-term criminal remedies has allowed the health authorities in D.C. to neglect their responsibilities to deal effectively with the problem of chronic alcoholism." The D.C. report never questioned that homeless alcoholics should be handled through public health means rather than through law enforcement or that the main goals of any governmental approach towards inebriates should be about improving their overall well-being. Published months after the *Easter* decision, the commission operated on the basis that it was illegal and unconstitutional to continue arresting and jailing known alcoholics. And they laid the blame for the failure to medically treat public inebriates at the hands of the District's government and their health department. In a statement that was oft-quoted in newspapers and congressional hearings, the commission declared:

> The response to *Easter* has been totally inadequate. If the law is not to become a mere façade, the District must establish a meaningful treatment program as an alternative to incarceration for alcoholics. Since *Easter* there has been in fact a marked deterioration in the health of the city's derelict alcoholics- a condition which goes unheeded only by a callous disregard for human life. Essential to any long term solution is the realization that chronic alcoholism is a serious public health problem that has been almost completely neglected.[193]

[193] *Report of the President's Commission on Crime in the District of Columbia* (D.C.: United States Government Printing Office, 1966), 486-490.

These kinds of declarations in the report on crime in D.C. were particularly powerful for how they called the District's response not just out of step with the law but also amounting to an immoral and inhumane indifference to the lives of the city's homeless residents. While the commission acknowledged the difficulty in determining the boundary between penalization and treatment, trying to pass off a facility like the Occoquan Workhouse as a "public health center" like the District had tried to do was clearly not the answer. Like the national crime commission, the D.C. group argued that the only solution was a comprehensive treatment program that accounted for safely getting chronic inebriates off the street and providing them with medical detoxification, inpatient treatment, and temporary residential options.

The significance of this moment for the individuals who had been advocating for alcoholism reform and decriminalization cannot be overstated. After the publishing of these reports Selden Bacon, the director of the Center for Alcohol Studies, wrote hopefully about the "potential historical significance" of this new federal recognition for the plight of alcoholic citizens. He explained the reason for his optimism: "This may well be a milestone in an area so little marked by any change, let alone progress for so many generations. For the first time, this task force is not a minor committee or academic or religious sect. It stems from the President of the United States." Appeasing concerns that there might be a "relapse into do-nothingism or dirty and futile punishment," Bacon wrote simply that "the world had changed."[194] Those who might support continuing to see alcoholics as criminals worthy of punishment were far outnumbered by those who believed in the rehabilitative potential of persons suffering from the illness of alcoholism. And this change was reflected at the highest levels of the United States government. Thus, in 1967, the President himself as well as the commissions under his direction charged

[194] Selden D. Bacon, "Alcoholism and the Criminal Justice System: Review of Task Force Report- Drunkenness," *Law and Society Review* 2, no. 3 (May 1968): 492; 495.

Congress with finding ways to remove alcoholics from the criminal justice system and support them through public health means. Armed with the lessons learned from the District disaster, the findings of these reports, as well as the promises of the New York and St. Louis pilot programs, members of Congress began drafting legislation for D.C. that sought to answer some of the questions that still remained unsolved despite all of these experiences and studies. In particular, they attempted to outline the boundary between punishment and rehabilitation for indigent alcoholics.

In April of 1967, the House of Representatives held its first hearings on alcoholism in the District of Columbia. The hearing was set to discuss the "crash program bill" being introduced by G. Elliot Hagan, a Democratic representative from Georgia, that would establish and fund a comprehensive alcoholism treatment system in D.C. Joseph D. Tydings, a Democrat from Maryland, introduced similar legislation in the Senate. Peter Barton Hutt, the lawyer behind *Easter,* and his associates wrote the policy in response to the "growing crisis" around alcoholism in the nation's capital. But they also hoped the establishment of a rehabilitation system in the District could demonstrate best practices that other cities could follow "in making the transition from criminal to public health treatment of chronic alcoholics."[195] To bolster support for the bill and to testify to the necessity of changing the state's approach to indigent alcoholics, Hagan and Tydings called on a number of key individuals involved in the decriminalization effort.

Throughout the hearings, congressional representatives of the D.C. Subcommittee heard about the extent of the "revolving door" cycle from David Pittman, about how the law had changed to see alcoholics as sick individuals from ACLU lawyers, and about the judicial support

[195] Stuart Auerbach, "House Committee to Hold Hearings on 'Growing Alcoholism Crisis' Here," *The Washington Post,* February 24, 1967, C22; Stuart Auerbach, "Hearings Set on Bill to Treat D.C. Alcoholism as Illness," *The Washington Post,* March 12, 1967, D2.

for this change from Judge Logan of the North American Judges Association. Once the extent of the problems with continuing the criminal treatment of Skid Row alcoholics had been outlined, Hagan and Tydings called on individuals who could testify to the ability of chronic inebriates to respond to medical treatment. Congressmen heard from Dr. Alford of Atlanta about the promise of Antabuse, from Colonel Dowd about the strides made with detoxification in St. Louis, and from Jack Donahue about the potential of halfway houses like the kind he established in Boston. These testimonies were buttressed by statements of support from the D.C. Medical Society, the local Health and Welfare Council, the Department of Justice, the National Capital Civil Liberties Union, and the North American Association of Alcoholism Programs.

The hearings on alcoholism were designed in the short-term to provide emergency funding to expand treatment options for the 4,080 persons who had been determined alcoholics by the D.C. Court of General Sessions since *Easter*. However, they were also meant to serve a longer-term function by illustrating the importance of extending federal involvement in the alcoholism field.[196] By outlining the inefficiency and inhumanity of the revolving door cycle of arrests and incarcerations as well as promoting the promise of a public health approach, the hearings put in the Congressional record the work and goals of the decriminalization and alcoholism reform movements. While the individuals testifying fielded questions about how much funding would be necessary or what would be counted as successful "rehabilitation" of homeless alcoholics, there was little pushback from the Congressmen about the basic tenents of decriminalization.[197] Showing, as Selden Bacon had written, how much "the world had

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[196] "D.C. Alcoholic Plan Seen As National Model," *The Washington Post,* April 9, 1967, B5.

[197] Robin Room, an alcoholism policy researcher, called this level of agreement around decriminalization and medicalization among alcoholism researchers, health professionals, civil liberties lawyers, judges, federal commissions, politicians, and the press the "1960s consensus." Getting "chronic drunkenness offenders off the street and into long-term treatment" was seen as the best solution by all parties. Robin Room, "Drunkenness and the Law: Comment on the Uniform Alcoholism and Intoxication Act," *Journal of Studies on Alcohol* 37 (1976): 129.

changed," one of the major bodies of the federal government was now willing to accept the notion that alcoholism was a disease and the state had a role in combatting it.

Within the proposed "District of Columbia Alcoholic Rehabilitation Act," Hutt made a subtle move beyond what he and other ACLU lawyers had been fighting for with their test court cases. In addition to halting the punishment of chronic inebriates, the writers of the bill also sought to solidify the idea that access to rehabilitative treatment was a *right* that alcoholic citizens no matter their socioeconomic circumstances possessed. Because of this, the government had the responsibility of providing public health treatment to those who might not be able to pay for the private options. This sentiment was summed up in the final law as follows: "All public officials in the District of Columbia shall take cognizance of the fact that public intoxication shall be handled as a public health problem rather than a criminal offense, and that a chronic alcoholic is a sick person who *needs*, is *entitled to*, and *shall be provided with* appropriate medical, psychiatric, institutional, advisory, and rehabilitative treatment services of the highest caliber for his illness."[198]

These two goals, prohibiting the punishment of homeless alcoholics and promoting their right to treatment, reflected the lessons learned in the months after the *Easter* decision. In order for decriminalization to actually be implemented, there had to be workable alternatives to drunk tanks, jails, and workhouses since all decriminalization advocates argued that it would be just as inhumane to leave individuals sick on the streets. And the framers of the bill made it the government's responsibility to provide these treatment alternatives to which alcoholic citizens were entitled. Emphasizing an alcoholic's right to treatment and the state's role in supplying it served two functions that accounted for both the alcoholic's well-being and the public's safety.

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[198] Public Law 90-452, "D.C. Alcoholic Rehabilitation Act," H.R. 14330, August 3, 1968.

Allowing sick alcoholics to remain in public view without help became a violation of their legal entitlement to adequate medical help, an idea that was wrapped in humanitarian rhetoric around protecting the rights, health, and safety of the indigent alcoholic. But it also enabled the state to continue intervening in the lives of chronic alcoholics through health professionals, maintaining the notion that homeless alcoholics were still an unacceptable blight in public spaces.

For the first aim of prohibiting the carceral punishment of chronic inebriates, Hutt outlined steps that needed to be taken to remove these men from the arms of law enforcement. First and foremost, the law changed the criminal code of D.C. to decriminalize the act of public intoxication alone. Following the recommendations of the federal crime commissions, individuals drunk in public were now only be arrested if they were "conducting themselves in a manner which endangers the safety of other persons or property." Similar to the "victimless crime" argument made by legal scholars, the policy stated that the usual behaviors that often resulted in a drunkenness arrests such as "staggering, falling down, sleeping on a park bench, begging, singing, and so forth" might be "disagreeable."[199] But these actions did not endanger anyone else and therefore could not be considered criminal acts. After the *Easter* ruling, chronic inebriates intoxicated in public could still legally be arrested for this charge but they could now use alcoholism as a defense in drunk court. By changing the criminal code itself, Hutt tried to eliminate the cause for arrest and prevent homeless alcoholics from ever being brought to the drunk tank or sent to drunk court in the first place.[200]

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[199] "Alcoholism," *Hearings Before Subcommittee No. 3 of the Comm. On D.C.- House,* 90th Cong, 1st. Sess, April 1967, 3; 55.

[200] There was a concern that simply eliminating the charge of public intoxication would not stop the arrests of Skid Row alcoholics and that police would instead use similar codes. According to its writers, the "new legislation makes it clear that simple intoxication is not to be handled under such as disorderly conduct, loitering, vagrancy, or other related misdemeanor provisions." Ibid.

Years later, when decriminalization was attempted in other cities, certain police forces did continue to arrest "chronic inebriates" under other charges. However, removing public intoxication alone did lead to a large reduction of "Skid Row arrests" in most areas. One policy analyst in describing this phenomenon reasoned: "It changes the

Policy makers behind the Alcoholic Rehabilitation Act also tried to minimize police interaction with Skid Row alcoholics. Law enforcement officers were still authorized to remove alcoholics from the street if his health was in danger. However, police could no longer take them to the precinct. Instead, they would have to be taken to a detoxification center or other facility that had an "adequate number of personnel" who possessed the "highest professional qualifications and competence." Modeled off of Vera's Bowery Project, public health officers who would be working for the newly minted "Bureau of Alcoholism Control" within the District's health department were also authorized to approach chronic inebriates and offer them medical attention. Individuals could be taken to a health center only on a voluntary basis, without any threat of criminal prosecution. Furthermore, the facilities to which they were brought could not "be at the same location as any correctional institution."[201] The bill's sponsors sought to eliminate the vestiges of penalization that had led to so much criticism in D.C.

By reducing police involvement and increasing the responsibilities of health officials and facilities, this bill attempted to fully decriminalize drunkenness and alcoholism by transitioning the government's relationship with homeless alcoholics from one of punishment to one of aid and therapy. But police were still the ones going to be called upon to remove chronic inebriates from public view and the fact that officers were still authorized to do so ensured that Skid Row alcoholics continued to have run-ins with law enforcement. Even if these interactions did not result in an arrest or criminal conviction, they allowed for indigent alcoholics to continue to be caught in both the penal and medical mechanisms of the state.

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criterion for arrest from issues of people's appearance and mental state to issues of overt behavior, and this makes mass arrests in police 'sweeps' less feasible." More simply, "In many jurisdictions, an arrest under another charge is also considerably more trouble for the policeman."
Room, "Drunkenness and the Law," 138.
[201] "Alcoholism," *Hearings,* 4-5.

The second overall aim of the bill was to defend the alcoholic's right to treatment by expanding the alcoholism treatment programs funded by public dollars. This was done by setting up distinct functions that the D.C. government would have to serve in regards to servicing citizens struggling with excessive drinking. A physician or other "qualified administrator" was appointed to head the Bureau of Alcoholism Control within the health department. Their role was to "maintain an effective public health and rehabilitation program by providing a continuum of appropriate services for chronic alcoholics." The main focus of this "comprehensive" program was the building and funding of emergency services that could replace the current system of drunk tanks and jailhouses. The bill established 3 detoxification centers with 150 beds where individuals could stay for no longer than 72 hours to receive medical services for withdrawal symptoms. After detox, patients could then opt to go to "inpatient extended care" which had to have a minimum of 800 beds where they could receive "intensive treatment and rehab." Finally, the bill funded outpatient aftercare facilities which included social centers and vocational rehab services.[202]

This transition to medicalization remained limited by fixating on curing individuals of their drinking problem and dealing less with their economic or housing status. The primary goal of rehabilitation policy continued to be "[integrating] chronic alcoholics back into society as productive citizens."[203] Throughout the entire discussions around the rehabilitative legislation, testimonies centered around the ability of health programs to turn "the Skid Row type" into citizens who were "sober, working and dry."[204] Legislators defined successful rehabilitation and

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[202] Ibid.
[203] D.C. Alcoholic Rehabilitation Act, 621.
[204] *Hearings-Senate,* 95.
Another limitation in this legislation was that facilities for "homeless alcoholics" were only going to apply to men. The records of the hearings included a letter from a "Mrs. Jean Mack." She asked, "The public is informed of all that is being done at Occoquan and elsewhere to help these desperately ill *men*- while the equally sick women are quietly being committed to jail where little or nothing is done for them. With expanding these facilities, can't we please

restoration to "productive citizenship" by sobriety first, and steady employment second. This approach left little room for solutions that did not focus on alcoholics' pathological drinking behavior. Though a number of people testifying on the legislation acknowledged that comprehensive rehabilitation should include stronger aftercare supports, the attention paid to medicalized services like detoxification, outpatient, inpatient services and vocational rehabilitation far outpaced those around residential housing or even halfway houses.[205] One psychiatrist's testimony went so far as to say that "the treatment of homeless alcoholics should not be oriented toward providing them a home; rather the treatment should be directed toward their alcoholism. It is the alcoholism which has led to their being homeless, and not otherwise."[206] Directors of the model programs alternatively explained that their experience had taught them that Skid Row alcoholics could not fully integrated back into mainstream society without greater attention being paid to alleviating circumstances of poverty or homelessness. But policy makers largely ignored these structural issues in favor of providing temporary medical services.

One of the primary questions surrounding this newly created treatment program was the use of civil commitment procedures. David Pittman for example wrote that court-ordered civil

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have equal rights for all?" Legislators responded that a focus on women alcoholics would be handled in future plans but did not earmark any specific funds within the D.C. bill. Ibid., 159.

[205] The concept of halfway houses for substance abusers was relatively new in the late 1960s. Supporters of the creation of such places argued that Skid Row alcoholics could "best be rehabilitated if their return to society [was] gradual rather than abrupt." Halfway houses would include small numbers of men where they were expected to stay sober and take on tasks to keep the home functioning. In such a place, alcoholics could rebuild their sense of "self-pride, respect, and responsibility." One of the first attempts to establish such a place occurred in Boston under the direction of Jack Donahue, himself a recovered alcoholic. He founded the "Hope House" in 1961, a sobriety home that took in men who had just been released from jail or from a mental hospital on account of their alcoholism. If the goal was to turn these men into full-functioning citizens, Donahue argued, halfway houses were essential by providing a path for "sober and wise reintegration into the community, the home, the family, and industry." Edward Blacker and David Kantor, "Halfway Houses for Problem Drinkers," *Federal Probation* 24 (1960): 18, 19; "The Incentive to Stay Sober is Main Idea of Hope House," *The Boston Globe,* February 4, 1969, 18; "Home Aiding Parolees with Alcohol Problem," *The Boston Globe,* November 1, 1964, 57

[206] Statement on the Extent of the Homeless Alcoholic Problem," *Hearings Before the Subcommittee on Public Health and Welfare,* 90th Cong., 2nd Sess, March 1968, 122.

commitment like what was being used for the mentally ill and narcotic addicts could be a possible option for the state to utilize towards Skid Row alcoholics. He wrote: "If we view the chronic intoxication offender as one whose behavior is a nuisance to society, then we can construct a case for compulsory intervention by public health measures."[207] This intervention could be utilized as a substitute for "street cleaning" measures currently being employed by the police to get drunk persons off the streets. The ACLU lawyers were wary of having mandated time in medical facilities replace jail sentences, especially since civil commitment tended to involve long-term or indeterminate time periods. Peter Hutt explained, "We have not fought for two years to extract DeWitt Easter, Joe Driver, and their colleagues from jail, only to have them involuntarily committed for an even longer period of time, with no assurance of appropriate rehabilitative help and treatment. The euphemistic name 'civil commitment' can easily hide nothing more than permanent incarceration."[208] Civil libertarian lawyers like Hutt thus made the voluntary nature of medicalized treatment a prominent distinguisher between penalization. They postured that while homeless alcoholics had a right to adequate public health treatment for their illness, they had an equally important "right to freedom" in which they could refuse treatment or leave a treatment center at any point on their own terms.[209]

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[207] David Pittman, "The Chronic Drunkenness Offender- An Overview," In *The Court and the Chronic Inebriate: Conference Proceedings* (Washington D.C.: U.S. Govt Printing Office, 1965), 8.
Julily Kohler-Hausman in her work on New York Governor Rockefeller's drug treatment programs in the late 1960s has illustrated how even as courts and medical authorities tried to decriminalize drug abuse, their reliance on "coerced drug treatment" resulted in "essentially forced institutionalization" that did not result in any real differentiation between "treatment" and "punishment" for heroin addicts. Kohler-Hausman, *Getting Tough,* 43.

[208] *Leroy Powell v. State of Texas,* 392 U.S. 514 (1968), 1266.

[209] One of the attorneys serving on the federal crime commission wrote that this "right to freedom" created a mutually beneficial relationship between the state and the alcoholic: "The government should not have the right to force sobriety upon the alcoholic by imprisoning him. A mutual effort by attorneys, physicians, and behavioral and political scientists must be made to impress upon society that this forgotten population of homeless alcoholics has the right to freedom. And society has the corresponding obligation to make available appropriate health and welfare facilities." Stern, "Public Drunkenness: Crime or Health Problem?," 156.

This emphasis on voluntary treatment was buttressed by claims from specialists who claimed that homeless alcoholics would accept treatment if it was offered to them. Within the various decriminalization projects that had been undertaken to serve as medicalized models, directors had intentionally highlighted how Skid Row alcoholics were willing to receive treatment voluntarily without any threat of force. One psychiatrist testified to Congress: "I had formerly believed that only a system involving physical restraint or threat of it would control the confirmed alcoholic…. It is obvious that voluntary agencies have made significant inroads [in treating alcoholics.]" The director of the detox center in St. Louis told a similar story that "without exception" alcoholic men had remained in the clinic on a voluntary basis and wanted to stay until they were ready to be discharged.[210] These testimonies which were founded on practical expertise and experience helped elevate the idea that civil commitment would be an unnecessary intrusion in the lives of alcoholic citizens. Thus, both the "right to treatment" and the "right to freedom" became pillars of the comprehensive alcoholism treatment program set up by the D.C. Alcoholic Rehabilitation Act. Though the state now had an obligation to establish publicly subsidized treatment facilities, officials did not have the ability to force alcoholic patients to spend time there either through civil commitment or through criminal sanctions. In doing so, the therapeutic arms of the state differed from the carceral elements in that they did not rely upon coercion.

President Johnson signed this bill into law on August 6, 1968, marking the first time that official federal recognition and funds were placed behind the idea that alcoholics were sick people worthy of and entitled to help from the state.[211] The strong rhetoric around the needs, rights, and entitlements of alcoholics was the culmination of years of work undertaken by

[210] Statement on the Extent of the Homeless Alcoholic Problem," 121.
[211] "Alcoholism Act Signed," *The Washington Post,* August 6, 1968, B2.

alcoholism reform groups, legal advocacy organizations, the media, and criminal justice reform commissions. Fighting against the traditional stigma assigned to alcoholics as being weak-willed individuals or immoral criminals took decades of groundwork being laid by dedicated persons who struggled to have alcoholics be legally recognized as sick persons worthy of help. Test cases undertaken by the ACLU throughout the mid-1960s led to the judiciary to uphold the constitutional protections that alcoholic citizens had against cruel and unusual punishment. With the D.C. Alcoholic Rehabilitation Act, the legislative and executive branches were also recognizing that alcoholic citizens had "the right to receive adequate and appropriate treatment."[212] Policy makers defined "adequate and appropriate" treatment as being completely medicalized in nature- meaning not housed in a penal institution, staffed with trained medical personnel, and run on a voluntary basis.

Though this law only applied to the District of Columbia, policy makers were already drafting similar therapeutic legislation that would operate on a national scale. As the *Easter* ruling had demonstrated, judiciary support for decriminalization was key to forcing changes in how the state understood and handled homeless alcoholics. Members of the decriminalization movement thus set their sights on the Supreme Court, in the hopes that a favorable ruling making incarcerating alcoholics unconstitutional would drive decriminalization and medicalization countrywide.

[212]"Alcoholism," *Hearings,* 74.

CHAPTER 3

"The Picture of the Penniless Drunk:"

The Fate of Decriminalization in the "Law and Order" Era

As in many areas of American social and political life, 1968 marks a major milestone in the history of alcoholism reform. It was in this year that advocates for the decriminalization of public drunkenness made their case before the Supreme Court, reaching a stage they had been building towards for years. All members of the movement firmly believed that the case of Leroy Powell, an indigent alcoholic from Texas, would end in victory. The federal court decisions in *Easter* and *Driver* had outlined legal precedent that could be nationalized with a favorable mandate from the highest court in the land. Reformers believed they had worked out some of the major kinks in the decriminalization process and were armed with lessons from the D.C. experience that could be executed in cities across the country. Furthermore, decriminalization no longer seemed like a controversial opinion. It had bipartisan backing in Congress, approval from the President of the United States, and support from the general media.

Once the justices agreed to hear *Powell v. Texas* in early 1968, the press forecast a favorable decision as a logical link in a series of progressive rulings from the Warren Court. One journalist remarked that protecting the rights of homeless alcoholics fit nicely into this Court's commitment to ensuring "the law and the Constitution serve the lowliest as fully as it serves the most powerful."[213] With tested legal arguments and a reformist Supreme Court, the ACLU

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[213] James C. Millstone, "Warren Court is Protector of Rights of Poor and Weak," *The St. Louis Post-Dispatch,* June 2, 1968, 3B. Decriminalization had even received a direct endorsement by a sitting justice. Abe Fortas wrote in 1966: "It is time for this court to meet this issue squarely. Punishment of alcoholics does society no good. It can be applauded only by the uninformed and the sadistic." "Supreme Court Reject Alcoholic's Plea," *The Boston Globe,* October 18, 1966, 14.

lawyers defending Leroy Powell had every reason to believe that the justices would rule that it was unconstitutional to punish alcoholics for exhibiting a symptom of their disease in public. Yet, in the summer of 1968, the Supreme Court ultimately ruled against Powell in a surprising 5-4 decision. For scholars who have since written on the legacy of the Warren Court, *Powell* has received little attention and analysis.[214] However, this chapter contends that the background leading up to *Powell,* the arguments laid out in the case briefs, and the deciding opinions reflect an important turning point in the history of criminal justice reform and the politics of substance abuse in 20th century America that needs to be fully understood. *Powell* illuminates how the moralistic, punitive view of public alcoholism persisted despite reformers' best efforts.

The unexpected outcome in *Powell* must be situated within the broader political trends of the late 1960s. Although a political consensus had been built around decriminalization, the appetite for social welfare causes had decreased by the time the justices were hearing Leroy Powell's case in 1968. Within a context of urban uprisings and political protests, calls for "law and order" threatened to outpace those for progressive social change. Conservative politicians blamed real or perceived increases in crime and disorder at the feet of liberal reforms including President Johnson's War and Poverty and the Warren Court's criminal procedure decisions. Analysts of the political landscape in the moment pointed out how anti-crime politics seemed to have an inverse relationship with anti-poverty politics. John Herbers of *The New York Times*, for example, wrote: "As crime has gone up as an issue civil rights [and economic support for the

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[214] A few exceptions include: Robert Batey, "The Costs of Judicial Restraint: Forgone Opportunities to Limit America's Imprisonment Binge," *New England Journal of Criminal and Civil Confinement* 33, no. 1 (2007): 29-60; Sanford H. Kadish, "Fifty Years of Criminal Law: An Opinionated Review," *California Law Review* 87, no. 4 (July 1999): 943-982; and Mark V. Tushnet, "The Jurisprudence of Thurgood Marshall," *University of Illinois Law Review* 4 (1996): 1129-1150.

disadvantaged have] gone down in almost direct proportion."[215] This new emphasis on being tough on crime was also parroted by Democratic officials. Even before Richard Nixon won the presidency in part due to his "law and order" rhetoric, funding for the War on Poverty and other welfare state programs was being slashed under the very administration that had piloted these measures. Towards the end of Johnson's final term, more funds were being directed towards police departments and other carceral institutions.[216] It was within this context of oscillation that the fate of indigent alcoholics was decided by the Supreme Court.

Powell did not fully stymie the political effort to decriminalize public drunkenness and medicalize the issue of alcoholism, despite it being described at the time as a death blow to the movement. While the justices ruled against national decriminalization of public drunkenness, they recognized the vast inadequacies of the system then being used to "treat" alcoholics. In doing so, the justices effectively punted the issue to state and federal legislatures by calling on them to build a public health apparatus that could replace the carceral infrastructure used for public inebriates.

The same legal minds behind the test cases that led to *Powell* then turned their energy towards creating federal law that could accomplish what they had hoped to gain through the judicial system. Their work resulted in the Uniform Alcoholism and Intoxication Treatment Act,

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[215] John Herbers, "Crime: Rights Take A Back Seat," *The New York Times,* February 11, 1968, E3. Herbers would go on to note the irony in pulling support for the very laws that were "intended to strike at the cause of crime and riots."
For similar historical interpretations, see: Naomi Murakawa, *The First Civil Right: How Liberals Built Prison America* (New York: Oxford University Press, 2014); Michael Flamm, *Law and Order: Street Crime, Civil Unrest, and the Crisis of Liberalism in the 1960s* (New York: Columbia University Press, 2005); Peter B. Levy, *The Great Uprising: Race Riots in Urban America During the 1960s* (Cambridge: Cambridge University Press, 2018); Goluboff, *Vagrant Nation*; Vesla M. Weaver, "Frontlash: Race and the Development of Punitive Crime Policy," *Studies in American Political Development* 21, no. 2 (2007): 233; and Katherine Beckett, *Making Crime Pay: Law and Order in Contemporary American Politics* (Oxford: Oxford University Press, 1999).
[216] Lyndon Johnson, "Statement Upon Signing the Omnibus Crime Control and Safe Streets Act of 1968," In *Public Papers of the Presidents: Lyndon Baines Johnson, 1968-1969* (Washington D.C: Government Printing Office, 1970), 725; Hobart Rowen, "LBJ Melts Some Butter to Provide More Guns," *The Washington Post,* January 30, 1968, A1.

a policy framework that all states could follow to both decriminalize drunkenness and establish a continuum of treatment for the indigent alcoholic population. The policy was passed in 1971 at a pivotal time in the history of America's welfare and carceral states. Unlike the decades before or after, the seventies were a period of intense debate over how the government should approach marginalized groups like alcoholics, drug addicts, and the poor or homeless.[217] There were no clear answers on whether rehabilitation and material help were the right solutions for people in need or whether they required other strategies like punishment and containment.

Throughout the early 1970s, concerns over "law and order" dovetailed sharply with controversies happening within rehabilitation and social welfare services being offered to public inebriates. This chapter argues that the coalescing of these two issues significantly influenced how homeless alcoholics interacted with and were understood by the state. Many initially promising, state-funded treatment programs that had been started after the passing of the Uniform Act in the early 1970s devolved a few years later into poorly run spaces that operated more as warehouses for alcoholics than fully functioning healthcare facilities.

While the reasonable explanation for these problems was underfunding and understaffing, the dominant narrative instead focused on the supposed deficiencies of the patient population. Though the Uniform Act outlined the need for a treatment system that could tackle an indigent patient's drinking problem and his socioeconomic circumstances, most cities enacting the law provided short-term detoxification but failed to adequately fund follow-up services. Most indigent alcoholics approached these limited treatment options the same as they had the drunk tank and jail, prioritizing their basic needs over their sobriety. As alcoholic patients failed to live up to the "sick role" expectation set by health and social welfare

[217] Kohler-Hausmann, *Getting Tough,* 4.

professionals in that they seemed unmotivated to promote their own recovery, those in charge of rehabilitation programs reverted to the idea that certain alcoholics might be beyond the point of help and were therefore underserving of state aid.[218] When these inherently flawed services were unable to turn Skid Row alcoholics into "productive citizens" the way reformers had promised, more policymakers also viewed this as proof that liberal programs were not effective and worthy of continual investment.

As this chapter will show, the failure to fund and maintain treatment options beyond detoxification throughout the 1970s also heightened a tension that had long been in the middle of the decriminalization effort. In decriminalized cities, homeless alcoholics were now caught in a "spinning door" between "treatment" and Skid Row.[219] After leaving detox, individuals were often back on the street and in public view more quickly than they had been under the carceral revolving door system. The ongoing visibility of public inebriates in decriminalized areas resulted in increasing complaints that their presence was a threat to public order. Facing the enduring question over whether to prioritize the rights and health of homeless alcoholics or the public's safety, city officials tended to favor the latter.

This decision affected the kinds of tactics utilized towards those found drunk in public. While a return to a purely carceral approach was not floated as an option, policymakers instead supported the idea that homeless alcoholics needed to be forcibly removed from public view and mandated treatment. Even after decriminalization, alcoholic citizens were faced with coercive state action that violated their "right to freedom" against involuntary institutionalization which

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[218] The "sick role" was a concept coined by sociologist Talcott Parsons in 1951. He argued that sick persons had certain "rights" and "obligations." Those labeled as "sick" had the right to care, but they also had the obligation to try to get well. Alcoholism treatment providers tended to believe that their patients were failing to uphold their obligations in working towards their own recovery. Talcott Parsons, "The Sick Role and the Role of the Physician Reconsidered," *The Millbank Memorial Fund Quarterly* 53, no. 3 (Summer 1975): 269.
[219] Room, "Drunkenness and the Law," 133.

reformers had long argued needed to be protected. In doing so, lawmakers reified homeless alcoholics as a deviant group less deserving of help and understanding when positioned against the needs of "the public."

Reflected in the *Powell* decision and throughout the implementation of decriminalization procedures, labeling homeless alcoholics as "sick" did not change the fact that many continued to believe they engaged in socially unacceptable behavior for which they should be held responsible. In an era of flux between welfarist and punitive politics, even those who were committed to offering medical treatment to ill alcoholics agreed that this could be undertaken through force and coercion. The state's handling of indigent alcoholics between 1968 and 1980 thus illustrates the political expediency of institutionalizing those who posed a public problem rather than invest in the turbulent and uncertain process of voluntary rehabilitation.

The Case of the Intoxicated Shoeshine Man

Civil liberty lawyers had been looking for the right face to represent the public drunkenness issue before the Supreme Court for years before they finally decided upon Leroy Powell, a white 66-year-old from Austin, Texas. Powell was married and had one daughter, whom he had been unable to financially support since injuring his back in 1955. This injury prevented him from being able to maintain a steady job and hastened a growing drinking problem. As a result, Powell's only source of income was money he received in taverns shining shoes. According to court testimony, the bulk of these earnings (about $12 a week) went to "buying wine."[220] Like many indigent alcoholics, Powell was wrapped up in the revolving door system and had a long arrest record for public drunkenness. Unable to pay the $25 fine

[220] Motion for Leave to File Brief and Brief for American Civil Liberties Union et. al as Amici Curiae in *Powell v. Texas*, 392 U.S. 514 (1968), 5-6.

associated with this statute under Texas law, Powell would periodically work his intoxication charges off in jail. Lawyers from the ACLU got involved with Powell in December of 1966 when he was once again arrested and convicted for public intoxication. By appealing Powell's conviction for drunkenness, his lawyer Don L. Davis laid the groundwork for a Supreme Court case that he hoped would make the incarceration of chronic alcoholics for public intoxication illegal across the country. The foundations of the decriminalization movement were mirrored in the series of questions Davis asked Powell before the Texas appellate court:

> Q: How often do you drink?
> A: Well, I drinks wine every day.
> Q: How often do you get drunk?
> A: About once a week.
> Q: Have you ever been arrested for being drunk?
> A: Yes sir, many times.
> Q: Approximately how many times would you say?
> A: Oh, I guess around a hundred times.
> Q: Would you like to be cured of your drinking problem?
> A: Yes sir.
> Q: Do you have any money to pay a doctor to treat you for this problem?
> A: No sir.
> Q: Do you consider yourself to be a chronic alcoholic?
> A: Yes sir.
> Q: Have you ever stopped drinking for a period of time?
> A: Yes sir, I have.
> Q: About how long did that last?
> A: Well, not too long on account of I don't have the means.
> Q: In other words, as soon as you get enough money, you start drinking again?
> A: Yes sir.
> Q: If you could control your movements when you are in a state of intoxication, would you go into public?
> A: No sir.[221]

Within this leading line of questioning, Davis highlighted both Powell's lack of control over his drinking and his desire to get help. Furthermore, he made it clear that Powell's consistent arrests had done nothing to stop him from drinking and that what he really needed was medical assistance to treat his self-described alcoholism problem.

[221] "NAJA Joins Amici Curiae Brief in *Powell v. Texas," Municipal Court Review* 7 (1967): 7.

When the Supreme Court agreed to hear Powell's case, the fundamental question before the justices was whether or not the conviction of a chronic alcoholic for public intoxication was a violation of the Eighth Amendment's cruel and unusual punishment clause. It was the same question that had been debated in the earlier test cases of *Driver* and *Easter.* The federal judges deciding in these precedent-setting rulings agreed that Dewitt Easter and Joe Driver were sick individuals suffering from the disease of alcoholism. Additionally, the fact that both these men were homeless settled the debate over whether their public intoxication was involuntary or not. Easter and Driver had no choice but to exhibit an inherent symptom of their disease (drunkenness) out in the open, therefore it was cruel and unusual to punish them with incarceration. Leroy Powell, however, was not homeless like the majority of chronic inebriates caught in the revolving door system. Although Powell "usually [slept] in public places such as the sidewalk when he [got] drunk," he "sometimes" spent nights at home with his wife and daughter. These circumstances did not prevent the lawyers behind Powell's case, including Don Davis and the veteran ACLU lawyer Peter Barton Hutt, from deeming Powell to be the right person to represent the "estimated 500,000 indigent alcoholics" across the United States.[222] Their lack of concern over his housing situation speaks to the confidence of decriminalization advocates who firmly believed that they had laid enough groundwork over the past few years to all but guarantee a Supreme Court ruling that would making the jailing of chronic alcoholics unconstitutional across the country.

Recognizing the importance of this opportunity for alcoholism reform, groups representing different sectors pulled their weight in a vast Amicus Curiae Brief that outlined the necessity for decriminalization. The brief included statements from leading medical and legal

[222] Brief for ACLU as Amici Curiae, 6; 2.

organizations including the ACLU, the AMA, NAJA, the North American Association of Alcoholism Programs (NAAAP), and the Texas and D.C. Area Councils on Alcoholism.[223] Especially in light of the chaos that had ensued in the wake of the *Easter* decision, supporters sought to use the brief to eliminate practical concerns about what this medicalized transition would look like on the ground in major American cities. Each group's endorsement was thus significant for different reasons. Individuals traditionally involved in handling chronic drunkenness offenders such as municipal judges and correctional officers wrote their support for removing this issue from the realm of criminal justice. The AMA explained that doctors and hospitals were willing to take on the responsibility of caring for alcoholics, stating they "officially recognize alcoholism as a disease that is properly within the scope of medical practice rather than criminal law."[224] Attempting to prove that there was a viable alternative to the carceral approach, the NAAAP pointed to the successes of various localized and tax-supported rehabilitation programs. In sum, the players involved in the amicus brief made their case that the nation was ready for the changes a decriminalization mandate would bring.

Echoed throughout the brief was the idea that all hope of reform regarding homeless alcoholics rested upon a decision that sided with Powell. Reformers saw a mandate from the highest court in the land as essential to jumpstart the nation-wide "development of proper public health procedures for the handling of intoxication and alcoholism."[225] There was wide-spread fear, grounded in early failed legislative efforts to decriminalize, that a loss in *Powell* would prevent the expansion of treatment resources and allow for the rights of public inebriates to

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[223] They were joined by the Correctional Association of New York, Methodist Board of Christian Social Concerns, and the North Conway Institute.
[224] This declaration within the amicus brief mirrored the AMA's statement supporting the disease concept back in 1956. Brief for ACLU as Amici Curiae, 3.
[225] Ibid., 16.

continue to be denigrated. Hutt explained the sentiment a few months before the decision was announced: "If the Supreme Court were to uphold the state of Texas in *Powell* and rule that alcoholism is not a defense to public intoxication, I would be very pessimistic about the possibility of convincing any state legislature to repeal its drunkenness statute. Derelict alcoholics wield no political power… Thus, the possibility of a legislator championing criminal reform in this area, absent a court decision forcing the issue, is very small indeed."[226] While some states and localities might be willing to initiate decriminalization on their own terms, Hutt argued that without a Supreme Court order most areas would opt instead to leave chronic alcoholics stuck in drunk tanks and jails.

In terms of the legal arguments presented for decriminalization, Powell's lawyers attempted to solidify the idea that alcoholics could not be held criminally responsible for behaviors beyond their control. Focusing in on the disease concept of alcoholism and the notion of "victimless crimes," they argued that criminal convictions required voluntary behavior to have taken place. Their brief contended: "Under long-settled common law a person cannot be punished for conduct produced by a disability that is recognized as depriving him of the capacity to refrain from his offending behavior. The name of his disability is not important. Neither is its cause." This last point was especially important to establish in relation to alcoholics, since many still claimed that they bore some level of responsibility for their illness because they had made the conscious decision to start drinking in the first place. Hutt and Davis tried to counter this argument by making alcoholism as innocuous as other common diseases like diabetes. A diabetic was not considered any less sick because he ingested sugar.[227] Similarly, an alcoholic no longer

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[226] Peter Barton Hutt, "Perspectives on the President's Crime Commission- The Problem of Drunkenness," *Notre Dame Law Review* 43, no. 6 (1968): 863.
[227] This comparison was made by a variety of people interested in medicalizing alcoholism. Diabetes was seen as "akin to alcoholism" in the sense that it involved a negative interaction between "an agent- sugar" and a "host- the

had the ability control his consumption of alcohol and therefore could not be criminally prosecuted.

Powell's lawyers also aimed to ease any concerns about the lack of consensus around what kind of disease alcoholism was. Yes, Hutt and Davis conceded, the "disease" concept of alcoholism was a fairly recent phenomenon. There was no general agreement amongst "experts" over whether alcoholism was related to genetics, biochemistry, personality, or environment. Nor did anyone studying and treating alcoholics know what caused one drinker to become an alcoholic while many others did not. And no, there was no sure "cure" for the disease of alcoholism. However, Powell's lawyers asserted, the changes that had recently occurred in medicalizing alcoholism still had significant legal ramifications. As they stated in their brief, "The delay in widespread recognition of alcoholism as a serious disabling disease only underscores the fact that the unconscionable punishment of alcoholics for public intoxication has continued far too long. It provides no justification for perpetuating it."[228]

On the other side, a young lawyer named David Robinson who was representing the Texas Attorney General sought to counter the decriminalization arguments given by Hutt and Davis and to stem a tide that had been building for years. As Robinson recalled decades later, the legal winds were not in his favor as he stood before the court that had brought about a "criminal

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diabetic." Just as a diabetic might initially consume sugar without knowing they are vulnerable to diabetes, an alcoholic could do the same with alcohol without being aware of their "vulnerability" to alcoholism. Therefore, as Powell's lawyers contended, an alcoholic could not be held responsible for their decision to first start drinking. Elizabeth D. Whitney, *The Lonely Sickness* (Boston: Beacon Press, 1965), 17.
They also compared alcoholism and its public symptoms to epilepsy or heart disease. Whereas persons would not be criminalized for having seizures or heart attacks in public, neither should alcoholics be arrested for being visibly intoxicated. Brief for ACLU as Amicus Curiae, 14.
[228] Ibid., 30. This notion was further buttressed by the comments of judges and correctional officers that were well acquainted with the criminal justice system's handling of drunkenness. Judge Botein's quote is one poignant example: "Speaking as a judge, our courts should not serve as disposal centers for cleaning the streets of chronic drunks; nor should judges be constrained by present conditions to impose frequently repeated prison terms resulting in what is virtually a sentence to life imprisonment on the installment plan."

justice revolution" expanding protections for the poor and disadvantaged. At a glance, maintaining "the status quo in the context of public intoxication" appeared to be a similar "paradigmatic case of dysfunctional persecution of the already oppressed."[229] However, in Robinson's view, what the Supreme Court was being asked to consider would radically transform the very foundation on which American criminal law stood and would do so on very shaky ground.

Robinson saw a key weakness in the effort to decriminalize drunkenness as being the movement's overreliance on the "disease concept." Within the brief submitted against Powell, Robinson and the Texas AG maintained that the term "disease" was "almost wholly vague." Especially in the areas of "mental disease" or "behavior disorder," there were great "overlaps in the [actions]" now considered to be health issues and behaviors traditionally "proscribed by criminal laws."[230] Thus turning behaviors that had long been considered voluntary conduct into uncontrolled "symptoms" of a disease and doing so utilizing imprecise terminology threatened to inherently change the notion of "criminal responsibility."[231] If the Supreme Court sided with Powell*,* this decision might lead to a cascading effect where persons could now argue that they were "ill" for all kinds of reasons and therefore not legally liable when engaging in criminal behavior. Furthermore, while decriminalization advocates were limiting their disease defense to public drunkenness, Robinson argued that there was no way to stop this plea from being used against more serious crimes including rape and homicide.

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[229] David Robinson Jr., "*Powell v. Texas:* The Case of the Intoxicated Shoeshine Man- Some Reflections a Generation Later by a Participant," *American Journal of Criminal Law* 26 (1999): 416.
[230] Brief for Appellee – *Leroy Powell v. State of Texas* on Appeal from the County Court at Law No. 1 of Travis County, Texas," 392 U.S. 514 (1968), 9-10.
[231] For 19th century background on this debate: Susanna L. Blumenthal, *Law and the Modern Mind: Consciousness and Responsibility in American Legal Culture* (Cambridge: Harvard University Press, 2016).

According to Robinson, alcoholism was a clear example of a "disease" that was too vague to account for this radical transformation in criminal law. On the one hand, there was no consensus amongst experts about the definition of alcoholism. While there might be a general agreement about alcoholics exhibiting a "loss of self-control" over alcohol consumption, this phrase did not do enough to differentiate between chronic alcoholics and other excessive drinkers who could still be held criminally responsible for public intoxication.

These assertions about the loose definitions of alcoholism quickly slipped into defending traditionalistic notions of drunkenness, in which compulsive drinkers were weak-willed rather than sick. In Powell's case, the appellee brief stated, "it should suffice that were was a subjective consciousness of freedom to choose each time [Powell] began to drink, knowing that his past experience has been that he would continue to ingest alcohol to the point of public drunkenness."[232] Of course, this line of reasoning was contrary to what the reformers behind medicalization had been arguing since the 1930s and 1940s. To be an alcoholic meant that there was no truly conscious choice to continue to drink, which could be seen in the way that alcoholics kept drinking despite the legal, social, or economic consequences they might face as a result. Though Robinson did not have any "expert" testimonies from people studying alcoholics to back his arguments, he was able to rely on the hundreds-year old idea that drunkenness was a choice for which individuals could be held legally responsible. This debate between the two sides of the *Powell* case illustrates how the medicalization of alcoholism remained an incomplete process. Indeed, the counterpoints outlined by Robinson would be raised throughout the 1970s with more healthcare professionals, legal scholars, and politicians regularly reexamining whether alcoholics were truly sick or if they were willfully engaging in destructive behavior.

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[232] Ibid., 16.

In the oral arguments, the justices offered little pushback regarding the constitutional claims being made by Powell's lawyers that his criminal punishment for public intoxication was a violation of his 8th and 14th Amendment protections. Instead, the line of questioning from the judges was much more focused on the practical application of the changes being proposed by legal reformers on behalf of Leroy Powell and other indigent alcoholics. Chief Justice Earl Warren and Justice Thurgood Marshall in particular had not been convinced by the amicus brief's claim that municipalities were prepared to handle alcoholics through public health means. The chief justice queried: "What are we going to do in all these communities where the states have never awakened to the need for doing something in this area other than to just lock them up for 48 hours or 4 days or whatever it is?"[233] Davis retorted that a lack of medical facilities was not a justification for continuing to infringe upon a chronic alcoholics' constitutional rights.

Furthermore, though there were bound to be "temporary dislocations" if the justices sided with Powell, the level of pressure like the kind exhibited in D.C. after *Easter* was crucial to getting the momentum needed to fund and build medical facilities. During Hutt's turn answering questions, he sharpened this point further with an unsubtle nod to Thurgood Marshall. "We don't have all the plans," he said. "The reason is that communities have never been awakened to the problem… we have found that with the court decisions that have been handed down up to now, the communities have been awakened. You might liken it to the situation after this Court decided *Brown v. The Board of Education.*"[234] Just as the *Brown* decision had been fundamental in advancing civil rights, *Powell* could serve a similar purpose in expanding the rights of alcoholics.

[233] *Powell v. Texas*- Oral Argument, *Oyez,* March 1968, 10.
[234] Beyond *Easter* and *Driver,* Hutt claimed that court decisions had forced medicalization in Atlanta and Philadelphia. Hutt also noted that many of the organizations involved in the amicus brief, from the AMA to NAAAP, were "prepared to undertake treatment" once jails could no longer "hide the problem." *Powell v. Texas*- Oral Argument, 10-11; 36.

Without jails to rely on, communities would be forced to find alternatives to handle indigent alcoholics outside of the carceral system. In the same way that the Supreme Court had not been hesitant to demand racial integration, Hutt contended they should not be afraid to mandate a substantial societal shift for the indigent alcoholic.

By the end of the oral arguments, it was clear that some of the Supreme Court justices who had often utilized their positions to make the law more responsive to the needs and rights of the poor and disenfranchised were wary of extending this consideration to the chronic public inebriate. Whether this stemmed from the lack of consensus around the definition of alcoholism, the question over public safety, or the absence of viable treatment alternatives to the carceral system, it was no longer inevitable that a majority of justices would rule in Powell's favor. Many of the justices seemed especially interested in Robinson's contention that siding with Powell would cause irreparable harm to the notion of criminal responsibility.[235] However, Justices Douglas, Brennan, Stewart, White and Fortas still seemed amenable to overturning intoxication charges for chronic alcoholics like Powell. Their support was most reflected in Justice Stewart's retort to Robinson's arguments: "How can that kind of condition or situation (alcoholism) warrant criminal prosecution? How can a civilized society criminally prosecute those who can't help themselves?"[236] Even though Stewart was usually counted "among the court's conservatives," he seemed swayed by the idea at the bedrock of the decriminalization effort that

[235] Robinson's oral argument would go on to be reflected in the majority decision: "The appellant's argument seems to us to be that there exists a [unitary disease] called chronic alcoholism. And that this destroyed his will to abstain… and therefore he ought to be treated not as a responsible human being but rather as an ill person who is acting without volition. At the outset, it ought to be noted that this argument, if accepted by the Court, would have revolutionary implications for the criminal law." Ibid., 54.
[236] Ibid., 70-71.

the penalization of sick alcoholics for a condition beyond their control had no place in modern American society.[237]

A few months later in June of 1968, the Supreme Court upheld the public intoxication conviction of Leroy Powell. The majority decision, written by Thurgood Marshall and joined by Justices Warren, Black, and Harlan, wavered between practical and constitutional arguments. On the practical side, Marshall wrote that there was no agreement around the disease of alcoholism and even more importantly there was no "effective method of treatment or adequate facilities or manpower" to begin to deal with alcoholics outside of the criminal justice system. From the legal perspective, unlike in the case of the narcotic addict in *Robinson,* Powell was convicted for public *behaviors*-- not for the *status* of "being an addict or being a chronic alcoholic."[238] Many of the successful legal reforms that had occurred throughout the 1960s had tackled status-laws that "criminalized people themselves." In Marshall's view, "crimes of conduct" were different as they criminalized those who committed unlawful acts rather than punishing someone for "being a particular type of person."[239] Powell's lawyers claimed that this differentiation between status and behavior would led to an incongruous practice where it could be unlawful to criminalize a person for having a disease yet continue to punish them for exhibiting that illness' symptoms.[240] But Marshall maintained that the "symptom" of drunkenness still "[created] substantial health and safety hazards" and "[offended] the moral and aesthetic sensibilities of a large segment of

[237] John P. Mackenzie, "Judge Criticizes Criminal Actions Against Alcoholics," *The Washington Post,* March 10, 1968, A3.
[238] *Powell v. Texas,* no. 405, 392 US, June 17, 1968, 515; 532.
[239] The "status law" claim was the case for vagrancy laws as well as those concerning racial discrimination and the poor. Goluboff, *Vagrant Nation,* 27.
[240] This notion was best articulated in the amicus brief: "No one can doubt that it would be unconstitutional to punish a person for having a common cold or, accordingly, for sneezing in public… If chronic alcoholism cannot be made criminal because it is a disease, chronic alcoholics cannot be punished for succumbing to it in public." Brief for Amicus Curiae, 41.

the community."[241] Effectively disagreeing with the notion of public intoxication being a purely "victimless crime," Marshall and the other justices in the majority contended that Skid Row alcoholics could not be allowed to exist in public especially without an alternative place they could be taken that was not the drunk tank or jail.

Finally, Marshall claimed that siding with Powell would cause an upending of substantive criminal law. It was too risky to bring about a "wide-ranging new constitutional principle" based on ill-defined notions of "disease" and its relationship to individual responsibility. Nothing in what Powell's lawyers were asking for "would limit its application to chronic alcoholics," Marshall wrote, "If Leroy Powell cannot be convicted of public intoxication, it is difficult to see how a State can convict an individual for murder, if that individual, while exhibiting normal behavior in all other respects, suffers from a 'compulsion' to kill." Possibly harming the concept of personal accountability by allowing the chronic alcoholism defense for public intoxication was too precarious of an endeavor for the Court to undertake. As Marshall declared, "It is simply not yet the time to write into the Constitution formulas cast in terms whose meaning, let alone relevance, is not yet clear either to doctors or to lawyers."[242] While it might be surprising that a long advocate for using the law to bring about broad societal changes wrote this decision, Marshall's biographer has written that this case should be seen as an example of Marshall operating as a "pragmatic social engineer" who understood the "barriers to change."[243] To Marshall, there was not enough infrastructure ready to implement this decriminalization shift and it was best left up to local governments to do so on their own terms.

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[241] *Powell,* 532.
[242] Ibid., 534-537.
[243] Mark V. Tushnet, "The Jurisprudence of Thurgood Marshall," *University of Illinois Law Review* 4 (1996): 1149.

This majority opinion in *Powell* foreshadowed a developing resistance against the medicalized view of alcoholism especially as it related to the alcoholics visible to the public eye. Thurgood Marshall lent the weight of the court to the idea that the disease concept was not solidified enough to warrant a change that would mandate seeing alcoholism as a health rather than criminal problem under the law. Furthermore, he plainly endorsed the notion that the presence of homeless alcoholics on the street of urban America could still be considered a threat to public safety. By upholding Powell's conviction, the court prioritized public order over the rights of alcoholic citizens. This concern over keeping the public safe from possible "hazards" posed by public inebriates would only intensify in the coming decade.

Up until June, a majority of justices still favored overturning Powell's conviction. The draft of this majority decision was written by Justice Abe Fortas. This case resonated deeply with Fortas, whose feelings for "the poor and downtrodden" in the words of one of his clerks "sprang from the gut."[244] In addition to his concern for the underprivileged, Fortas in his time before the Supreme Court had helped develop the Durham test which was a legal doctrine that allowed for a mental illness to be used as a defense in criminal court. *Powell* represented an opportunity for Fortas to expand this further. In his original majority decision, Fortas attempted to utilize the alcoholism case to create a broad constitutional doctrine that would have allowed for there to be "no criminal liability for an act that was a pattern of a disease" rather than just a product of that disease. He also eliminated the requirement that doctors must prove the disease was "mental."[245]

Legal scholars would later note that if this had been put into effect, it would have been nothing short of revolutionary. Not only would it have changed the tradition of allowing states to determine their own rules around substantive criminal law, but it also would have radically

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[244] Laura Kalman, *Abe Fortas: A Biography* (New Haven: Yale University Press, 1990), 258.
[245] Ibid.

altered the role of voluntary conduct and individual responsibility in determining who was or was not guilty of engaging in criminal behavior. It was this transformative aspect of Fortas' decision that lost him the majority. Justice White was the last to jump ship with this note: "Dear Abe: I am with you part of the way but I am leaving you in other respects and in the result, the upshot being that I do not join your opinion or those on the other side either. I have been back and forth for weeks but it is more than likely that I am at rest, at least for now."[246]

Fortas' lost majority affected the trajectory of judicial activism and criminal justice reform in the remaining decades of the twentieth century. Reformers had expected *Powell* to be another instance where this Supreme Court utilized the law to expand the rights of the poor. Once decriminalization of public drunkenness was successfully realized, legal advocates hoped to turn their sights onto other "victimless crimes" including narcotics addiction, prostitution, homosexuality, and abortion. In the immediate aftermath of the decision, several legal scholars blamed the surprise outcome on the shakiness of the legal arguments being made which relied heavily on the 8th Amendment and dealt less with constitutional issues concerning due process and class discrimination.[247] Yet the failure to overturn Powell's conviction also showed how the tides were turning against sweeping legal reforms on behalf of the underprivileged. While calls for "law and order" amidst supposedly rising crime rates and urban violence were only just beginning, it was clear by the time the *Powell* decision was handed down in the middle of 1968 that there was now a building counterforce against liberalizing approaches to law enforcement.[248]

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[246] Robinson, "The Case of the Intoxicated Shoeshineman," 432.

[247] Due process claims would have dealt more with discriminatory flaws in the law that the justices might have been more comfortable supporting over those relating to criminal responsibility. Mike E. Stevenson, "Chronic Alcoholism and Criminal Responsibility," *Gonzaga Law Review* 4 (1969): 341; Richard A. Merrill, "Drunkenness and Reform of the Criminal Law," *Virginia Law Review* 54, no. 6 (Oct. 1968): 1151; Gerald Stern, "Handling Public Drunkenness: Reforms Despite *Powell," American Bar Association Journal* 55, no. 7 (July 1969): 656.

[248] One legal scholar decided to put his reflections on this development in a stanza format: "Then came the second great American wave of crime, J. Edgar Hoover's statistics in response began to climb… Three great Americans, by assassin's bullets were felled, and the public's aroused concerns for law and order swelled. The criminal justice

Though *Powell* has not received the attention given to other cases from the Warren Court era, the few legal historians who have examined it have pointed to the case as a watershed moment in the history of criminal justice. Writing about *Powell,* the leading criminal law scholar Sanford Kadish called it "the constitutional revolution that failed" despite "all the stars [seeming] to favor it" in the 1960s. Unlike in Canada, the Supreme Court justices stopped short of creating a national standard for how much "personal culpability was necessary for criminal conviction."[249] Other scholars have theorized that this constitutional mandate might have tempered the punitive turn undertaken during the War on Drugs of the late 20th century. Had the Supreme Court ruled that alcoholics could not be charged with public intoxication, it would have been much harder to build a regime of harsh sentencing based on mere drug possession. As law professor Robert Batey has reasoned, "If chronic alcoholics become drunk involuntarily and therefore cannot constitutionally be punished criminally for that conduct, drug addicts surely possess drugs involuntarily and should likewise be immune from criminal conviction for that conduct."[250] Ruling against Leroy Powell and other indigent alcoholics thus prevented the creation of guardrails against the hyper-punitive and racially discriminatory practices that would be characteristic of drug policy from the 1980s onward.[251]

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reforms the Court tried to promote became for politicians a convenient new scapegoat." Gary V. Dubin, "The Ballad of Leroy Powell," *UCLA Law Review* 16 (1968): 149.

[249] Sanford H. Kadish, "Fifty Years of Criminal Law: An Opinionated Review," *California Law Review* 87, no. 4 (July 1999): 964.

[250] Robert Batey, "The Costs of Judicial Restraint: Forgone Opportunities to Limit America's Imprisonment Binge," *New England Journal of Criminal and Civil Confinement* 33 (2007): 35; Burr C. Hollister, "Alcoholics and Public Drunkenness: The Emerging Retreat from Punishment," *Crime and Delinquency* 16, no. 3 (July 1970): 238-254.

[251] It is quite notable that activists involved in the criminal justice reform movement of today often utilize language similar to the decriminalization effort of the 1960s, with calls for ending unnecessary punishment that disproportionately impacts the poor and people of color and favoring instead a public health approach to issues like drug addiction. For example: Pew Charitable Trusts, "More Imprisonment Does Not Reduce State Drug Problems," March 2018; Maia Szalavitz, "Treating Addiction as a Crime Doesn't Work," *The New York Times,* January 26, 2022, 3.

Reactions to *Powell* and Retooling Alcoholism Reform

Regarding decriminalizing public drunkenness, however, the *Powell* decision was far from the end. In the press, the decision was described as a "surprise," a "disappointment," and "a severe blow" to the decriminalization movement.[252] But the sharply divided court had left the door open for a path forward in changing the government's approach to public inebriates. Within his dissenting opinion, Justices Fortas upheld the notion that alcoholics were sick individuals and that it was a violation of their legal rights to be punished by the state.[253] Justice White also supported this fundamental idea that a modern society had no business punishing rather than treating sick individuals in his concurring opinion. The only problem with Leroy Powell was that he had a home he could return to so technically he had the ability to not be drunk in public. White wrote: "The fact remains that some chronic alcoholics must drink and hence must drink *somewhere.* Although many chronics have homes, many others do not…. As applied to them this statute is in effect a law which bans a single act for which they may not be convicted under the Eighth Amendment: the act of getting drunk."[254] In essence, Powell was the wrong man to be testing the cruel and unusual argument for chronic inebriates. Had it been an individual like Easter or Driver who indeed were houseless and had no choice but to be drunk in public, then their punishment would be unconstitutional.

Even within Thurgood Marshall's majority opinion, there was support for the general idea that homeless alcoholics should not be sent to jail for public intoxication. It was this

[252] "Court Backs Jailing of Alcoholics," *The Washington Post,* June 18, 1968, A1; "The Supreme Court Faces a Reality," *The Hartford Courant,* June 18, 1968, 14; John P. Mackenzie, "High Court Rejects Alcoholism as Illness," *The Boston Globe,* June 18, 1968, 1; "Alcoholic Haze," *The Atlanta Constitution,* June 19, 1968, 4; "Non-Agreement on Alcoholism as Disease Cited," *The Globe and Mail,* June 18, 1969, 27; and "Chronic Alcoholics' Jailing for Intoxication is Upheld," *The New York Times,* June 18, 1968, 1.
[253] He wrote that what was at stake in *Powell* was "the foundation of individual liberty and the cornerstone of the relations between a civilized state and its citizens: criminal penalties may not be inflicted upon a person being in a condition he is powerless to change." *Powell*, 567.
[254] Ibid., 551.

statement that was most often quoted in the stories covering the decision: "The picture of the penniless drunk propelled aimless and endless through the law's 'revolving door' of arrest, incarceration, release and re-arrest is not a pretty one."[255] This seeming support for rethinking the penal approach to public inebriates, and the possibility of winning a majority of the justices over if White was presented with the right person, kept the decriminalization effort going. *Powell* proved however that even a liberally minded Supreme Court was more comfortable leaving these kinds of choices about what should be considered a crime versus a disease to states and localities. Rather than providing a broad national mandate, legislatures might be best suited to make these determinations about the law, health, and public safety for their individual communities.

Powell served as a wake-up call for those interested in decriminalization and the broader effort to expand alcoholism treatment. National professional groups like the AMA and APA as well as localized health agencies expressed their disappointment while agreeing with Justice Marshall's opinion that most cities were not prepared to handle the changes that a favorable verdict in *Powell* would have brought. But the decision also represented an opportunity. Dana Farnsworth, a leading psychiatrist, wrote that the "the desired change only awaits a state of readiness on the part of medical facilities to care for alcoholics."[256] Once this "readiness" was proved, most believed another Supreme Court case might be possible in the near future. This case could have a different outcome if those involved with treating alcoholics could show "unity" in their definition of alcoholism and in their ability to come together to provide indigent

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[255] Ibid., 530; "Richardson on Alcoholics," *The Boston Globe,* June 29, 1968, 6.
[256] Dana Farnsworth, "Alcoholism- The Supreme Court Decision," *American Journal of Psychiatry* 125, no. 6 (Dec 1968): 827.

alcoholics with a "continuum of care."[257] However, Justice Fortas' resignation in 1969 made the chances of receiving a decriminalization mandate from the Court far less likely.

A little over three years later, advocates shifted tactics away from the judiciary and toward preparing federal legislation that might initiate decriminalization on a national scale. Representatives from the American Bar Association and American Medical Association wrote the first of such drafts, modeled off the D.C. Alcoholic Rehabilitation Act that Congress had passed in 1968. According to their draft policy, the Supreme Court in *Powell* had in fact found that "punishment of the homeless for intoxication violated the 8th Amendment." They had just declined to extend this same holding to "alcoholics with a home and family." Most significantly, all of justices offered "unanimous recognition that current facilities, procedures and legislative responses to the problem [had] been wholly inadequate." An "increased federal response" was thus needed to address this insufficiency and to ensure that homeless alcoholics' rights against undue punishment were protected.[258] Similar sentiments were found in other draft legislation sponsored by Columbia University and the National Institute on Mental Health which studied all state laws regarding drunkenness and prepared a proposal for how these statutes could be modified.[259]

In response to these model laws and the continued concern over the criminal handling of public inebriates, the Commissioners on Uniform State Laws took on the issue of alcoholism at their national conference in 1971. The commission consisted of representatives from each state

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[257] Ronald Kotulak, "Chicago Groups Attack the Supreme Court's Ruling on Alcoholism," *The Chicago Tribune,* July 14, 1968, 22; Ray Zeman, "County Pushes New Approach to Alcoholics: Revolving Door Arrest Pattern on Way Out As Emphasis Shifts to Medical Treatment," *The Los Angeles Times,* February 24, 1969, E1.
[258] Quoted in National Conference of Commissioners on Uniform State Laws, "Uniform Alcoholism and Intoxication Treatment Act with Prefatory Note and Comments," (Washington D.C., U.S. Government Printing Office, 1971), 3-4.
[259] Norman Kurtz and Marilyn Regier, "The Uniform Alcoholism and Intoxication Act: The Compromising Process of Social Policy Formulation," *Journal of Studies on Alcohol* 36, no. 11 (1975): 1431-1432

and their purpose was to aid in the development of policies that could be enacted at the state level across the country. According to the commission, their work on alcoholism was undertaken "in response to the nation's changing attitude" on the issue and the general consensus amongst medical and legal professionals that alcoholism and public intoxication should be handled "from a health standpoint" rather than through carceral means. At the most basic level, the "Uniform Alcoholism and Intoxication Treatment Act" created by the commissioners sought to have states enact two primary objectives: 1) the decriminalization of public intoxication and 2) the establishment of sufficient treatment opportunities for indigent alcoholics.[260] States that adopted the policy had to officially recognize "that alcoholics and intoxicated persons may not be subjected to criminal prosecution because of their consumption of alcoholic beverages but rather should be afforded a continuum of treatment in order that they may lead normal lives as productive members of society."[261] Built into this phrasing was one of the core tenants of the decriminalization movement that individuals who had long been counted out by society were capable of redemption if they were given a second chance.

The policy outlined what lawmakers considered to be an adequate treatment system for homeless alcoholics. Earlier policies primarily dealt with the funding of detoxification centers that were to replace the traditional drunk tanks for chronic public inebriates. While the use of such facilities in areas like New York City and St. Louis did give the police a non-carceral place

[260] The Uniform Act received the support of the Nixon administration with the Attorney General John Mitchell endorsing the idea that decriminalization had to be coupled with an expansion of treatment resources. He stated, "We know that it does little good to remove alcoholism from the purview of the law if you do not substitute a full-dress medical treatment- not only a detoxification process, but a thoroughgoing program aimed at recovery from the illness of alcoholism." John Mitchell, "Alcoholism- To Heal, and Not to Punish," in *First Special Report to the U.S. Congress on Alcohol and Heath* (Washington D.C.: U.S. Government Printing Office, 1971), 121.

[261] National Conference, "Uniform Alcoholism and Intoxication Act," 3-5. According to the commissioners, this phrasing was designed to preclude criminalizing drunkenness by handling it through other statutes like disorderly conduct or loitering. When accompanied with intoxication, the policy makers hoped behavior like "sleeping on a park bench, lying unconscious, begging, or singing" would be handled by civil rather than criminal procedures.

to take drunkenness offenders, they also demonstrated that detoxification alone did not result in successful rehabilitation. Decriminalization supporters were now starting to recognize that more investment needed to be made in providing additional treatment for homeless alcoholics if the goal was to have them "restored" to "productive citizenship." A "continuum of treatment" needed to consist of "emergency [detoxification], outpatient, intermediate and inpatient services and care including diagnostic evaluation, medical, psychological and social services care, vocational rehabilitation and career counseling."[262] Ideally, implementation of this policy would direct the full force of public and private state institutions onto the issue of alcoholism with hospitals, community mental health centers, halfway houses, and employment offices being utilized together to aid the homeless alcoholic population. In essence, this system was designed to provide comprehensive treatment that could follow chronic alcoholics from detoxification through re-entry into mainstream society.

In one of its most consequential sections, the Uniform Alcoholism and Intoxication Treatment Act sought to settle the question over whether homeless alcoholics could still be forcibly removed from public view. Under the influence of civil liberties lawyers, the decriminalization movement had long prioritized treatment on a voluntary basis. Law groups like the ACLU understood that policy makers might tend to see mandated rehabilitation as a viable replacement to the carceral approach and could be packaged "under the guise of altruism."[263] With civil commitment, alcoholics could be given the medical help reformers had argued they had a right to receive. But perhaps more importantly, officers could also continue removing "derelicts off the street" and address public safety concerns. Throughout the decriminalization effort, civil liberty lawyers attempted to put up roadblocks against court-ordered treatment. They

[262] Ibid., 7.
[263] Stern, "Public Drunkenness: Crime or Health Problem?," 156.

warned that utilizing civil commitment procedures for indigent alcoholics would substitute "more frequent periods of criminal confinement" with "long-term civil incarceration."[264]

The Uniform Act reflected this concern about forced treatment. When crafting the standards states were to follow in developing a continuum of rehabilitation services, policymakers included the principle that alcoholics be "treated on a voluntary basis" in all phases of treatment because this was "more desirable from a medical and legal point of view."[265] On the health side, alcoholics were far more likely to succeed in achieving sobriety if they agreed to receive help on their own terms. From a legal standpoint, keeping treatment self-controlled prevented the state from infringing on an alcoholic citizen's civil rights. Having treatment be voluntary relied on the assumption that indigent alcoholics would indeed accept help if it was offered to them. The commissioners behind the Uniform Act attempted to allay concerns that this might not be the case. "Experience has shown," the law stated, "the vast majority of alcoholics are quite willing to accept adequate and appropriate treatment."[266]

Despite this optimistic sentiment, policymakers included a provision within the Uniform Act that provided a loophole for those drunk in public who might not willingly agree to go with authorities. For individuals "incapacitated" to the point they were "unconscious or incoherent or similarly impaired in judgment that they cannot make rational decisions with regard to their need for treatment," law enforcement or emergency services patrols could take these people into "protective custody." The law was clear that this was meant only for those "seriously in need of care" or those that posed a "threat to himself or others."[267] Simple refusal to undergo treatment did not justify forced removal or institutionalization. But in creating this clause, policymakers

[264] Merrill, "Drunkenness and Reform of the Criminal Law," 1161.
[265] National Commissioners, "Uniform Alcoholism and Intoxication Treatment Act," 20.
[266] Ibid., 20.
[267] Ibid., 24.

subtly acknowledged that the needs of the public had to be weighed against the rights of individual indigent alcoholics. Despite having established the belief that being drunk in public on its own should not be grounds for criminality, they also cautioned that visible alcoholics still posed a problem that warranted intervention. There were no solid answers to these ongoing questions: "At what point is an alcoholic dangerous to himself or others? When does society assume the responsibility of not allowing a man to slowly commit suicide?"[268] This vagueness meant that individual police officers were the ones left to determine what justified serious need for treatment and on what grounds a person could be forcefully removed for being visibly drunk.

The Commissioners on Uniform State Laws approved the Alcoholism and Intoxication Treatment Act in August of 1971. Unlike laws passed by Congress, uniform laws operated more as statutory frameworks rather than strict directives for state governments. States could decide on their own whether to accept the policies created by the commission. If they did so, state representatives were obligated to share the law with their legislatures and press for its enactment. Despite these limitations, this legal framework was the most robust response to Justice Marshall's opinion in *Powell* that called out "the almost complete absence of facilities and manpower for [a] rehabilitation program" directed towards homeless alcoholics in cities across the country.[269] Lawmakers believed that the Uniform Act was the most realistic avenue remaining to fill this treatment void in the absence of a Supreme Court mandate. But in taking this approach, decriminalization was now largely left "dependent" upon the "will of the [states]"

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[268] Irving W. Shandler, "The Housing and Treatment of the Public Inebriate," in *Joint Conference on Alcohol Abuse and Alcoholism* (Washington D.C.: U.S. Government Printing Office, 1972), 62.
[269] *Powell*, 530.

themselves.[270] Incentives to do so increased three years later in 1974, when Congress allotted 13 million dollars to the states who agreed to adopt the provisions of the Uniform Act.[271]

By the end of the 1970s, 34 states had decriminalized public drunkenness and had adopted the treatment legislation in some form. In effect, Hutt's pessimistic warnings to the justices about what would happen without pressure from the court were realized as chronic inebriates remained wrapped up in the carceral revolving door system in a significant portion of the country. For the states that did try to implement both the decriminalization and the medicalization provisions of the Uniform Act, tensions erupted over the disjuncture between the lofty goals promised by reformers and the reality of attempting to treat individuals with a variety of other socioeconomic issues that could not be solved by medicalization alone.

"A Spinning Door:" Decriminalization in Practice

As more states made moves throughout the 1970s to replace the drunk tank and jail with treatment centers for Skid Row alcoholics, city officials and service providers were left on their own to decide the real goals of this transition. Over the previous decade, reformers had given a variety of explanations for why decriminalization was necessary. These reasons included protecting the constitutional rights of homeless alcoholics as sick individuals, safeguarding their health and safety, and freeing up the criminal justice system to focus on serious crimes rather than "victimless" ones like public intoxication. In the 1960s, advocates articulated these different ideas together and would highlight one or the other depending on the milieu of political discussion. By the 1970s, it became more important for those involved in the effort to determine

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[270] "The Legal Status of Intoxication and Alcoholism," in *First Special Report to the U.S. Congress on Alcohol and Heath* (Washington D.C.: U.S. Government Printing Office, 1971), 97.
[271] Congressional Research Service, "The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974- Legislative History," August 1974, 7.

which goal was most important. Was decriminalization being undertaken mainly to remove a burden on the criminal justice system? If so, success could be measured purely by a reduction in arrest and prison population numbers for drunkenness offenses. Or was it to truly offer indigent alcoholics a second chance beyond life on Skid Row? Achieving this objective would mean that more formerly homeless individuals were now working, sober, and in a semi-permanent housing situation. This second option required far more dedication to a population that had long been ignored or looked down upon by not only the public but also the very people who were now being called upon to provide them with help. As the provisions of the Uniform Act were instituted in the 1970s, how those in charge of implementing decriminalization answered these questions shaped the ways in which homeless alcoholics interacted with the state and often determined how "voluntary" treatment was for these newly designated patients.

One key element influencing the line between rehabilitation and punishment in these new medicalized approaches towards public inebriates concerned who oversaw the removal of homeless alcoholics from public view. A few cities sought to follow the model established by the Vera Institute in their Bowery Project that utilized rescue teams to approach homeless alcoholics and offer them medical help.[272] The Uniform Act also favored the use of civilian emergency service patrols in the pick-up and transport stage of detoxification. Policymakers behind the law clearly recognized that eliminating the role of law enforcement was key to preventing alcoholics

[272]In Seattle, for example, the city established the use of emergency service patrols (ESP) vans to transport patients from Skid Row to the publicly funded detoxification center. The ESP was a "corps of civilians, [who were] well acquainted with the skidroad scene from previous professional and/or personal experience." They drove large vans around downtown Seattle, "seven days a week and sixteen hours a day," and offered free medical help to those appearing intoxicated in public. After the first year of its operation, public inebriates tended to "await pick-up by the vans" rather referring themselves to the detoxification center or waiting to get taken there by law enforcement.[272] According to one study, Seattle's use of civilian pick-up teams greatly reduced the need for police in dealing with the issue of public drunkenness. The success of this civilian transport approach also proved to those in the field that Skid Row alcoholics were willing to accept help without a threat of force from the police or a mandate from the court. Ronald W. Fagan Jr. and Armand L. Mauss, "Padding the Revolving Door: An Initial Assessment of the Uniform Alcoholism and Intoxication Treatment Act in Practice," *Social Problems* 26, no. 2 (Dec 1978): 241-242.

from being "treated as criminals."[273] However, these efforts to remove the police entirely from dealing with public inebriates remained largely isolated to a few select cities. In urban areas without civilian patrols, police were no longer allowed to take homeless alcoholics to jail but still were required to remove them from public view. Officially, officers were now being asked to transport alcoholics to the hospital, a detoxification center, or another kind of medical facility.

But in practice, policemen used their own discretion when it came to implementing decriminalization policies. Unlike in the revolving door system, transporting public inebriates to a health facility did not add to the precinct's or an individual officer's arrest and prosecution statistics. When asked about how he felt about the policeman's role following decriminalization, one officer in D.C. remarked: "Why waste time with a drunk when it won't help your monthly scandal sheet…. It's sloppy, bothersome work so why bother unless there is some criminal charge involved?" Achieving one of the primary goals of decriminalization in replacing the drunk tank system with medical aid now rested with individual officers and their willingness to actively help alcoholics enter treatment. One survey found that most police officers failed to do so because they tended not to see "helping inebriates" as "an appropriate task for the police," complaining that it took away from their real job of "crime fighting."[274] This viewpoint of individual officers was also reflected by top law enforcement leaders. Especially in the law-and-order era, police departments were under immense pressure to crack down on an uptick in violent crimes. Police officials used this as the reason for "a reduced organizational commitment to the public inebriation problem."[275]

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[273] National Commissioners, "Uniform Alcoholism and Intoxication Treatment Act," iii.
[274] The survey covered police departments in Washington D.C., St. Louis, and Minneapolis, MN. David Arronson, C. Thomas Dienes, and Michael C. Musheno, *Public Policy and Police Discretion: Processes of Decriminalization* (New York City: Clark Boardman Company, 1984), 62.
[275] Ibid., 270.

How committed police officers and their department heads were to bringing public inebriates in for medical treatment had an outsized impact on how homeless alcoholics themselves experienced decriminalization. Nowhere was this clearer than in St. Louis. Despite being the city where the police department itself was behind the move to begin offering homeless alcoholics detoxification rather than jailtime, officers in charge of ensuring this transport often did not do so. The case of James Mcnew served as a primary example. Towards the end of 1969, a journalist found Mcnew "in a stupor, lying in a patch of grass several hundred feet north of the floodwall gate" near the riverfront of St. Louis. Mcnew had not ended up there on his own. He was brought there by the police. According to the *St. Louis Post-Dispatch,* "[dumping] alcoholics picked up on the streets" alongside "the deserted section of riverfront" rather than taking them to the detox center had become a common practice of the SLPD.[276] A follow-up report undertaken by the American Bar Foundation found that police officers "frequently used informal methods of getting drunks off the street" because they "operated under a policy that discouraged non-quality arrests, including those for drunkenness."[277] The St. Louis case illustrated that the continued reliance on police officers to get inebriates off of the street meant not only that alcoholics were still being forced to interact with law enforcement on a continuous basis but also that they were frequently not receiving the kind of medical help that they were now supposed to be provided.

The use of police in the transportation process also impacted how truly voluntary detoxification and further treatment was for individuals taken off the street. In assessing cities that had implemented the Uniform Act in the early 1970s, one scholar found the mode of

[276] Frank Leeming, "City Police Dumping Alcoholics Near Floodwall Despite Protest," *St. Louis Post-Dispatch,* November 5, 1969, 1.
[277] "ACLU Assails Police Inquiry," *St. Louis Post-Dispatch,* January 16, 1970, 3. Also see: Frank Leeming, "Law Group's Study Shows Police Dumped Drunks," *St. Louis Post-Dispatch,* January 14, 1970, 1; Frank Leeming, "Dowd Censures Dump-Drunk Activity, *St. Louis Post- Dispatch,* January 18, 1970, 14; William Reivogel, "Police Neglect Found in Alcoholic's Death, *St. Louis Post-Dispatch,* May 3, 1979, 10.

transport to be one of the major differences between a medicalized and carceral approach to handling homeless alcoholics. Civilian emergency patrols could only take those found drunk in public to receive medical help "with the consent of the subject."[278] With the protective custody provision in the Uniform Act, police officers did not need the approval of the patient to remove them from public view or to bring them in for treatment. Additionally, "rescue units" were only authorized to deal specifically with the problem of drunkenness. Police patrols could continue to utilize other criminal codes besides drunkenness (such as disorderly conduct) to forcibly remove or arrest those intoxicated in public.[279] Despite the hope underlying the Uniform Act and the decriminalization movement in general of removing police completely from dealing with public inebriates, very few cities invested the resources in developing alternative methods for removing homeless alcoholics from city streets. Thus, even in the metropolitan areas that underwent decriminalization, alcoholic citizens continued to face forced removal. While most were now sent to a detoxification center or a hospital rather than to a jail cell, many of these individuals were not necessarily receiving this short-term "treatment" on a truly voluntary basis.

While the Uniform Act incentivized states to institute a "continuum of services" for homeless alcoholics, localities that initiated this process focused mainly on the building of detoxification centers. This emphasis on detox made sense for city officials who often saw the primary (or at least the most pressing) objective of decriminalization to be replacing the drunk

[278] Paul Astor, "Mobilization in Public Drunkenness Control: A Comparison of Legal and Medical Approaches," *Social Problems* 25, no. 4 (April 1978): 376.

[279] Even in cities that removed public drunkenness from the criminal code, police officers could utilize disorderly conduct statutes for the same purposes of arresting homeless alcoholics. What constituted "disorderly conduct" was left up to the subjective discretion of an individual officer and did not require them to send these individuals to a detox center. Especially when police departments faced pressure from "individual residents, businesses and other groups for the removal of drunken persons from streets and public places," they tended to turn to "informal dispositions and substitutions of other criminal charges like disorderly conduct or begging" for "street cleaning" purposes. One study of Houston and San Jose, Texas, for example, found that a decrease in patients at the detox facility and a rise in numbers at the jail were linked to an increase in calls police were receiving from disgruntled businesses. Arronson, et. al, *Public Policy and Police Discretion,* 217.

tank with some form of healthcare. By the end of the 1970s, 34 states initiated some form of publicly subsidized detoxication and established varying goals for doing so. Detroit's detoxification center was meant to provide "medical treatment – rather than jail- for public inebriates."[280] The staff's primary objective was to provide a safe space for those undergoing alcohol withdrawal. Chicago took a similar approach. Haymarket House, a former tropical fish store turned detoxification center, provided Skid Row alcoholics a "five-day stay" where a person could "dry out, receive food and shelter, and be counseled about his alternatives." When asked about the reason for such a facility, the center's leader did not promise cures to patients' homelessness, poverty, or even their drinking. "No one would try to reach them in the drunk tank," he said. "But we're giving it a try- because it is the humane thing to do."[281] Atlanta's approach was slightly more far-reaching. Detoxification was seen as a gateway to further treatment, especially on an out-patient basis. This "treatment-rather-than-arrest approach" to alcoholism could provide "the patient with alternatives to coping with the myriads of life's problems without the crutch of booze."[282] These fairly modest objectives illustrate that those in charge of this first phase of decriminalization understood that there was a limit to what detoxification alone could achieve. At the very least, public inebriates would no longer be incarcerated. At best, alcoholic individuals could begin the path to sobriety.

Access to these services was not universal, particularly for women. Female alcoholics had largely been left out of the debates over decriminalization, an oversight that carried over into the operations of detoxification and treatment centers. Most agencies "did not believe there were

[280] "Detox Center Offers Rehab for Alcoholics," *Michigan Chronicle,* June 23, 1973, B11.
[281] Bonita Brodt, "Down-And-Outers Get Help," *Chicago Tribune,* April 10, 1980, A1.
[282] Neil Swan, "Chronic Public Inebriates To Get the Cure in 1975," *The Atlanta Constitution,* September 22, 1974, 2A.

many females on skid row" and therefore did not set aside space for women.[283] In 1971, a "coalition of alcoholics and community workers" protested this "rank sex discrimination" that barred female alcoholics in D.C. from receiving treatment while "almost any man [was] picked up off the gutter and was getting at least some help."[284] At the alcoholism treatment ward in the District's general hospital, women were only admitted if they had been detoxified for five days. Community mental health centers turned away alcoholic women because staff members were prejudiced "against lady drunks" and "simply did not want to admit them."[285] This inequality was common in cities across the country. Women in Boston even marched in front of the administration building of the city hospital "to protest the city's neglect of women alcoholics."[286] Similar to the group in D.C., they demanded a specific halfway house and hospital treatment ward for female alcoholics. Once these were open, the number of visits from female Skid Row alcoholics skyrocketed demonstrating that there had always been a need for such a space. These requests illustrate that though the medical services created as a result of decriminalization may have been limited in scope, for many, they were still better than nothing. Furthermore, they

The racial demographics of patients in detoxification and treatment facilities varied by city. In D.C., for example, the average individual being served at the detoxification center was a Black man. However, in many areas, a racial disparity existed amongst those receiving medical help for alcoholism. St. Louis' center, for instance, was made up of 70-80% white men. It was not until later in the 1970s, "under pressure from the Black community" that more Black patients

[283] Anita Harris, "Women Derelicts: To Be Old, Homeless, and Drunk," *The Real Paper,* July 25, 1973, 4.
[284] Claudia Levy, "Bias Against Women Alcoholics Charged: Many Females Are Being Refused Treatment," *The Washington Post,* September 12, 1971, D1.
[285] In response, the city opened a detoxification center specifically for female alcoholics. But the facility for women only had 16 beds, while the space for men had 150.
Claudia Levy, "16 Bed Detoxification Center for Women Opens This month," *The Washington Post,* November 8, 1971, C7; Claudia Levy, "Facility for Women Alcoholics Opens," *The Washington Post,* December 2, 1971, B2.
[286] Ray Richard, "Marchers Try to Aid Women Alcoholics," *The Boston Globe,* March 27, 1969, 40.

were admitted for detox. And in Minneapolis, a study found that homeless alcoholics who were older and white were far more likely to be sent to a health facility rather than "undergo criminal prosecution."[287] One report attributed these different paths to the fact that white alcoholics were far more likely to be "officially" considered sick. Black and Native American homeless alcoholics on the other hand were still likely to be seen by police and public health officials as "criminal," placing them on "the legal track" instead of "the treatment and rehabilitation track."[288] Another stereotype hindering racial equity in the treatment space was the unsupported idea that Black alcoholics would be taken care of without institutional support. As one medical official in Atlanta claimed, "Negroes will help a Negro alcoholic and even take him into their homes while the white community completely shuns the white alcoholic."[289] The unfounded assumptions that the chronic inebriates in need of help were likely to be white and male affected how accessible treatment services were for those who did not fall into these categories.

Throughout the 1970s, the question became whether these limited outcomes were worthy of public investment.[290] Detoxification in the nation's capital once again serves as a prime example. After the passing of the Alcoholic Rehabilitation Act (ARA) in 1968, the District's Alcoholic Detoxification Center (ADC) became the "nation's first federally started facility for

[287] Arronson et. al, *Public Policy and Police Discretion,* 264, 303, 342.
[288] According to the American Indian Policy Commission, "the Indian population was 10 times as likely to be arrested for [drunkenness] as were non-Indians." *Report on Alcohol and Drug Abuse: Final Report to the American Indian Policy Review commission,* (Washington D.C.: Government Printing Office, 1976), 89.
H. Eugene Hodges and George D. Lower, "Race and Change in Rates of Treatment and Deaths Due to Alcoholism in a Southern State: 1970-1974," *Phylon* 38, no. 2 (1977): 152.
[289] George M. Coleman, "Fully Racial Equal Program Called For: Experiment May Aid Alcoholics," *Atlanta Daily World,* March 19, 1963, 1.
[290] This was not a unique development for welfarist programs like publicly subsidized treatment. Growing cynicism about the government's ability to manage spending and to solve social problems propelled public disinvestment throughout the 1970s. John Ehreneich, *The Altruistic Imagination: A History of Social Work and Social Policy in the United States* (Ithaca: Cornell University Press, 1985); Edward D. Berkowitz, *America's Welfare State: From Roosevelt to Reagan* (Baltimore: The Johns Hopkins University Press, 1991); Molly C. Michelmore, *Tax and Spend: The Welfare State, Tax Politics, and the Limits of American Liberalism* (Philadelphia: University of Pennsylvania Press, 2012).

sobering up" alcoholics. This new center was seen as a radical departure from the carceral Occoquan facility that had been used to "detox" homeless alcoholics in the initial years after *Easter.* In its first year of operation in 1969, journalists remarked that the ADC had "well-lighted, spotless facilities." Patients were "treated kindly, quietly but firmly" and "usually" reacted "favorably to the clean pajamas, wholesome food and the interested attention of the staff." Nurses and doctors at the facility portrayed a sense of optimism about their patients. As one Nurse Bradley stated, "I do not feel that any alcoholic is helpless. Some certainly require more help for a much longer time than others. But I think any alcoholic can be reached."[291] In the beginning, the patients at the detox center also painted a positive picture of the facility. When asked to compare the center with the traditional drunk tank process, a patient summed up the difference: "In order to start to help yourself, you've got to believe you can be helped. In jail, they were treating you like a convict. They didn't think you were worth helping. If it wasn't for this program, I'd be drunk on the street and I know it."[292] For some patients like these, the detoxification center did feel like a marked departure from the carceral revolving door system in both the atmosphere and in the kind of medical treatment they were receiving. Another patient named Marvin agreed. "You come in here," he said, "and they treat you like a human being."[293]

However, by 1973, conditions at the center started to deteriorate. The Washington Area Council on Alcoholism, the same citizen agency that helped with the *Easter* decision, sued the city government for failing to comply with the ARA. In particular, the suit castigated the public health department for running a detoxification center "so overcrowded that patients [had] been forced to sleep on the floor, [had] been discharged too early to make room for others or [had]

[291] Elizabeth Shelton, "Detox: Where Alcoholics Dry Out," *The Washington Post,* June 15, 1969, 135.
[292] Donald E. Graham, "Court Aided DC Alcoholism Treatment," *The Washington Post,* February 9, 1971, A1.
[293] Donald E. Graham, "Alcoholic Center Has Busy Saturday," *The Washington Post,* February 9, 1971, A1.

been refused aid because of lack of space."[294] While the time for "adequate" detoxification was 72 hours, the center now routinely discharged patients within 24 hours to deal with overcrowding. Similarly, despite the provisions of the ARA, the only long-term rehabilitation center for alcoholics remained housed at the former Occoquan detention facility. WACA's suit demanded relocation, arguing that "an effective and therapeutically sound treatment for program for alcoholics [could] not be administered on the site of an existing correctional institution." Public health officials and treatment staff responded that the reason for these inadequate conditions was a lack of proper investment in the centers. According to Dr. Vanderpool, the clinical director at the rehabilitation center, "a lack of support from the District government" and continual budget cuts meant that the center could not "give even adequate custodial care to very sick persons."[295] The city government's chronic disinvestment in alcoholic rehabilitation reflected an issue that would continue to plague decriminalization efforts across the country. Especially in the "law and order" era, political incentives to fund carceral institutions increasingly outpaced motivations for doing the same with therapeutic facilities.[296]

This funding issue also affected how alcoholics were discussed in public discourse with city officials continuously reverting to traditional, moralistic views that reformers had been working to overturn since the 1940s. One newspaper article, published two years after the meager improvements the D.C. government instituted after the WACA lawsuit, illustrates this predicament. According to the journalist, the rehabilitation center which had once been "an

[294] Raul Ramirez, "Alcoholic Unit Sues District: City Held Lax in Expanding Aid Program," *The Washington Post,* June 28, 1973, B1; Patricia Saltonstall, "Alcoholics' Condition," *The Washington Post,* February 8, 1973, A23; William Claiborne, "Alcoholic Unit Suit Mulled," *The Washington Post,* January 23, 1973, C5.
[295] William Claiborne, "Director Reproved At Alcoholics Centers," *The Washington Post,* January 19, 1973, C5.
[296] "Crime Fighters' Funds to Rise $310 Million in Year; War on Poverty to Become Secondary Engagement," *The Wall Street Journal,* February 3, 1970, 6.
This funding problem would only intensify in the 1980s with Reagan-era cutbacks to social welfare programs. Julily Kohler-Hausmann, "Guns and Butter: The Welfare State, The Carceral State and The Politics of Exclusion in the Postwar United States," *The Journal of American History* (June 2015): 91.

innovative facility for alcoholism" was now "overcrowded, understaffed, and underfunded" and served "mainly as a warehouse for alcoholics rather than a true rehabilitation center." While recognizing that these problems could in part be attributed to the lack of funding and a shortage of appropriate medical staff, he also believed that a primary issue was the alcoholic patients themselves. Many of the alcoholics at the facility were "run-of-the-mill persons" who were "not highly motivated to quit drinking," and it was their lack of motivation that turned the institution into a "storage bin."[297] These sentiments were repeatedly echoed by city officials in charge of funding and staffing treatment facilities. Rather than blame inadequate treatment services on the lack of monetary investment, alcoholic patients and their refusal to respond to help were causing treatment programs to fail.

This tendency to disparage alcoholics was also evident amongst the medical and social welfare professionals now in charge of providing patients with aid. The Uniform Act and the disease concept upon which it was based relied on the assumption "that the sick will actively seek help and cooperate in promoting their recovery."[298] As a few scholars assessing the effectiveness of the Uniform Act noted, Skid Row clients often failed to live up to this "sick role" expectation set by healthcare professionals. Treatment staff judged homeless alcoholics for appearing to not be motivated enough to stop drinking, for leaving treatment early, or frequently relapsing. One survey on "the medical and ancillary personnel" working in the treatment field found that they held a "generally ambiguous attitude toward the alcoholic." Though most agreed that the alcoholic was a sick person, they indicated "corresponding feelings" similar to those

[297] Douglas C, Lyons, "No Aid to Alcoholic: Agency Runs Overcrowded Warehouse," *The Washington Post,* January 23, 1975, B1.
[298] Kurtz and Regier, "The Uniform Alcoholism and Intoxication Treatment Act,"1435.

raised in the *Powell* case that "the alcoholic is also responsible for his condition."[299] The medical and social workers interviewed were particularly harsh when it came to assessing how driven alcoholic patients were in receiving help, reporting that their attempts to provide treatment were being wasted on "nonmotivated" individuals. Feedback from the staff on an alcoholism ward in a mental health hospital in California serves as an example. One nurse stated, "They're not grateful for all that is done for them. A staff member can work and work with an alcoholic and he will repay him by picking up one day and taking off without a word."[300] While of course not reflective of all those involved in alcoholism treatment, this prevalence of negative attitudes towards alcoholic patients amongst those called upon to help them had significant ramifications for the success of the decriminalization effort as a whole. As in all forms of medical care, effectiveness of alcoholism treatment corresponds to the dedication of medical professionals. When understanding turned into apathy or even disdain for homeless alcoholics, this transition affected the kind of help patients were able to receive.

A lot of these frustrations could be explained by an incongruity between the lofty aspirations set by decriminalization advocates and the practical realities of Skid Row patients. Reformers had long promised that when chronic inebriates were provided with adequate medical help rather than carceral punishment, many of them would be able to stop drinking, find a home,

[299] H. Paul Chalfant and Richard A. Kurtz, "Alcoholics and the Sick Role: Assessment by Social Workers," *Journal of Health and Social Behavior* 12, no. 1 (March 1971): 66; H. Paul Chalfant and Richard A. Kurtz, "Factors Affecting Social Workers' Judgements of Alcoholics," *Journal of Health and Social Behavior* 13, no. 4 (Dec 1972). Similar judgmental attitudes had long been documented amongst physicians, psychiatrists, and nurses. As one psychiatrist told a researcher, "The usual alcoholic has no motivation toward health, is unwilling to assume responsibility, deprives [other] psychiatric patients of care by consuming the therapists time in fruitless efforts." While this was a theory held by many medical professionals towards alcoholics of all backgrounds, it was found to be particularly strong towards those who were poor or homeless. Robert Straus, "Medical Practice and the Alcoholic," *The Annals of the American Academy of Political and Social Science* 315 (Jan 1958): 121; Irving Wolf, Morris Chafetz, Howard Blane, and Marjorie Hill, "Social Factors in the Diagnosis of Alcoholism: Attitudes of Physicians," *Quarterly Journal of Studies on Alcohol* (26, no. 1 (1965): 72-79.
[300] Wiseman, *Stations of the Lost,* 148.

and steady employment. Even by the 1970s, when experience had taught treatment providers to set slightly more modest goals, the expectation remained that public investment in Skid Row alcoholics was worth it if they could be "restored" to "productive citizens." Yet, homeless individuals tended to approach detoxification and follow-up treatment services the same way they had jailtime- to meet their basic needs of food, warmth, and shelter rather than to quit drinking. As one group therapy leader observed, "Seven out of ten alcoholics are only interested in some favor. They want you to call a hotel or call up welfare to tell their worker they won't be in. They are not interested in treatment."[301] Rather than seeing this as a patient trying to take care of himself, service providers tended to see this as proof that alcoholics were unwilling to receive help or that they were manipulating those who were trying to give them a second chance.

This incompatibility between what homeless alcoholics wanted and needed versus what treatment providers demanded was also seen in how most detoxification centers had very high rates of recidivism. Robin Room, a leading alcoholism researcher, observed in 1976 that medicalization had not eliminated the carceral revolving door system but instead had replaced it with a "spinning door" where inebriates were "often back on the street more quickly than under criminal justice procedures."[302] The civil liberty lawyers behind decriminalization might have seen this as a positive sign that alcoholic patients were not being held indeterminately against their will. Yet quick discharges and a lack of follow-through with other forms of care had a cyclical effect, heightening the tension between the rights of public inebriates and the desire for public order. When alcoholics returned to the street, businessowners amped up their calls to law enforcement departments requesting their removal. City residents also complained about the ongoing public presence of homeless alcoholics. In New York City, for example, people referred

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[301] Ibid.,135.
[302] Room, "Drunkenness and the Law," 133.

to public alcoholics as "winos" and "a variety of crazies" that were "a constant and sometimes hazardous nuisance."[303] Police would respond to these kinds of complaints by bringing more individuals into protective custody and forcing them back into detox treatment.[304]

The net effect of this cycle was renewed calls for involuntary institutionalization. Arthur Pratt, for example, who ran the detoxification center for public inebriates in Indianapolis wrote: "Having supervised the detoxification of over 2,000 alcoholics, I have found them both difficult and sometimes dangerous to manage. More important is the difficulty of keeping them in a long-term treatment program on a purely voluntary basis."[305] He recommended that civil commitment procedures in which patients could be held for an indeterminate amount of time in a mental health hospital (or some other kind of treatment facility) might be of better use for the indigent alcoholic population. By the end of the 1970s, this support for mandatory rehabilitation for Skid Row alcoholics became a common refrain amongst many service providers, alcoholism researchers, and those in charge of subsidizing treatment programs.

The National Institute on Alcoholism and Alcohol Abuse (NIAAA), the main federal organization studying and promoting treatment efforts, agreed that the policy commitment to voluntary treatment needed to be revisited. After conducting a national survey, the NIAAA found that the Uniform Act had "caused substantial changes in the delivery of health care services" and produced "major and beneficial effects" in the states that had moved "public inebriates from the criminal justice system." The agency also claimed that one of the problems preventing these services from being as effective as possible was the "question of

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[303] Pranay Gupte, "Derelicts Vex Residents," *The New York Times,* July 17, 1973, 81.
[304] Ibid., 134; Kurtz and Regier, "The Uniform Alcoholism and Intoxication Treatment Act," 1437; Arronson et. al, *Public Policy and Police Discretion,* 273.
[305] Arthur D. Pratt, "A Mandatory Treatment Program for Skid Row Alcoholics: Its Implications for the Uniform Alcoholism and Intoxication Treatment Act," *Journal of Studies on Alcohol* 36, no. 1 (1973): 169

'voluntariness.'" Under the Uniform Act, the government was "required to provide treatment services but alcoholics and inebriates [were] not required to accept them." It was this principle that the NIAAA now believed deserved "much greater analysis at the levels of both theory and operations."[306] Reflected in most of these statements calling for mandated treatment was the idea that alcoholic patients were not adequately fulfilling their role under the new medicalized paradigm. The continued "disinclination of public inebriates to seek help voluntarily" as well as "their inclination to disorderly behavior" was "[disrupting] a purely medical approach."[307] Coercing alcoholics into treatment became the solution to try force alcoholic patients to fulfill the expectations set by those providing them healthcare services.

Leaders in the field also saw involuntary treatment as an answer to the public order and safety concerns caused by decriminalization. By the end of the 1970s, 28 of the states that were formally considered to have decriminalized public drunkenness had involuntary civil commitment provisions included in their alcoholism legislation. In doing so, city officials were offering their response to the ongoing complaints from businessowners and community members "to clean up downtown areas" and "remove inebriates from the street."[308] According to one study, these "ordering into treatment" provisions still included a "strong emphasis on due process and [the retention of] full civil rights."[309] While lawmakers did not promote returning to the arrest and incarceration of public inebriates, they did endorse a procedure that allowed for the city in the words of one lawyer to "get away with storing its alcoholics involuntarily in an institution."[310] It is clear by this return to mandated institutionalization that many states had

[306] National Institute on Alcohol and Alcohol Abuse, "Survey Finds Major Impact of Care by Uniform Act," *NIAAA Information and Feature Service* 36 (May 1977): 1.
[307] Fagan and Mauss, "Padding the Revolving Door," 234.
[308] Room, "Drunkenness and the Law," 133-134.
[309] S. George Clarke, "Public Intoxication and Criminal Justice, "*Journal of Drug Issues* (Summer 1975): 231.
[310] Quoted in Room, "Drunkenness and the Law," 130.

determined, just as the Supreme Court majority had in *Powell,* that having chronic inebriates out of public view was to be given priority over protecting the rights or welfare of alcoholics.

While those calling for mandated treatment had the loudest voice, there was a small but significant number of researchers, reformers, and treatment providers who were beginning to call into question whether trying to ameliorate homeless individuals' problematic drinking behavior was the right starting point. For some researchers, the problem with the Uniform Act was that it had made decriminalization "conditional in that criminalization was to be exchanged for medical treatment." Emphasizing "illness behavior and its treatment" as the primary solution to handle the Skid Row population outside of the criminal justice system was always going to be limited in what it could accomplish.[311] Though many scholars attributed this to the failure of indigent alcoholics to live up the "sick role" envisioned by reformers, others pointed out that medicalization could not solve the underlying socioeconomic issues that kept many individuals on Skid Row in the first place. As the director of the alcoholism rehabilitation program in California contended**,** the "public inebriate problem is primarily a housing problem, not a treatment problem."[312] This idea was most clearly articulated by those with firsthand experience in both the carceral and medicalized approaches to public alcoholism. Prince Wright, a volunteer at the Occoquan rehabilitation facility in D.C., who had been sentenced to jail over 100 times when public drunkenness was a crime aptly described what he saw as being the limitations to the medicalized approach for alcoholics like himself. "A man's physical needs must be met," Wright said, "and then he can start to concentrate on his other problems."[313] This housing first versus treatment first debate would increase in the 1980s as broad economic shifts and changes in the

[311] Kurtz and Regier, "The Uniform Alcoholism and Intoxication Treatment Act," 1438.
[312] Arronson, et. al, *Public Policy and Police Discretion,* 224.
[313] Claudia Levy, "Bridging the Gap: Rehabilitation of the Alcoholics," *The Washington Post,* August 28, 1971, B1.

demography of the homeless population forced a rethinking of whether drinking behavior alone could explain why an individual was without a job or home.

The Limits to Legislating Decriminalization

In the *Powell* decision, Justice Marshall had called on states to solve the problem of "the penniless drunk" on their own. However, as Hutt had predicted, the lack of pressure from the Supreme Court had allowed for states and localities to initiate the decriminalization process gradually and often ineffectually. Just as the Court refused to constitutionally mandate a change in how indigent alcoholics were handled by the state, pressure was building to slash social welfare spending to focus instead on issues of crime and disorder. Additionally, faith was diminishing in the state's ability to solve complex social problems. Thus, there was not a lot of political incentive to expand and publicly subsidize healthcare services for the homeless alcoholic. The main policy achievement in this area, the Uniform Act, was limited in scope. Though 34 states had adopted the provisions of the law, the treatment of indigent alcoholics continued to vary across the country.

These states were most effective at achieving the "divestment goal of decriminalization" as they were able to reduce the amount of criminal justice resources being directed towards the problem of public drunkenness.[314] The "revolving door" system as it had been known was effectively ended, with Skid Row men no longer circulating in and out of jail due to drunkenness charges. However, alcoholics even in decriminalized states continued to be arrested "often on other charges, such as disorderly conduct or disturbing the peace."[315] For some involved in the

[314] Dan Beuchamp, "Precarious Politics: Alcoholism and Public Policy," ProQuest Dissertations Publishing (1973), 328.
[315] First National Conference on the Public Inebriate, *The Public Inebriate: Overview and Alternatives to Jail* (Madison: Wisconsin Clearinghouse, 1981), 1.

movement, this result would largely be considered a success. Criminalizing public drunkenness and alcoholics by extension was problematic precisely because it "was a drain on the resources of the criminal justice system" and was a "distortion of normal legal processes."[316] Especially in years highlighted by fears over violent crime, the fact that decriminalization had allowed the criminal justice system to focus on these more substantial areas was a victory.

Replacing the carceral approach with a medicalized system of treatment for homeless alcoholics was a slightly different story. As one scholar surmised, legislating decriminalization through the Uniform Act possibly just meant that the penalization of alcoholics had become "softer and more comfortable with detoxification centers" rather than jails.[317] The failure to adequately maintain detoxification and treatment facilities as well as a lack of investment in follow-up services that could aid in improving a patient's socioeconomic circumstances meant that homeless alcoholics remained wrapped in a cycle where they were forcibly removed from public view, provided with brief medical treatment, and then returned to the street.

Service providers often realized the limitations that therapy for drinking could provide for individuals dealing with chronic issues of houselessness, underemployment, and poverty. But rather than calling into question the efficacy of medicalized "rehabilitation," the blame easily shifted back onto the homeless alcoholics themselves. While those involved in the field were committed to the idea that alcoholics were sick individuals and not criminals, there remained even amongst social welfare and medical professionals a lingering sense of apathy toward alcoholics and an enduring feeling that they had in some ways brought this fate upon themselves. Treatment providers felt they were fulfilling their responsibility towards the alcoholic by offering them care. It was the alcoholic himself who was failing in his obligations as a sick citizen, by not

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[316] Mitchell, "Alcoholism- To Heal, and Not to Punish," 119.
[317] Fagan and Mauss, "Padding the Revolving Door," 244.

committing to his own health and sobriety. These sentiments allowed for policymakers to accept the idea that mandated long-term treatment was a sufficient alternative to incarceration for homeless alcoholics, permitting involuntary institutionalization in a different form.

CHAPTER 4

"We Are Eminently Salvageable:"

A Bill of Rights for the "Hidden" Alcoholic

"Drugs are the fair-haired child," Willard Foster told *The Washington Post* in 1970. "They are getting all the gold yet there are ten times as many alcoholics as there are drug addicts." Foster was the coordinator of alcoholism treatment programs in the state of Maryland. Like many other individuals involved in the substance abuse field, Foster lamented the "nation-wide hoop-la over drug abuse and the general ho-hum attitude toward alcoholism."[318] This "hoop-la" began soon after President Nixon's arrival to the White House in 1969. As many historians have documented, Nixon made the problem of illicit drugs (marijuana, LSD, and heroin in particular) a part of his general promise to reinstate "law and order" and reduce crime.[319] With Nixon declaring drug abuse to be "America's public enemy number one" in the early 1970s, an interesting dynamic formed between those dedicated to alcoholics and those worried over other drug users.[320] At a time of significant budgetary cuts to health and social welfare services, the new administration remained willing to invest heavily in not only drug

[318] "Alcoholism in MD- A Neglected Killer," *The Washington Post,* June 14, 1970, A1.
[319] Michael Massing, *The Fix* (Berkeley: University of California Press, 1998); Eric Schneider, *Smack: Heroin and the American City* (Philadelphia: University of Pennsylvania Press, 2008); Dan Baum, *Smoke and Mirrors: The war on Drugs and the Politics of Failure* (Boston: Little, Brown, 1996); Katheen J. Frydl, *The Drug Wars in America, 1940-1973* (Cambridge; Cambridge University Press, 2013).
[320] Richard M. Nixon, "Remarks About an Intensified Program for Drug Abuse Prevention and Control," *Public Papers of the Presidents of the United States, Richard Nixon 1969* (Washington D.C.: US Government Printing Office, 1971), 738.
A number of scholars have written about how this concern over illicit drug abuse was overblown, with even President Nixon acknowledging that there was no agreement "with respect to the size and the importance of the drug problem." No matter the actual extent of drug use, there was a presumed linkage between narcotics and criminality that Nixon and his advisors found politically expedient. To do something about the drug problem was also a way to be seen as doing something tangible about crime. David F. Musto and Pamela Korsmeyer, *The Quest for Drug Control: Politics and Federal Policy in a Period of Increasing Substance Abuse, 1963-1981* (New Haven: Yale University Press, 2008), 60.

enforcement but also rehabilitation programs for addicts. For those working in the arena of alcoholism treatment, the political attention and funding being devoted to drug users posed an opportunity to expand this focus to include other substance abusers.

Treatment workers, reformers, and journalists attempted to shift attention to alcoholism in several different ways. Some consistently brought up the estimate that there were 5 to 6 million alcoholics in the country, a number that far outpaced the estimated 125,000-250,000 narcotics abusers.[321] Others emphasized the fact that alcohol too was a drug, one that just happened to be legal and socially acceptable. Even more significantly, this "ignored drug with the polished image" was the most destructive in its impact on families, the economy, and individual well-being.[322] While perhaps true, these points were no match for the hysteria generated by the idea of illicit drug abuse especially among the white, suburban youth of America. To explain this seemingly misdirected frenzy, one reporter described it this way: "Drugs are a bigger scene: newer, mysterious, conjuring up images of opium dens, scar faced gangsters, border runs in Tijuana, and the very juicy illicitness of it all. Alcohol, on the other hand is dull… The alcoholic has become invisible because he's so common." The level of visibility given to a certain substance in the newsroom or in the halls of the government was not without consequence. Visibility resulted in money, research, and treatment programs. Or to put it simply: "Legislators don't vote money for invisible men."[323]

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[321] "Alcohol Still Remains the Biggest Addiction," *The Boston Globe,* November 1, 1970, 26; "Alcoholism's Financial Hangover," *Los Angeles Times,* July 20, 1964, A4; "Alcoholism Supersedes Drug Addiction as Community Problem," *New York Amsterdam News,* May 3, 1969; Louis Cassels, "Alcoholism Outrivals Drugs," *Hartford Courant,* October 18, 1970; and "Alcoholism is Called No. 1 Drug Woe," *The Atlanta Constitution,* November 5, 1969, 2A.
[322] Colman McCarthy, "Alcohol: The Ignored Drug with the Polished Image," *The Washington Post,* December 6, 1969, A22; Sam Hopkins, "Alcohol's Peril Worst of Drugs," *The Atlanta Constitution,* September 20, 1969, 3A; and "Drug Abuse Also Includes Drinkers," *The Atlanta Constitution,* July 11, 1969, 32.
[323] David Nyhan, "Drugs Get the Attention, Alcohol Bigger Scourge," *The Boston Globe,* June 20, 1971, 1.

However, as the 1960s shifted into the 1970s, decades of momentum had been building around the matter of alcoholism. The decriminalization movement had sharpened the political rhetoric concerning the rights and entitlements of alcoholics that could be applied to persons of all backgrounds. Decriminalization supporters had also gotten the ball rolling in terms of asserting a certain level of public and governmental responsibility towards citizens struggling with excessive drinking. Thus, despite often being overshadowed by the early iterations of the drug war both in the reporting of the time and in the historical record, alcoholism remained a key political issue at the dawn of the seventies. With the crucial election of Senator Harold Hughes in 1968 and the continued dedication of the alcoholism reform effort, advocates were able to use the mass attention placed on drug addiction to pass legislation that has been called the "Emancipation Proclamation," the "Magna Carta," and "The Bill of Rights" for alcoholics.[324]

This legislation was largely the result of the work of individuals in the modern alcoholism movement, an effort that both overlapped and departed from the decriminalization movement. Both groups emphasized the rights of alcoholic persons, the need to remove forms of penalization, and the use of governmental resources to return alcoholics to productive citizenship. But while decriminalization advocates were primarily concerned with indigent alcoholics caught up in the carceral revolving door system, people involved in the alcoholism movement were concentrated on those they described as "the hidden and neglected alcoholics." The alcoholics making up this group were those "working in business and industry as well as the professional people such as doctors, lawyers, dentists and so forth."[325] Advocacy groups like the National Council on Alcoholism (NCA) that represented this "neglected" segment of the

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[324] Jay S. Lewis, "Congressional Rites of Passage for the Rights of Alcoholics," *Alcohol Health and Research World* 12, no. 4 (1988): 243.
[325] "Alcoholism and Narcotics- Denver Pt. 2," *Hearings Before the Special Subcommittee on Alcoholism and Narcotics of the Committee on Labor and Public Welfare- Senate,* 91st Cong., 1st Sess., September 29, 1969, 350.

alcoholic population had tolerated decriminalization and its focus on the "Skid Row alcoholic" because it got people in positions of power talking about the issue of alcoholism. They understood that while their experiences with alcoholism tended to be "latent and difficult to bring to view," homeless alcoholics were "visible and obstructive."[326] In this way, political conversations around public drunkenness were advantageous in getting cities to build treatment services that could be of use to all alcoholics not just the indigent.

This partnership between the alcoholism reform and decriminalization movements had always been an uneasy one. For many, the image of the "Skid Row bum" hampered the effort to destigmatize alcoholism and overshadowed the fact that most alcoholics were "respectable" individuals who were employed and housed. In the aftermath of *Powell,* reformers sought to use the opportunity to pivot away from decriminalization and onto issues impacting alcoholics of other socioeconomic backgrounds. As the previous chapter showed, conversations around the impoverished alcoholic did not go away at the end of the 1960s. But the debates around decriminalization were in many ways kept separate legislatively and politically from those dealing with the "respectable" alcoholic. Unlike chronic inebriates, these alcoholics were not visibly exhibiting a symptom of their disease that some saw as an ongoing threat to public safety. Because of this, the political conversations around expanding treatment for the non-public alcoholic avoided some of the "law and order" challenges that plagued the decriminalization effort throughout the 1970s. While the struggles of "hidden" alcoholics were obviously less visible than those exhibited by Skid Row cases, advocates argued that they were just as in need and possibly more deserving of public investment. Members of organizations like the NCA

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[326] Dan Beuchamp, "Precarious Politics: Alcoholism and Public Policy," ProQuest Dissertations Publishing (1973), 258.

called on the government to now turn its attention to those who had been overshadowed by the focus on the indigent- in particular white men of working, middle, and upper class backgrounds.

This chapter will examine how some of the major goals of the alcoholism movement became institutionalized and federalized through the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act or the more commonly known "Hughes Act" in the early 1970s. It will analyze how this law and the political conversations around it broadened the kinds of rights-claims being made by alcoholics and their supporters. These claims transitioned away from emphasizing rights against carceral punishment to focus more on what healthcare services alcoholics had a right to receive. By constructing the category of the "alcoholic" in similar ways to how racial minorities had been understood in civil rights law, reformers and policymakers aimed to codify two key ideas: 1) alcoholics possessed the right to receive quality medical care for their disease and 2) alcoholics deserved protections against discriminatory practices in the areas of hospital admission, insurance coverage, and employment.

With these two notions forming the basis of the Hughes Act, the federal government became largely responsible for forcing changes in the nation's economic and healthcare landscape for American alcoholics. Additionally, alcoholics and their allies won mass infusions of federal funding into rehabilitation at a time when such uses of the state were being castigated as ineffective. The successful passing of the Hughes Act marks a remarkable shift in the political history of alcoholism in the United States. In the span of forty years, the federal government had gone from prohibiting the sale and use of alcohol to becoming the biggest funder of treatment and the leader in combatting discrimination against alcoholic patients.

However, this chapter will argue that the benefits of the Hughes Act were unevenly distributed. In drafting this federal alcoholism legislation, lawmakers intentionally differentiated

employed and housed alcoholics from the "public drunk" who lacked ties to the mainstream society and economy. As individuals who were already fulfilling their obligations of being "tax-paying and job holding" citizens, all working alcoholics needed according to policymakers was the "chance to get well" by having access to adequate healthcare services that were covered by insurance.[327] By putting aid for alcoholics of differing socioeconomic backgrounds on separate tracks, the Hughes Act incentivized the creation of a rehabilitation infrastructure that favored private alcoholics and especially those who had the means to pay.

The Push to Federalize Alcoholism Treatment

Though Congress had passed legislation concerning alcoholism in 1968, the funding it supplied only applied to the District of Columbia. Drafts of similar bills that aimed to deal with the problem on a national scale had been around since at least 1966 but had failed to receive enough momentum or political support to pass.[328] This logjam began to give way when Harold Hughes won a seat to the Senate in 1968. Hughes, a former truck driver and army veteran, had publicly revealed that he was a recovering alcoholic while running for governor of Iowa a few years earlier.[329] In an intimate portrait published in *LOOK* magazine, Hughes did not shy away from the darker side of his bout with alcoholism that resulted in him spending time in jail, inflicting pain on his loved ones, and almost committing suicide in a hotel room miles away from his home. When his story turned into national news once he was elected governor of Iowa in

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[327] The Impact of Alcoholism," *Hearings Before the Special Subcommittee on Alcoholism and Narcotics of the Committee on Labor and Public Welfare- Senate,* 91st Cong., 1st Sess., July 1969, 119; 220.
[328] These bills, alternatively known as "Alcoholism Control Act," were sponsored by Jacob Javitts, a Republican in the Senate, and Eliot Hagan, a Democrat in the House. The Alcoholism Control Act would have created a Bureau of Alcoholism that would be run under the Surgeon General. The office would coordinate grants and divert funds to "create the public health facilities" needed to "treat [the alcoholic] medically and socially as opposed to criminally." *Congressional Record*- May, 3, 1967, 11610; "To Fight Alcoholism," *The Washington Post,* February 14, 1966, A16.
[329] Fletcher Knebel, "One Man's Triumph," *Look Magazine* 28 (October 1964): 97.

1963, he became one of the most visible faces of the disease in the political world. With widespread attention on his own substance use disorder, Hughes decided to use politics as an avenue to help others struggling with the same illness. Talking about his career towards the end of his life, he explained: "I committed myself, as a recovered alcoholic, when I crawled out of a bathtub after almost blowing my brains out, to try to find the truth of whatever the hell put me in that bathtub."[330]

Alcoholism treatment was a prominent feature of Hughes' political platform. Coming into politics during the heyday of the Great Society, Hughes worked to add alcoholics to the expanding group of individuals entitled to governmental assistance. As governor, he started a state-wide treatment program in Iowa with War on Poverty funds that aimed primarily to help indigent alcoholics. Upon entering the Senate, Hughes sought to initiate these kinds of changes nationally through the development of comprehensive federal legislation. Though public dollars for social and health services were being reduced, Hughes continued to maintain that "the state" had the biggest share of responsibility in ensuring "alcoholics be given the hope to bring them back to wholeness."[331] With this assertion, Hughes joined a growing group of voices who began to see federal policy as the main way to assist alcoholics on a national scale.

This push to federalize alcoholism treatment was buttressed by the inadequacies of programs attempted at the local and state level throughout the 1960s. In the wake of *Easter* and the anticipated outcome of *Powell,* a few states had instituted their own rehabilitative programming. Maryland, for example, passed a "comprehensive intoxication and alcoholism control" law in 1968 that tackled both decriminalization of drunkenness and broader areas of medialization. It stripped public intoxication from the criminal code and established an

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[330] "Conversation with Senator Harold Hughes," *Addiction* 92 (1997): 145.
[331] Gordon Young, "Hughes Urges Government to Face up to Alcoholism," *The Daily Iowan,* September 9, 1968.

arrangement of detoxification, outpatient, and inpatient treatment services. However, this system was not backed up by sufficient funding from either state or municipal budgets. As a report on the program noted, the bill had given "hope to alcoholics and their families but a lack of funding meant new services failed to develop fast enough to make the hope reality."[332] Similar funding obstacles bedeviled the treatment programs undertaken in Georgia, Iowa, and even D.C. with fledgling services being some of the first to be cut when it came to allocating public funds. The North American Association of Alcohol Programs (NAAAP), an organization that studied rehabilitation work, reported in 1968: "Not one state or community is adequately equipped to handle the problems [brought on by alcoholism] and not one will be able to establish the very minimal facilities and resources necessary without significant aid from the federal government."[333] For those interested in alcoholism treatment, federal leadership and sustained funding was essential to fixing this money problem. Most assumed that though this pool of money might not be permanent, it would be enough to get programs off the ground across the country. Once the demand for and necessity of these services were realized, state and localities would have to find ways to maintain their existence.

In addition to funding, individuals and groups who had long been involved in conversations around alcoholism believed that federal action was essential to gaining legitimacy

[332] Division of Alcoholism Control, "The Year of the Alcoholism Law: Annual Report for 1968," December 1968, 5, MSC0385.1.S35, Harold E. Hughes Senatorial Papers, University of Iowa Special Collections, The University of Iowa Libraries, Iowa City, IA.

[333] Advocates particularly saw special "incentive" grants from the federal government as vital to overcoming the barriers in certain states and localities where professional interest and community support in alcoholism treatment was lacking due to people seeing these services as "expensive" and believing alcoholics to be "difficult to treat" or "lacking the means to pay for their own care."

"A Bill to Amend the Public Health Service Act," *Hearings Before The Subcommittee on Public Health and Welfare- House,* 90th Cong., 2nd Sess. March 1968, 31; 190.

Anne Hebald, "District Lags in Care for Alcoholics," *The Washington Post,* November 25, 1969, C1; Letter from Sargent Shriver to Harold Hughes, February 1968, Box 1, Folder 20, Harold E. Hughes Gubernational Papers, University of Iowa Special Collections, The University of Iowa Libraries, Iowa City, IA; and Gene Stephens, "Dr. Fox to Quit Clinic- Blasts Alcoholism Lag," *The Atlanta Constitution,* December 31, 1969, 1A.

for the disease. Since the 1940s, the NCA alongside the Christopher Smithers Foundation and the NAAAP had been leading the charge in educating the public that alcoholism was a treatable disease. Individuals within these organizations were some of the most prominent voices to be featured in the political discussions around the development of alcoholism treatment law in the late 1960s and early 1970s. Founded by Marty Mann, "the first lady of AA," the NCA was a self-described "voluntary health agency" made up of recovered alcoholics of middle and upper class backgrounds who were concerned with establishing alcoholism as a sickness just like cancer or heart disease.[334] The NCA and the other groups mainly led public education campaigns that sought to destigmatize those who struggled to control their drinking and to direct them to available resources like AA. As Mann pointed out to Hughes in 1969, the state could do more to achieve these goals than any volunteer organization. She wrote: "The federal government's attack on the problem will provide the visibility and the priority which we in this field have been struggling to achieve in the minds of the public for 25 years."[335] In the view of Mann and others, federal legislation that understood alcoholism to be a public health problem would naturally lead to news coverage which could elevate the disease concept across the country.

Federal law was also seen as being capable of raising the respectability of the disease. One core part of the messaging that reformers like Mann pushed was that most alcoholics were not the "stereotypical bum" that most people associated with the disease. "Skid Row alcoholics" only made up 3% of the alcoholic population, meaning that "97% of the victims of alcoholism in the United States" were "average citizens" who were "working, living at home, with their

[334] Alton Blakeslee, "Alcoholism Knowledge Aids in Cure," *The Atlanta Constitution,* December 2, 1962, 5B. The national organization had 82 group affiliates across the country that were tasked with educating their communities that alcoholics were sick people who were capable of being treated.
[335] Letter from Mann to Hughes, July 1969, MSC0385.1.S35, Harold E. Hughes Senatorial Papers, University of Iowa Special Collections, The University of Iowa Libraries, Iowa City, IA.

families."[336] The classist differentiation between the "bum" and "the average citizen" was not ambiguous. Take the statement of Dr. Ruth Fox, the medical director of the NCA, as an example. According to Dr. Fox, it was important that the "public image" of the alcoholic had been changing from "that of a worthless, weak-willed skid row derelict to that of a worthwhile person suffering from an illness which can be successfully arrested so that he (or she) can take his rightful place in society- a good parent, good spouse, good worker, and a productive citizen."[337] This rhetoric around proving the "worthiness" of the average alcoholic was similar to how decriminalization advocates had discussed the rehabilitative potential of those found on Skid Row. Diverging from the homeless population, however, leaders in the alcoholism treatment movement argued that the majority of alcoholics were already "respectable" and "worthwhile people" when one measured these values by employment, homeownership, and family life. Once their drinking was controlled after receiving proper care, they could easily be back to fully functioning in American social and economic life in ways distinct from homeless alcoholics.

Although some of these individuals might have had access to private sanitoriums, supporters of far-reaching treatment policy argued that the "hidden alcoholic" also needed help from the state. As one man in recovery asked, "What about men like myself who still have families, homes and are employed or are employable? Where do these people go? Where do they find help?"[338] Federal recognition was seen as essential in giving alcoholics of all backgrounds the recognition required to overcome continual barriers to receiving adequate healthcare services. With Hughes' election to the Senate, the NCA and the broader alcoholism movement now had a face representing the "forgotten" alcoholic in the halls of Congress who could help further the

[336] Marty Mann, "The Challenge of Alcoholism," *Federal Probation: A Journal of Correctional Philosophy and Practice* 24, no. 1 (March 1960): 20.
[337] Ruth Fox, "Alcoholism in 1966," *American Journal of Psychiatry* 123, no. 3 (Sept 1966): 337.
[338] "Alcoholism and Narcotics- Denver Pt. 2," 351.

cause of gaining legitimacy and respectability for the disease of alcoholism. His willingness to wage a governmental attack on alcoholism was believed to be essential in expanding treatment opportunities for alcoholic citizens nationwide and giving alcoholism "the recognition that the country's No. 3 public health problem rightfully [deserved]."[339]

"Primetime for Alcoholics:" The Subcommittee on Alcoholism and Narcotics

Quickly after Hughes' arrival to Washington, the newly elected Nixon administration became highly troubled by a presumed rise in illicit drug use especially among soldiers returning home from Vietnam.[340] Nixon led a bifurcated response to this drug problem that consisted of both law enforcement and treatment measures. Unlike what we now know as the hyper-carceral "War on Drugs" that arose primarily during the Reagan presidency, the Nixon administration's drug war was less contingent on harsh sentencing and instead leaned heavily on new therapeutics like methadone to deal with addicts. Writer Michael Massing has pointed out the irony that Richard Nixon, "the apostle of law and order," made "treatment his principal weapon" in his version of the drug war.[341]

This seeming incongruity makes more sense when one fully appreciates how the racial dynamics at work in drug politics in the late 1960s and early 1970s were different than they would be just a decade later. Heroin and marijuana became political issues precisely because they were not just being used by "citizens in the ghetto areas."[342] Drugs had now "invaded" largely white spaces like college campuses and the suburbs. As historian Matthew Lassiter has

[339] The leading health problems were heart disease and cancer. "The Impact of Alcoholism," 152.
[340] For the concern over Vietnam veterans, see Jeremy Kuzmarov, *The Myth of the Addicted Army: Vietnam and the Modern War on Drugs* (Amherst: University of Massachusetts Press, 2009). Kuzmarov points out how alcohol was actually the most abused drug amongst those returning from combat.
[341] Massing, *The Fix,* 112.
[342] "Alcoholism and Narcotics- Los Angeles- Pt. 1," *Hearings Before the Special Subcommittee on Alcoholism and Narcotics of the Committee on Labor and Public Welfare- Senate,* 91st Cong., 1st Sess., September 26, 1969, 28.

examined, this image of the white drug user was a significant reason behind the drive to rehabilitate rather than incarcerate addicts. Though medicalized treatments like methadone maintenance were not absent of coercion and surveillance, they did allow for narcotics abusers to be handled outside of the criminal justice system. Additionally, the decision to aid drug addicts unlocked a large pool of federal funds within an administration committed to cutting back on government-supported health and welfare services.[343]

The new federal attention to drugs and treating those addicted to them also opened doors for those concerned with rehabilitating alcoholics. Reformers continued to fail in their endeavor to have alcohol be considered the most widely abused and dangerous drug in the United States. However, after Hughes' election to the Senate, he was able to "piggyback on the drug issue" to start debating the political handling of alcoholic citizens. With the support of the prominent senators Ted Kennedy and Ralph Yarborough, Hughes received permission to create a "Special Subcommittee on Alcoholism and Narcotics" within the Committee on Labor and Public Welfare in 1969.[344] As chairman, Hughes decided that the subcommittee should hold hearings in various cities including Los Angeles, Denver, New York City, and Des Moines to fully document the extent of drug and alcohol addiction across the country. At the first hearing held in D.C., Hughes explained what he saw as unique in their approach to the problem: "[This is] the first

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[343] Matthew D. Lassiter, "Impossible Criminals: The Suburban Imperatives of America's War on Drugs, *Journal of American History* 102, no. 1 (June 2015): 126-140.
Between 1970 and 1973, funding for drug treatment jumped from $33.5 million to $350.3 million. Drug enforcement also received an increase but a much more restrained one- from $8.5 million in 1970 to $45.7 million three years later. Mical Raz, "Treating Addiction or Reducing Crime? Methadone Maintenance and Drug Policy under the Nixon Administration," *Journal of Policy History* 29, no. 1 (2017): 73; Musto and Korsmeyer, *The Quest for Drug Control:* 97.
[344] Yarborough had been planning on starting a subcommittee to focus on the problem of narcotics addiction. Hughes successfully convinced him to add alcoholism to the equation. Other Senators on the bi-partisan committee included Jennings Randolph, Harrison Williams, Ted Kennedy, Walter Mondale, Jacob Javits, Peter Dominik, and William Saxbe. "Conversation with Senator Harold Hughes," 142; Nancy Olson, *With a Lot of Help From our Friends: The Politics of Alcoholism* (Lincoln, NE: Writers Club Press, 2003), 16-17.

congressional subcommittee exclusively devoted to the cause of helping individual citizens and society gain relief from the human blights of drug and alcohol abuse. Other committees have moved into these areas indirectly and principally from the standpoint of law enforcement, rather than health."[345] From this point on, Hughes demonstrated little patience for debate over whether substance use disorders should be considered illnesses or not.[346] Hughes took the disease-concept as being an undebatable truth and only wanted answers to questions about how alcoholics and addicts could best be served through the nation's healthcare system.

His personal experiences were effective in shutting down those who were either skeptical or ambivalent about considering alcoholism to be a treatable illness. In hearings across the country, Hughes castigated politicians for only engaging in "tokenism" when it came to alcohol abuse despite how many civilians across the country were directly impacted by the problem. His opening statement at the first subcommittee hearing reflected his sense of indignation:

> I have been deeply involved with the problems of alcoholism- from both a personal and social standpoint- for more than 25 years. If at times I sound like an angry and frustrated man, it is because I am. I see this great abundant land of ours with resources beyond compare. I see the wonderful achievements of our science and technology, the miracles of modern medicine, the explosive growth of knowledge in numberless areas…But in this vital, accessible area we have fallen flat on our faces. It is a national disgrace. The next time you see some drunk making a spectacle of himself in public, mark it down that we are the ones who should be ashamed for out gutless failure to meet this problem, not the miserable victim of the affliction… We have failed to make a small dent in the treatment, control, and prevention of a killing illness that is as widespread and as familiar as the common cold. But while we have forthrightly met other public health menaces, we are

[345] Unlike in earlier Congressional hearings that had been held to discuss the impacts of decriminalization, Hughes' subcommittee was far less focused the reduction of crime or on unburdening the criminal justice system. "The Impact of Alcoholism," 1.

[346] He did so even though *Powell* had raised major concerns about the lack of consensus around the nature or definition of alcoholism. Regarding relying on the Supreme Court to institute changes towards alcoholics, Hughes said: "I don't think we should wait on the Supreme Court to someday act to say the alcoholic is a sick person. The alcoholic is a sick person. The alcoholic user is a sick person and other drug abusers are also sick. A proper health program and proper political leadership in any community would not wait but would immediately set up rehabilitation programs, administered and conducted by properly trained and sympathetic people." "Alcoholism and Narcotics- LA," 21.

> still merely shadowboxing with one… I am just determined to plow new ground, and extremely impatient with the slow pace of our advancement.[347]

With his statement, Hughes laid out themes that would be consistent throughout the hearings. As the NCA had been saying for decades, alcoholism was a public health problem that in a modern, civilized society deserved the attention of other recognizable diseases such as cancer and heart disease. Furthermore, alcoholics were not hopeless cases. Hughes himself proved that alcoholics were capable of being rehabilitated. Finally, alcoholism was so widespread and debilitating that a substantial portion of governmental resources needed to be directed towards research and treatment for the disease. Even in a moment when "budget cutting in HEW areas [was] the order of the day," Hughes believed the time was "ripe to launch an unprecedented, all-out campaign against alcoholism on the massive, realistic scale that [it] needed."[348]

These sentiments were buttressed by the testimonies of several prominent individuals associated with advocacy groups who had long been involved in the modern alcoholism movement. Many offered very personal accounts of the fear and heartache associated with their drinking days including experiences with blackouts, hallucinations, and periods in jail or large mental institutions. Marty Mann described her bout with alcoholism as a "living hell" particularly because she had no idea what was wrong. Like others, she testified to the power of "learning the word 'alcoholism'" and discovering that "it was an illness [which] something could be done about." Bill W., the founder of Alcoholics Anonymous, spoke about the recovery

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[347] "The Impact of Alcoholism,", 3-4.
On top of his obvious emotional connection to the issue of alcoholism, Hughes had an appearance and speaking style that won him many admirers from the national media outlets covering his crusade to help alcoholics. The *New York Times* called him "big, with a barrel chest, a leonine head, and a resonant bass voice." They also remarked on his ability to "grip" audiences as an "old-fashioned orator, one of those who hushes a hall rather than rousing it to frenzy." R.W. Apple, "The Mood Changes When Senator Hughes Speaks," *The New York Times,* March 3, 1971, 20. Other press supporters included: Alan Otten, "Politics and People: Iowa's Outspoken Governor," *The Wall Street Journal,* July 19, 1968, 8; Colman McCarthy, "Getting off the Bottle and Staying Off," *The Washington Post,* December 8, 1969; and Myra Macpherson, "The Rise and Rise of Harold Hughes," *The Washington Post,* December 20, 1970, F1.

[348] "The Impact of Alcoholism," 4.

process and how often he had seen the ability of fellowship to return alcoholics to “citizenship in the world.”[349] In being open about their own experiences, these individuals hoped to personalize the disease. Additionally, by discussing their own recovery, all of their statements tried to accentuate the idea that alcoholics were worthy of public investment precisely because they were sick people who were capable of getting well once given the help to do so.

Hughes was also intentional in having recognizable people testify in the hearings to help gain visibility and support for the work of the subcommittee. The most famous spokeswoman the subcommittee heard from was the Academy Award-winning actress Mercedes McCambridge. After recalling her own struggles with drinking, she made the case for why alcoholics like herself deserved help and attention: “Nobody need die of this disease. We are eminently salvageable. We are well worth the trouble. We are eminently equipped to enrich this world. We write poetry, we paint pictures, we compose music, we build bridges, we head corporations, and often too many of us die from our disease, not our sin, not our weakness.”[350] Her declaration was the most widely circulated quote after the first hearing, appearing in a number of newspaper articles and TV stories that covered the subcommittee’s proposals to fight alcoholism.[351]

Besides McCambridge, the hearings showcased many professionals in recovery including judges, doctors, and clergymen. These individuals were deliberately chosen to illustrate that not all alcoholics were “Skid Row bums.” Instead, they were highly regarded and skilled people who just happened to be suffering from an illness characterized by a lack of control over alcohol. After the press reports on the hearings, Marty Mann wrote to Senator Hughes that this

[349] Ibid., 107-108; 142.
[350] Ibid., 83.
[351] The L.A. chapter of the NCA supposedly received over 1,200 calls (700 of them being from women) after seeing Mercedes’ testimony on broadcast news. Noel Greenwood, “A Kind of Hell: Actress Tells Senate Panel of Alcoholism,” *Los Angeles Times,* September 28, 1969, B; “Actress Withstands Alcoholism,” *The Hartford Courant,* February 17, 1979, 16A; Will Lissner, “U.S. Held Lagging in Alcohol Fight,” *New York Times,* October 4, 1969, 35; “Alcohol Still Remains the Biggest Addiction,” *The Boston Globe,* November 1, 1969, 26.

"exposure" was "the greatest breakthrough alcoholics have ever had." While alcoholics had been the focus of much political discussion in the past decade, to those who made up the middle-class recovery community, these debates over public inebriates had not been representative of most alcoholics. For individuals like Mann, these hearings marked the first time that widespread attention was being given to alcoholics like her. As she exclaimed in her letter to Hughes, "Primetime for alcoholics-- how about that?"[352]

The press coverage of these hearings on alcoholism led to multitudes of supportive responses from citizens all over the United States. Many people in and out of recovery wrote that they wanted to assist Hughes in making progress in the treatment field. One man from Missouri described himself as a veteran who had been a practicing alcoholic for 20 years. He asked if he could testify at any future hearings to show "that an alcoholic can be successfully treated and live a useful life." Another, John, wrote from San Quentin prison: "As an alcoholic I know and now accept what tragedy and heartache alcohol has caused me and my loved ones. I'd like to help you in your work."[353] Some had specific requests for how they thought Hughes and the subcommittee should be approaching the topic. One woman from Iowa, for example, lamented that she had lost her husband to alcoholism and asked that the subcommittee consider the "family aspect" of the illness in their work.[354] Others asked specific questions about employment, insurance coverage, or rehabilitation access for themselves or their family members. But the majority of letters generally expressed gratitude that alcoholism was being openly discussed by the subcommittee as a treatable disease. As a resident of Virginia described, "You have infused a great deal of hope

[352] Underline included in the original. Letter from Mann to Hughes.
[353] Letter from Gerald C. to Harold Hughes, July 25, 1969 and Letter from John to Harold Hughes, MSC0385.1, Box 136, Harold E. Hughes Senatorial Papers, University of Iowa Special Collections, The University of Iowa Libraries, Iowa City, IA.
[354] Letter from Ruth to Harold Hughes, July 1969, MSC0385.1, S135, Harold E. Hughes Senatorial Papers, University of Iowa Special Collections, The University of Iowa Libraries, Iowa City, IA.

into the souls of innumerable alcoholics, recovered and otherwise, through your public hearings and determination to come to grips constructively and sanely with the problem."[355] The large number of correspondences Hughes received illustrated how many Americans had been directly touched by alcoholism. Their positive response to the subcommittee's desire to expand alcoholism treatment also illuminated how many were eager to have something be done to expand rehabilitation resources across the country.

However, the subcommittee's emphasis on the voices of white professionals to represent "the alcoholic" did not go unnoticed by a number of alcoholics of color. Many of these individuals wrote to Hughes requesting that any new developments in rehabilitation benefit all alcoholics equally. One person identified himself as a "reformed alcoholic" who had "lost a home, a car, and at one time came close to losing [his] family" while under the influence of alcohol. In his experience, he found that "we (Negroes, Indians, and Mexican-Americans) although accepted tokenly by A.A. were not wanted."[356] He asked that Hughes utilize any federal funds to target the groups that had not been aided by mainstream resources which had been developed primarily for white, middle-class men. Another constituent asked, "Is this delivery of services a right or a privilege? I strongly endorse it as a right for every American to have the best medical care in the country. If it is a privilege, an Indian in a reservation [or] a Negro will not get the service."[357] These inquiries illustrate how many citizens pushed policymakers to see the

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[355] He went on: "I have heard enthusiasm for your proposals and aims expressed widely at some dozen or so AA meetings I have attended int the past 2 weeks. Most alcoholics, as you doubtless have learned don't know what hit them. They were just drinking along, as other people do, then something within them broke down, and they were unable to place any value in life above the desire to drink. So explaining alcoholism to a non-alcoholic, as I have found, is a very difficult task, but one eminently worth tackling." Letter from J.M. to Harold Hughes, August 7, 1969, MSC0385.1, Box 135, Harold E. Hughes Senatorial Papers, University of Iowa Special Collections, The University of Iowa Libraries, Iowa City, IA.

[356] Letter from Gerald to Harold Hughes, May 1969, MSC0385.1, S135, Harold E. Hughes Senatorial Papers, University of Iowa Special Collections, The University of Iowa Libraries, Iowa City, IA.

[357] Letter from R. to Hughes, July 1969, MSC0385.1, Box 136, Harold E. Hughes Senatorial Papers, University of Iowa Special Collections, The University of Iowa Libraries, Iowa City, IA.

diversity of backgrounds and experiences making up the alcoholic population. They expressed a fear that if the "alcoholic" was understood narrowly as white and male within federal legislation, many sick people would not be touched by the progress possible in a national attack on alcoholism. In doing so, they were making their own health rights claims around treatment equity and access. Despite these requests, the subcommittee rarely distinguished between alcoholics of different racial or gendered backgrounds when discussing treatment programs.

It was not unusual for the political framing of major healthcare reforms in this time period to vary based on the presumed class and racial make-up of groups receiving assistance from different government programs. For instance, lawmakers firmly understood Medicare as an "entitlement program." And most Americans saw these benefits "as earned" or as the government "returning to them contributions they had made" through their taxes. Alternatively, Medicaid was "stigmatized" as a welfare measure for the "categorically and medically needy." Medicare had "beneficiaries," while Medicaid participants were "recipients." This delineation went beyond mere language, with the "needy" receiving different types of aid and coverage than those automatically considered deserving of and entitled to quality healthcare.[358]

The political conversations around alcoholism treatment were no different, especially in regard to class distinctions. During the decriminalization effort with its focus on the Skid Row alcoholic, publicly-funded treatment was framed in ways similar to how help to other disadvantaged groups had been in the Great Society era: as a welfare program for the poor. Funding treatment for alcoholics who were housed and employed was packaged differently. As

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[358] Alan Cohen, David C. Colby, Keith A.Wailoo, and Julian E. Zelizer, *Medicare and Medicaid at 50: America's Entitlement Programs in the Age of Affordable Care* (Oxford: Oxford University Press, 2015), xiii, 44; Starr, *The Social Transformation*, 335-378; Beatrix Hoffman, *Health Care for Some: Rights and Rationing in the United States Since 1930* (Chicago: University of Chicago Press, 2012), 117-137.

tax-paying citizens, this group of alcoholics deserved to be recognized by their government as people worthy of a second chance. Or as one doctor explained to the subcommittee, alcoholic patients were "entitled to the same rights and opportunities for treatment accorded other sick people."[359] In theory, these rights belonged to all alcoholics no matter their socioeconomic or racial background. Practically speaking, recognizing the average alcoholic as being largely white and middle-class carried over into how the category "alcoholic" was constructed in comprehensive legislation and would impact how widespread access to treatment could be.

"Discrimination by Diagnosis:" Removing Barriers to Treatment

The rest of the hearings held by the subcommittee laid out the extent of the problem of alcoholism across the United States. An estimated 5 to 6 million or 4.5% of adult Americans were alcoholics, according to one report generated by the Department of Health, Education and Welfare (HEW). This number more than doubled when considering alcoholism to be a disease with consequences for family relatives, fellow employees, or other community members. Alcoholism also represented an "economic liability" to the country, with an estimated $4 billion a year being lost to absenteeism, lowered productivity, insurance expenses and other losses on account of alcoholic workers.[360] For policy makers and those testifying before the subcommittee, one of the explanations for the severity of alcoholism amongst the American populace was that the federal government had been deficient in responding to the issue. The state's lack of attention to the problem had effectively allowed for the American healthcare system to neglect alcoholic

[359] "The Impact of Alcoholism" 328.
[360] HEW defined an alcoholic as someone who used alcohol to such an extent that it was "interfering with their health or psychological well-being or with their ability to function effectively in their primary family, job, and community responsibilities." National Advisory Committee on Alcoholism, *Interim Report to the Secretary of the Department of Health, Education and Welfare* (Washington, D.C.: US Government Printing Office, 1969), 3.

patients. Reformers and lawmakers alike believed that the federal government had to stop "abdicating its responsibility" and launch a full-out attack on alcoholism.[361] Federal incentives were seen as necessary to instigate the development of healthcare services that could treat alcoholics throughout the country. By laying out the problem this way, politicians accepted the notion that the government had a role in ensuring that alcoholic citizens had access to rehabilitation resources.

Hughes' subcommittee and the citizens he called upon to speak before it all posited fairly simple propositions that had significant political implications. At the most basic level, Hughes believed that the federal government should be involved in "helping sick people get well."[362] However, wrapped in this basic assertion was something slightly more profound. In order to actually help the sick alcoholic in question here "get well," services and expertise that were basically nonexistent in the late 1960s had to be provided. When addressing this lack of healthcare infrastructure for alcoholic patients, advocates and government officials framed the issue through the lens of rights. Political leaders on the subcommittee recognized that alcoholics possessed the "right to get well."[363] This "right to treatment" rhetoric shaped how policy makers envisioned the state's role in approaching the alcoholism problem. Assuming responsibility in protecting the health needs and rights of the alcoholic citizenry required that the federal government ensure that alcoholics had access to adequate care for their disease. To do this successfully, alcoholism treatment had to be taken out of "the ad, hoc experimental category" and instead placed "into the mainline of essential public services."[364]

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[361] "Alcoholism and Narcotics- Denver," 354.
[362] "The Impact of Alcoholism," 4.
[363] Ibid., 119
[364] Most of the funding that had been given to alcoholism treatment had been given out on a temporary basis, with these projects serving as "demonstration programs" rather than permanent facilities.
"Hughes Cites Weakness in Alcoholism Treatment," *Press-Citizen,* September 9, 1967.

The types of health facilities reformers and policymakers considered to be "essential" for alcoholics went beyond detoxification. They considered the treatment process more comprehensively, proposing services akin to what one might currently find in a "rehab" program today. The "principle services [required] for alcoholics" included "readily available emergency care, both medical and psychiatric," inpatient treatment, a suitable network of outpatient services, and halfway houses that could "provide at least temporary shelter to those alcoholics who need a bridge between the hospital and the community."[365] Multiple medical doctors, psychiatrists and other health professionals testified before the subcommittee that all these different treatment layers were critical to many alcoholic patients' path to recovery. As Dr. Marvin Block stated in representing the viewpoint of the American Medical Association, not every alcoholic would need all of these facilities but those who did "deserved all of [them]."[366] After outlining that alcoholics both deserved and had a right to access all these treatment resources, the subcommittee's Senators interrogated the deficiencies in the medical system's handling of alcoholics up to that point. In doing so, they had to decide what existing healthcare services could be of use to alcoholic patients and what treatment areas would need to be built from the ground up.

Throughout this examination, lawmakers found that one of the major barriers preventing alcoholics from receiving adequate treatment was the discriminatory policies of general hospitals. This issue was particularly important at a time when the hospital had taken on a new significance in the delivery of medical care. Because a vast pool of federal funds had been directed towards hospital construction in the years following World War II, hospitals could be found in nearly every major community throughout the United States by the end of the 1960s. As

[365] "The Impact of Alcoholism," 298.
[366] Ibid., 334.

a result, Americans often replaced a visit to an individual physician or community clinic with a trip to the hospital. The expansion of the hospital also led to the "rise of the emergency room" where more patients began to expect to receive "around-the-clock care." As historian Beatrix Hoffman has illustrated, the emergency room became the site for new healthcare rights-claims being made by the American public in the second half of the twentieth century. Citizens started to articulate a "right to emergency care" precisely because they saw the ER as a place where a sick person "could not be turned away."[367] Up until the late 1960s, however, this "right to emergency care" competed with the continued allowance of hospitals and doctors to refuse treatment. Hospitals denied care for a number of factors including one's race, residence, insurance type, and ability to pay.

Hospital administrators and doctors also could turn patients away based on the condition with which they were presenting. It was this area that proved most burdensome and occasionally lethal for individuals suffering from alcoholism. Take the case of Carl as an example. Carl was a resident of Iowa, a former serviceman who had reached a physically critical phase of his battle against alcoholism in 1967. During that period, Carl showed up to a VA hospital in Forest Hills, Iowa vomiting blood, acting incoherent, and having convulsions. The VA hospital refused to admit him as a patient because he was intoxicated. Instead of treating him, the VA doctors advised that he "sleep it off" and come back in the morning if his symptoms grew worse. Carl died later that night.[368] Carl's story was not an unusual one. In hearings across the country, the subcommittee heard personal experiences of alcoholics who tried to get hospital care and were

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[367] Hoffman, *Health Care for Some,* 78-80.
[368] Documentation Form, April 1967, Box 1, Folder 22, Harold E. Hughes Gubernational Papers, University of Iowa Special Collections, The University of Iowa Libraries, Iowa City, IA.

instead redirected to a mental hospital ward or to a jail cell.[369] For some, this denial of treatment started even before they reached the hospital. Mercedes McCambridge told a story of how officials responded to a female acquaintance suffering from an alcohol-induced seizure. When McCambridge called for help, the police told her that the best they could do was to take her to the local precinct and if she were still sick in the morning she could be committed at the state hospital. McCambridge referred to these practices as "Elizabethan," and she queried, "Where are the hospital beds for alcoholics? Where are the detoxification centers?"[370] With these questions, she effectively articulated the idea that alcoholics were deserving of emergency hospital care. The fact that discriminatory policies had life or death consequences as seen in how many of these cases ended tragically made this need even more acute.

The reasons why hospitals refused to admit alcoholics varied. An estimated two-thirds of the nation's general hospitals rejected alcoholic patients.[371] This exclusion could happen either through official policy or informal practice. Some hospitals were blatantly discriminatory in their refusal to treat alcoholics. As the medical director of the County Hospital in Chicago openly stated, "We do not have the space to treat drunks and alcoholics."[372] Others had formal policies around refusing to admit those who were intoxicated, a condition that was hard to avoid for alcoholics in the critical phase of their disease. Discrimination also occurred on account of individual doctors. Hospital physicians tended to consider alcoholics "troublesome, disruptive,

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[369] Those with personal experiences with alcoholism were especially adamant that mental hospitals were not the proper location for alcoholic patients. On the one hand, alcoholics largely did not consider alcoholism to be a mental illness and did not want to be in a facility with the stigma of mental illness. Two, if alcoholics were considered "mentally ill," they feared being involuntarily committed to a mental hospital that could only offer "custodial care" with "no special help or attention or treatment" for the alcoholic. "The Impact of Alcoholism," 125-126.
For patients being sent from the hospital to jail or elsewhere: Hoffman, *Health Care for Some,* 86-87.
[370] Alcoholism and Narcotics- Los Angeles Pt. 1," *Hearings Before the Special Subcommittee on Alcoholism and Narcotics of the Committee on Labor and Public Welfare- Senate,* 91st Cong., 1st Sess., September 26, 1969, 125.
[371] "The Impact of Alcoholism," 111.
[372] "Court's Patient Banned; Judge Flays Hospital," *The Chicago Tribune,* March 28, 1953, B7.

and time-consuming" and therefore refused to treat them.[373] For others, their decision not to provide care was less about their stereotypes of alcoholic patients and more about feeling that they did not have the training or tools to help.[374] No matter the explanation for the exclusion, reformers viewed the refusal to treat alcoholics in the hospital setting as a violation of alcoholic citizens' right to medical care. As one HEW official stated, "We must remove the barriers of discrimination that have so long barred the alcoholic and the narcotic addict from receiving truly comprehensive care- a discrimination based on diagnosis, which is just as intolerable as discrimination based on race."[375] Equating discrimination of "diagnosis" to "race" helps illustrate how advocates were envisioning the ways in which alcoholics needed to be handled through public policy. Taking their cues from the most successful social movement of the time, supporters of alcoholism reform tackled problems around healthcare access by working to get protections against "discrimination by diagnosis" propagated by law while ignoring the racial dimension of their own advocacy work.

Policymakers favored using the general hospital to provide emergency detoxification care for alcoholic patients. Massachusetts General Hospital (MGH) served as a model lawmakers believed others could follow. With a grant from the National Institute of Mental Health, Dr. Morris Chafetz had started an alcoholism clinic within MGH in the late 1950s. Recognizing the "increased public acceptance of the general hospital as a health center of the community," Dr. Chafetz aimed to see whether the hospital setting could provide emergency medical services to

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[373] "Alcoholism United Haled," *The Des Moines Tribune,* February 14, 1968.
[374] One of the main questions that Senators asked doctors and other health professionals testifying before subcommittee was whether or not alcoholism had been included in their medical school curriculum. Training doctors, psychiatrists, social workers, teachers, and others to be able to handle alcoholics became a primary goal of reformers and policy makers in this time period. "The Impact of Alcoholism," 157.
The Hospital Care of the Alcoholic Conference Notes, April 1970, MSC0385.1, Box 138, Harold E. Hughes Senatorial Papers, University of Iowa Special Collections, The University of Iowa Libraries, Iowa City, IA.
[375] "A Bill to Amend," 43.

alcoholic patients and serve as an entry point to get them on the road to long-term recovery. Since most alcoholics were visiting the hospital because they had reached a "crisis" point in their disease, Chafetz believed that "the motivation for treatment" was at its peak.[376] After detoxing the patient, hospital physicians were asked to encourage these individuals to visit the hospital's alcoholism clinic where they could receive ongoing inpatient and outpatient therapy as well as social services. While rehabilitation needed to continue outside of the hospital through other community agencies, MGH's structure showed that a number of treatment services could be concentrated in the hospital environment. MGH's self-reported success with their program was consistently highlighted in the subcommittee's hearings. According to Chafetz, "the excellence of the comprehensive care given to alcoholics by the general hospital [challenged] the idea that alcoholics [needed] specialized detoxification centers and treatment units."[377] The fact that leaning on the hospital to provide both emergency and comprehensive care could cut down on the price tag of alcoholism treatment made it particularly appealing to lawmakers.

This focus on the hospital naturally led into another area in which alcoholics faced discrimination that impacted their ability to receive help: insurance coverage. Hospital administrators and doctors frequently refused to treat alcoholic patients because of their stereotype that these persons could not pay for healthcare. While this was partly grounded in the idea that most alcoholics were of a lower socioeconomic status, it also was tied to the understanding that alcoholics were not covered by most insurance providers. An official from the

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[376] Morris E. Chafetz, Howard T. Blane, and Marjorie Hill, *Frontiers of Alcoholism* (New York: Science House, 1970), 37, 42.
This too required that doctors be correct and open in their diagnosis of alcoholism, something which they tended to not do if the patient was not the "Skid Row stereotype." As a MGH study found, diagnosis of alcoholism was far more likely if the patient was "poorly clothed, unshaven, separated from family and unemployed." Public Health Service, *Alcohol and Alcoholism* (Chevy Chase, MD: NIMH, 1967), 30.
[377] "Comprehensive Alcohol Abuse and Alcoholism Legislation," *Hearings Before the Special Subcommittee on Alcoholism and Narcotics of the Committee on Labor and Public Welfare- Senate,* 91st Cong., 2nd Sess., September 1970, 247; 346.

American Hospital Association testified to the subcommittee: "It is obvious that insurance companies and Blue Cross have discriminated against the alcoholic patient. He has either been completely left out of coverage or if he is covered, he is covered as a psychiatric patient and therefore has limited coverage."[378] According to the AHA, this problem was one of the reasons that hospitals remained leery to accept alcoholic patients and provide them with potentially life-saving care. By the end of the 1960s, there had been some piecemeal efforts to change how health insurance policies handled alcoholism. One national study found that treatment was usually covered by state disability insurance programs and some from Blue Cross and Blue Shield. However, there was a "wide variation in the protection" provided by such plans with the majority only covering care for the "acute phase" of alcoholism (detox) as opposed to "long-term treatment."[379] Reformers turned to the federal government to provide guidance that insurance companies could follow regarding alcoholism coverage in order to ensure that payment was not a problem for those seeking treatment.[380]

Additionally, supporters of alcoholism reform viewed discriminatory policies by insurance providers as a major obstacle in their effort to equate alcoholism to other diseases like cancer or TB. Because insurance companies often did not cover alcoholism, individuals tended to not be honest on their forms about why they were in the hospital. Doctors too would not label "alcoholism" as the primary diagnosis on medical records- instead writing "gastroenteritis or ulcers or something of this nature" on documents that would be submitted to insurance companies.[381] Advocates claimed that discriminatory insurance policies and the intentional

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[378] "The Impact of Alcoholism," 157.
[379] PHS, *Alcohol and Alcoholism,* 58.
[380] Cost estimates for treatment programs varied based on the city and hospital. One doctor testifying before the subcommittee stated that he had been able to set up 10 treatment programs in VA hospitals for $300,000. Others contended that setting up rehabilitation programs for the state of California alone would cost upwards of $2 billion. "The Impact of Alcoholism," 180; 336.
[381] "Alcoholism and Narcotics- LA," 261.

mislabeling that resulted was allowing for continued stigma to be placed on alcoholics. With the help of doctors, alcoholics were being encouraged to be dishonest about their disease which could discourage them from continuing to seek treatment outside of the hospital setting. Thus, supporters called on policymakers to utilize federal legislation to "develop national guidelines" regarding the insurance coverage for alcoholics precisely because this step was necessary in "providing recognition for and legitimizing the problems of alcoholism."[382] Coverage for alcoholism treatment was obviously necessary for many to be able to afford healthcare services, but it also was articulated as being vital in destigmatizing and gaining respectability for the disease of alcoholism and those suffering from it.

For the insurance companies that were open in their reasons for why they discriminated against alcoholics, they explained it by claiming that alcoholism was a self-inflicted problem which insurance suppliers should not be responsible for covering. Many private providers had blatant clauses stating that hospital stays were covered except in the cases of "rest, convalescence, drug addiction, or alcoholism." When an insurance agent from one company was asked why, he responded: "I would like to point out the purpose of insurance is to provide coverage for the policyholder's misfortunes and not his deeds."[383] With this statement, the agent illustrated the remaining prevalence of the view that alcoholics were dealing with the consequences of their own actions. In the arenas of healthcare and insurance coverage, this belief had significant ramifications for alcoholics. Where insurance companies fell on the debate over whether alcoholism was a treatable disease determined whether or not alcoholics had access to help that they could actually afford.

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[382] National Advisory Committee, *Interim Report,* 13.
[383] "Alcoholism and Narcotics- Denver," 356; "Comprehensive Alcohol Abuse and Alcoholism Legislation," 437.

By the late 1960s, alcoholic citizens and their families were fighting back against the notion that their excessive drinking was due to a lack of willpower or personal responsibility. Instead, they claimed that they had a right to proper treatment for a disease that manifested itself as a loss of control over alcohol consumption. This "right to treatment" required adequate medical facilities that could provide alcoholics with health services with care that was affordable and therefore adequately covered by health insurance plans. Mrs. E.R. Crawford's correspondence with Senator Hughes reflects this rights-consciousness around alcoholism treatment and coverage. Her husband had spent 10 days in a rehabilitation center in Des Moines, Iowa, where he received treatment for his "alcoholism disease" that was "very beneficial to him." However, his Blue Cross and Blue Shield plan refused to cover his stay because the rehabilitation center was not considered a "hospital." Mrs. Crawford called out the pointlessness of having an effective treatment program be out of reach of alcoholics in need of help because limited insurance policies made the services unaffordable. She asked, "I know that there are other hospitalization plans which cover treatment for alcoholism and I wonder how Blue Cross-Blue Shield can be an exception?"[384] In doing so, she articulated her belief that alcoholics like her husband deserved treatment for their disease that was adequately covered by all insurance companies.

One other major area that concerned alcoholic constituents was the problem of discrimination in employment. Many individuals from a variety of different employment sectors wrote to Senator Hughes explaining how their experience with alcoholism had resulted in a job loss. For example, Willie Lee, a postal worker from Los Angles, had been fired from his job of 9

[384] Letter from Mrs. Crawford to Senator Hughes w/ Letter from Blue Cross-Blue Shield to Mr. Crawford, July 1969, MSC0385.1, Box 136, Harold E. Hughes Senatorial Papers, University of Iowa Special Collections, The University of Iowa Libraries, Iowa City, IA.

years on account of his alcoholism. He asked Hughes if he could help appeal the decision by convincing his employer that "alcoholism is a disease the same as any other."[385] With his inquiry, Lee demonstrated how alcoholic workers like himself believed that their drinking problem was not a fair basis for termination. Others were even more adamant in articulating the idea that alcoholics should not be prohibited from holding employment just because of their diagnosis. Ed Dentz, a shoe-salesmen, asked how an alcoholic job-seeker should approach a prospective employer. He feared that being honest about his alcoholism being the "reason for the gap in his career" would raise questions about his "dependability" and therefore keep him out of a job. Like others, he framed this impediment to employment through the language of rights. "In this enlightened age of civil rights and equal employment opportunity," Dentz stated, "the recovered alcoholic is still discriminated against. In reality, the recovered alcoholic, like many other handicapped persons, makes a better employee… He has a burning desire to make good. He is grateful just to be alive, sober, and working."[386] Dentz thus equated employment barriers on the basis of alcoholism to other civil rights issues and expressed his conviction that alcoholics deserved a second chance to prove themselves in the workplace. Similar to the discriminatory practices of hospitals, the subcommittee responded to these complaints regarding employment barriers by gauging the extent of the issue. By the end of the hearings, employment protections became a key component of the reform law with the subcommittee generally agreeing that alcoholics merited job protections as they sought treatment for their drinking.

According to a NCA study, an estimated 5.8% of the American industrial workforce could be classified as alcoholics. This "hidden man" in industry and business was causing

[385] Letter from Willie Lee to Harold Hughes, January 6, 1970, MSC0385.1, Box 138, Harold E. Hughes Senatorial Papers, University of Iowa Special Collections, The University of Iowa Libraries, Iowa City, IA.
[386] Letter from Ed Dentz to Harold Hughes, January 14, 1970, MSC038.1, Box 137, Harold E. Hughes Senatorial Papers, University of Iowa Special Collections, The University of Iowa Libraries, Iowa City, IA.

significant economic damage on account of his absenteeism (estimated to average about 20 days a year), chronic lateness, and lowered productivity.[387] Historically, most companies took an approach to the alcoholic worker that had "been largely punitive with little or no effort directed toward treatment and rehabilitation." In many industries, employers usually were "reluctant to deal with the problem drinker until the problem became so overt that corrective action [had to] be taken."[388] With the rising acceptance of the disease concept, certain industries attempted to change their methodology for dealing with employees suffering from alcoholism throughout the 1960s by instituting programs that offered workers therapy before definitive termination. Most companies like Eastman Kodak, Minnesota Mining, Pacific Telephone and others advertised this shift as being an economic rather than a humanitarian decision.[389] Firing or ignoring the problem drinker was now seen as being the "most expensive way" to deal with the alcoholic employee, as it costed more to hire and train a new worker than it did to "rehabilitate" someone already situated to the job. According to employers, this system was mutually beneficial. Kenneth Rouse, the director of the rehabilitation program at Kemper Insurance, explained the reason for the new approach this way: "For the employer, the desire is to retain a valued employee and to reduce excessive costs. For the employee, the goal is to keep his job and to arrest a serious illness which will get progressively worse unless she gets qualified help."[390]

Industrial rehabilitation plans were designed from the basis that alcoholism was a disease that could be treated through appropriate medical help. Because of this, these programs were

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[387] "The Impact of Alcoholism," 220; Barbara Milz, "Aid Urged for Hidden Alcoholics," *The Atlanta Constitution,* March 19, 1963, 7.
[388] "The Impact of Alcoholism," 223.
[389] Others included Algan Aluminum, IBM, Hughes Aircraft, Kaiser Steel, the U.S. Navy, local branches of the U.S. Post Office, and General Motors. Summary of Industrial Services, October 1969, MSC0385.1, Box 136, Harold E. Hughes Senatorial Papers, University of Iowa Special Collections, The University of Iowa Libraries, Iowa City, IA.
[390] Jean Dietz, "Don't Fire Alcoholics, Firms Told," *The Boston Globe,* May 24, 1967, 25; Ronald J. Ostrow, "Industry's $2 Billion Hangover, *The Washington Post,* May 22, 1966, N3; "Industry Stepping Up Attack on Alcoholism," *The Los Angeles Times,* December 13, 1965.

primarily instigated by companies that had internal medical departments. Most of these programs operated similarly to that of Pacific Telephone. Their handbook stated: "Alcoholism is recognized as a serious illness [and] the company stands ready to assist anyone suffering from it as quickly as the need can be recognized and diagnosed."[391] According to the company, it was management's job to detect the problem. Clues to be on the lookout for included "red eyes, hand tremors, loss of weight, moodiness, resentment, absenteeism, and careless work."[392] Once management recognized these signs, they sent the employee to the company's medical doctor. If the physician agreed that the worker had alcoholism, that person was walked through steps on how to get help. They were normally encouraged to join AA and to spend at least a week at a rehabilitation clinic. The recovery process would then be monitored by the company doctor who could clear the employee to return to work.

Though these steps were instituted to replace the traditional penal approach of outright firing, the rehabilitative system was not without coercive elements. Directors of these industrial programs relied on the threat of job loss to force alcoholic employees into treatment in a process called "constructive confrontation." Company leaders believed that an alcoholic's job was often "the last great bulwark of his defense against admitting his illness." Threatening termination was seen as a useful tool to "produce the inward crisis that is required" for the alcoholic "to submit to treatment."[393] Thus, employees who were diagnosed with alcoholism were often faced with the options to either agree to get help or to be fired. Some companies like Pacific Telephone even made open admittance to their drinking problem a prerequisite to rehabilitation. Only the

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[391] Harry Nelson, "Pilot Alcoholic Programs Show Positive results," *The Los Angeles Times,* November 29, 1965, A1; *Congressional Record*- January 1966, 797.
[392] Harrison Trice and William Sonnenstuhl, *Strategies for Employee Assistance Programs: The Crucial Balance* (Ithaca: ILR Press, 1986), 2; Arelo Sederberg, "Alcoholism is Costing Industry 2 Billion a Year- and Key Men," *The Los Angeles Times,* December 18, 1964, B13.
[393] Herrymon Maurer, "The Beginning of Wisdom About Alcoholism," *Fortune* 67, no. 5 (May 1969): 211.

alcoholic employee who "[accepted] the fact of loss of control of drinking" was "entitled to all his benefits while cooperating toward rehabilitation."[394] When faced with these choices, many workers opted to at least attempt treatment. Coverage of these efforts rarely questioned the threat of termination undergirding these programs. As one *New York Times* headline reported in 1970, "fewer alcoholics are losing their jobs nowadays" because "businessmen are becoming more compassionate toward their employees who have drinking problems."[395] Despite the coercive elements, these employer-instituted rehabilitation programs were written about by the press and discussed by the subcommittee as a positive development in alcoholism treatment as it kept alcoholics employed and productive.

The companies that instituted rehabilitation programs reported an average 30-40% success rate with individuals who agreed to get help. Programs were most successful when they had been developed through a management-union partnership.[396] During one of the subcommittee hearings, an official from the AFL-CIO testified that union officials had been slow in focusing on alcoholism as a "union problem" in part because of the view that problem drinking was a "matter for personal action and individual responsibility." Union representatives also tended to try to protect members by concealing the problem or by covering up possible "work failures" that happened on account of alcoholism.[397] However, by the late 1960s, more unions were recognizing "their obligation to the alcoholic as a sick worker" and began getting involved in ensuring that alcoholic employees were given the treatment they needed to stay on the job.[398] Unions covering individuals ranging from electrical to steel to auto workers negotiated

[394] *Congressional Record,* 797.
[395] "Fewer Alcoholics Lose Jobs Nowadays," *New York Times,* March 6, 1970, 55.
[396] Trice and Sonnenstuhl, *Strategies for Employee Assistance Programs,* 1; Harrison Trice and James A. Belasco, *"The Alcoholic and His Steward: A Union Problem," Journal of Occupational Medicine* 8, no. 9 (September 1966): 481-487.
[397] Herbert Black, "Alcoholism Thrown Out in Unusual Triple Play," *The Boston Globe,* June 23, 1967, A7.
[398] "Comprehensive Alcohol Abuse and Alcoholism Legislation," 153.

within their contracts clauses that specified how alcoholism should be handled by company management. The United Steelworkers of America serves as an example. Beginning in 1968, the union negotiated a clause under the banner of safety and health which stated that both the union and the company would "cooperate at the plant level" to "encourage employees afflicted with alcoholism" to undergo a coordinated rehabilitation program.[399] These policies focused on ensuring that alcoholism was officially handled as any other illness. In particular, union leaders sought to ensure that alcoholic workers who agreed to enter into a rehabilitation program would be entitled to paid sick leave while spending time at a hospital or treatment facility as a worker with another debilitating disease would be given.

Studies found that alcoholic employees were far more open to accepting treatment if they were entering into a program backed by the union. Workers read purely "management-run" programs as "witch hunts" rather than true offers of help. According to a representative of the United Steelworkers, unions also offered something in the industrial attack on alcoholism that could not be found elsewhere. The sick alcoholic "actively requires companionship, understanding, and love of his fellowman" perhaps more than those suffering from another kind of illness. "And it is this recognition by our union," the representative stated, "and the tradition of fraternity which is involved in the trade union perspective which provide a basis for a unique strength in this area: the knowledge of those affected by this disease that they are not alone."[400] In a particularly vulnerable time, when someone was being faced with either job loss or forced treatment, union representatives aimed to support individuals through the process. Perhaps this

[399] "Narcotics and Alcoholism, Pittsburgh Pt. 1- 1971," *Hearings Before the Special Subcommittee on Alcoholism and Narcotics of the Committee on Labor and Public Welfare- Senate,* 92nd Cong., 1st Sess., 309.
[400] Ibid., 311.

was why these programs boasted of successful recovery rates of 60-80%, a number which was significantly higher than those found in treatment proposals undertaken without union support.[401]

The demographics of who was being served by these therapeutic initiatives within various industries is not entirely clear. Most companies highlighted the fact that alcoholism did not acknowledge status barriers and that executives were just as likely to need these services as laborers working with their hands. But the reports on the programs that lawmakers were looking at did not break down the demographics of employees served by job title, race, or gender.[402] What is clear is that the leaders behind these industrial rehabilitation programs were intentional in differentiating the working alcoholic from those who were impoverished or houseless. In fact, this distinction was key to their marketing strategy. Employers could "identify and treat a victim of alcoholism," effectively intervening "years before he has become skid row material."[403] Keeping the "respectable" alcoholic off the street by helping him get sober and remain employed was seen as a key reason to invest in these kinds of programs.

Throughout the drafting of comprehensive alcoholism reform legislation, senators on the subcommittee used these employment-based rehabilitation programs as a model that the federal government itself could follow as an employer. Like other businesses, the subcommittee directed the Civil Service Commission to consider providing federal employees suffering from alcoholism rehabilitation before termination. This required that federal agencies create prevention and treatment programs in which employers had to "identify and offer rehabilitative

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[401] Constance Holden, "Alcoholism: On-the-Job Referrals Mean Early Detection," *Science* 179, no. 4071 (Jan 1973): 364-365.
[402] In the early 1980s, one article concerning black alcoholics remarked that these "Employee Assistance Programs" appeared to primarily be benefitting white workers. "As with community-based counseling programs" the article stated, "black clients referred by EAPs seem to be underrepresented." The article suggested that more efforts needed to be made to develop strategies that were "culturally relevant" and took into account how "racial problems" impacted "the black psyche and job performance." Millree Williams, "Blacks and Alcoholism: Issues in the 1980s," *Alcohol and Research World* 6, no. 4 (Summer 1982): 35.
[403] Holden, "Alcoholism," 363.

guidance to employees whose drinking habits [resulted] in job difficulties, including poor attendance and conduct." Furthermore, employees were to be granted paid sick leave if they agreed to participate in "approved" therapeutic programs. Policy makers hoped that having the federal government, "one of the Nation's largest employers," in the business of rehabilitating its employees would inspire other industries to follow its example and therefore reach alcoholic workers countrywide.[404]

By the end of the subcommittee's deliberations, these three areas of hospital admission, insurance coverage, and employment protections became the primary points of concern to be addressed by alcoholism reform legislation. Combatting "discrimination by diagnosis" in these sectors formed what would be considered the alcoholic "Bill of Rights." Unlike in earlier conversations dealing with constitutional rights against undue punishment, these debates largely covered what kinds of services and benefits alcoholics had a *right to* in addition to what they deserved *protections from.* If alcoholics possessed the "right to get well," then alcoholism had to be formally handled as a health problem rather than a moral or criminal issue. But this meant that major transformations needed to be instituted in the arenas of healthcare, insurance, and industry. Alcoholics had the right to be treated in general hospitals, to have this medical care be affordable, and to not fear losing their employment benefits for being open about their illness. These kinds of rights-claims were articulated by individuals testifying before the subcommittee as well as citizens writing in response to the senators' work. In lending support to these claims through policy, policymakers made the federal government the leading body in charge of protecting these rights by tackling continual forms of discrimination and other barriers to treatment that alcoholic citizens across the country faced.

[404] "Comprehensive Alcohol Abuse and Alcoholism Legislation," 22; "The Impact of Alcoholism," 224; 247.

The Passage of the Hughes Act

As the hearings culminated in the middle of 1970, policymakers on the subcommittee set about drafting legislation that aimed to touch on all the primary concerns brought up by alcoholics and those involved in the alcoholism field. The final bill, entitled the "Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act" but more commonly known as the Hughes Act, established a comprehensive program instituted by the federal government to deal with alcoholism as a national public health problem. At its heart, legislators sought to use the law to put the full weight of the state behind the disease concept. In defining the purposes of the law, the subcommittee wrote: "Alcoholism is an illness or disease that requires treatment through health rehabilitation services… A major commitment of health and social resources and Government funds is required to institute an adequate and effective Federal program for the prevention and treatment of alcohol abuse and alcoholism."[405] Legislators on the subcommittee aimed to use the federal government to institutionalize the core idea that reformers involved in the alcoholism movement had been working towards for decades, that tax-paying and job-holding alcoholics were sick individuals deserving and worthy of help.

The Hughes Act also dealt directly with discrimination against alcoholics in the three main areas of hospital care, insurance coverage, and employment. In terms of health insurance, the law only impacted federal employees but legislators hoped it could serve as a model for all providers. It stated: "All health and disability insurance policies and plans for Federal civilian employees hereafter contracted or renegotiated shall cover alcoholism in the same way as the problems, illnesses, and diseases that are not self-inflicted."[406] This emphasis on self-infliction was important, as the law supported the idea that alcoholism should be officially handled as a

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[405] "Comprehensive Alcohol Abuse and Alcoholism Legislation," 2-3.
[406] Ibid., 22; 26-27.

sickness rather than a problem of individual choices and behavior. The law was more aggressive in the realm of hospital discrimination, declaring that all private and public hospitals that used federal assistance had to "admit and treat" alcoholics and could not discriminate against patients "solely because of their alcoholism."[407] Hospitals were now subject to a loss of governmental funding if they continued to refuse to treat alcoholism patients.

With its provision regarding civil servants, the law also outlined necessary protections for alcoholic workers and officially stipulated that federal employees could not be terminated or denied benefits because of their alcoholism unless they turned down rehabilitation. The Hughes Act included specific policy that the Civil Service Commission now had to follow: "Federal civilian employees who are alcohol abusers or who are alcoholics shall retain the same employment and other benefits as other persons afflicted with health problems and illnesses, and shall not lose, solely because they are alcoholics, pension, retirement, medical or other rights." In an effort to destigmatize alcoholism, federal officials sought to encourage employees to willingly identify themselves as alcoholics and seek necessary treatment by formally articulating that their employment benefits would not be at risk as a result of them doing so. Furthermore, the law stated that "no person may be denied or deprived of civilian employment or a federal profession or other license or right solely on the ground of prior alcohol abuse or alcoholism."[408] If all employers followed the government, lawmakers hoped alcoholism could no longer be considered a cause for automatic firing or a reason to not hire a qualified job candidate. Additionally, employers had to respect the rights of alcoholic employees to maintain their benefits while seeking treatment just as they would for individuals dealing with other illnesses.

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[407] *An Act to Provide a Comprehensive Federal Program for the Prevention and Treatment of Alcohol Abuse and Alcoholism,* Public Law 91-616, *U.S. Statues at Large* 84 (1970): 1852.
[408] Ibid., 1849.

These clauses regarding the rights and protections to which alcoholic citizens were entitled were coupled with provisions concerning how federal funds would be directed towards alcoholism treatment and research across the country. For policymakers like Harold Hughes, a massive infusion of public funds was required for the federal government to be effective in aiding alcoholics on a national scale. Insisting on expanding the social safety net as it related to alcoholic citizens set up a relationship between Senator Hughes, the subcommittee, and the Nixon administration that was "lukewarm" at best. Nixon's staff consistently pushed back against the amount of funding for which the subcommittee was requesting.[409]

Leading medical professional organizations including the American Medical Association, the American Psychological Association, and the American Hospital Association signed on in support of the Hughes Act. The subcommittee was also aided by the advocacy power of influential members involved in alcoholism movement, including wealthy men in recovery like R. Brinkley Smithers. When it became clear in the last two weeks of 1970 that Nixon intended to give the Hughes Act a pocket veto because of the price tag attached to it, Smithers recruited associates he knew could sway the president.[410] After this behind-the-scenes negotiating, Nixon signed the bill into law on December 31, 1970. Heralded by those involved in the movement as an "Emancipation Proclamation" for alcoholics, reformers viewed this comprehensive alcoholism legislation as being capable of transforming the lives of alcoholics across the country by giving visibility to the problem from a public health perspective and by breaking down barriers to treatment.[411]

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[409] Grischa Metlay, "Federalizing Medical Campaigns against Alcoholism and Drug abuse," *The Milbank Quarterly* 91, no. 1 (2013): 137.
[410] The subcommittee requested $70 million for the year 1971. R. Brinkley Smithers, "Making It Happen: Advocacy for the Hughes Act," *Alcohol Health and Research World* 12, no. 4 (January 1988): 272.
[411] "Alcoholics Finally Get Help," *Los Angeles Times,* January 18, 1971; Jack Spalding, "A break At Last for Our Drunks, *The Atlanta Constitution, February* 27, 1970, "Senate Votes Funds for Alcoholism Unit," *The Washington Post,* August 11, 1970, A2.

With the passing of the law, Senator Hughes hoped to make governmental investment in alcoholism research and treatment a permanent fixture of the state. One way that the Hughes Act did this was through project grants and contracts. Individual states, localities, and agencies could apply for federal monies for "the prevention and treatment of alcohol abuse and alcoholism." These grants favored projects that provided "a comprehensive range of services" which aided alcoholics through all phases of recovery by including facilities like detoxification centers and halfway houses.[412] Though the amount authorized for these grants changed every year, almost 400 million dollars were distributed across the country between the years 1971 and 1973. Leaders in the alcoholism movement from various states celebrated this milestone in alcoholism treatment. As Charles Methvin who headed Georgia's community alcoholism units remarked, "the Hughes Act appropriations represents the first time the federal government has provided massive aid to the states for aiding in the treatment of alcoholics."[413] States across the country set out to use this new source of money to create comprehensive programs that included detoxification facilities, expanded alcoholism wards in general hospitals, halfway houses, and rehabilitation centers.

Another significant feature of the Hughes Act was the establishment of a federal body specifically devoted to the research, treatment, and prevention of alcoholism. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) operated under the banner of the National Institute of Mental Health but had its own director, staff, and budget. Hughes and his allies fought hard for a distinct governmental office like the NIAAA, believing that "nothing less"

[412] Public Law 91-616, 1851-1852.
[413] Dewitt Rogers, "Alcoholics Care Clinics Get Aid," *The Atlanta Constitution,* August 10, 1972, 8E; 18A ; Ronald Kotulak, "Alcoholism: No. 1 Drug Problem in the U.S.," *Chicago Tribune,* October 1, 1972, 2; William Stephens, "Must an Alcoholic Stay Dry Forever?" *Los Angeles Times,* December 30, 1973, D5; Louis Cassels, "U.S. Attacks Another Disease: Alcoholism," *New Journal and Guide,* January 23, 1971.

would "provide the visibility and the priority" needed to adequately tackle alcoholism on a national scale.[414] The NIAAA functioned (and continues to do so) as a kind of hub for gathering knowledge about alcoholism, producing materials that covered the latest and most effective methods of treatment and rehabilitation. Congress and the President received annual reports from the NIAAA as well, ensuring that the major branches of the federal government remained both aware and responsible for updating their alcoholism treatment programming.[415] Between the project grants and the NIAAA, Harold Hughes achieved his goal of using federal legislation to get alcoholism treatment into "the main line of essential public services."[416] Alcoholism research and treatment were now "essential" functions and obligations of the federal government.

After the Hughes Act was passed in 1970, there a widespread sense of optimism emanating from press coverage to constituent letters about what this portended for alcoholics. The law represented the first time that the federal government was devoting enough resources to fully meet the scope of the problem. One newspaper article declared, "at long last" the federal government was "mounting a serious attack on a disease that costs more lives each year than the Vietnam war."[417] While journalists covering the act were particularly excited about the price tag associated with the reform bill, citizens writing to express their support did so from a more emotional place. Union members, representatives of Native American tribes, business executives, veterans, and others from South Dakota to Puerto Rico to California expressed their excitement about legislation designed to "combat the living heck out of alcoholism."[418] On the

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[414] Letter from Marty Mann to Senators Jacob Javits and Harold Hughes, August 1969, MSC0385.1, Box 136, Harold E. Hughes Senatorial Papers, University of Iowa Special Collections, The University of Iowa Libraries, Iowa City, IA.
[415] Public Law 91-616, 1848.
[416] "Hughes Cites Weakness in Alcoholism Treatment," *Press-Citizen,* September 9, 1967.
[417] Louis Cassels, "U.S. Attacks Another Disease: Alcoholism," *Atlanta Daily World,* January 26, 1971, 6.
[418] Letter from Charles B. to Harold Hughes, December 1970, MSC0385.1, Box 141, Harold E. Hughes Senatorial Papers, University of Iowa Special Collections, The University of Iowa Libraries, Iowa City, IA.

one hand, alcoholics were optimistic about what the bill meant in terms of broadening access to treatment. But they were also hopeful for how federal policy could change public understandings towards alcoholics on a broad scale. Take Donald, a resident of Wisconsin, as an example. He wrote to Hughes: "For those of us who have suffered the agonizing tortures of this illness, we feel this means a complete reversal of attitude and apathy."[419]

By emphasizing the rights of alcoholics to receive appropriate medical treatment for their disease as well as the need for governmental protections against "discrimination by diagnosis," the law opened doors for alcoholics and their loved ones to be able to make certain claims on insurance providers, hospitals, and employers. In doing so, the law represented a major achievement for reformers who had been working towards these goals for decades. Alcoholics of a certain socioeconomic status were now receiving broad national attention from a public health standpoint. Additionally, the federal government was finally assuming responsibility for the care and treatment of its alcoholic citizenry. In essence, the legislation institutionalized the core idea of the NCA that alcoholism was "a public health problem and therefore a public responsibility." Letters from Americans across the country proved the importance of this transformation, offering personal accounts of how validating it was to hear officials at the highest level of government speaking about alcoholism through the lens of rehabilitation.

With the creation of the NIAAA, reformers also succeeded in raising the visibility of the problems facing the "hidden" alcoholic. In the first few years of the institute, the research and literature disseminated largely focused on the non-public alcoholic or those who were still employed and housed. The initial reports to Congress focused primarily on "problem drinkers on the job," "alcoholism and health insurance," and the relationship between alcohol use and other

[419] Letter from Donald G. to Harold Hughes, January 1971, MSC0385.1, Box 141, Harold E. Hughes Senatorial Papers, University of Iowa Special Collections, The University of Iowa Libraries, Iowa City, IA.

health issues.[420] Similarly, the institute waged public education campaigns in the early 1970s that centered around overturning the "traditional stereotype of the alcoholic person as a perverted, weak-willed delinquent."[421] They did so by aiming to dispel certain "myths" that dominated public understandings of alcoholics. Their first campaign mirrored earlier efforts to gain as much attention for alcoholism as was being devoted to narcotics addiction. The institute printed posters and pamphlets declaring "Alcohol is a Drug" and proclaiming that there were millions of "Alcohol Addicts in America." In these early years of the NIAAA, research and knowledge production considered the category "alcoholic" in a universalized way with little attention being paid to differences amongst people of varying genders or races.[422] However, the creation of the institute and its mandate for annual reports opened the door for further research into the needs of alcoholic citizens from a variety of backgrounds in the mid to late 1970s. As the next chapter will show, the fight against alcoholism would eventually extend into many areas seeking to aid other "invisible" alcoholics including women, Black, and Native alcoholics.

On a practical level, the policy's focus on the working and private alcoholic rather than the indigent as well as the attention to hospital care and insurance coverage significantly influenced the trajectory of alcoholism treatment broadly. The rhetoric around differentiating the working alcoholic from the one found on Skid Row was in part a response to how much political focus this population had received in the previous years. Those involved in the alcoholism movement sought to position the alcoholic employee as just as deserving of public attention and

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[420] U.S. Department of Health, Education and Welfare: National Institute on Alcohol Abuse and Alcoholism, *Second Special Report to the U.S. Congress on Alcohol and Health* (Washington D.C.: U.S. Government Printing Office, 1974).
[421] Gerald Globetti, "Attitudes Toward Recovered Alcoholic People," *Alcohol Health and Research World* 1 (Winter 1973/74): 18.
[422] Janet Golden, *Message in a Bottle: The Making of Fetal Alcohol Syndrome* (Cambridge: Harvard University Press, 2005), 49.

resources, if not more so. Though federal concern about alcoholism had started with a focus on the public and indigent alcoholic, it had now pivoted quite starkly to those who were not.

Yet, the employment-based rehabilitation programs and the federal discussion about them would have ramifications for alcoholics of all socioeconomic backgrounds. Employment programs' use of "constructive coercion" eventually infiltrated other public and private systems of treatment. As alcoholism researchers in the 1980s noted, "coercion" became key to how rehabilitation providers gained clients and could be seen in areas like court-ordered treatment for public inebriates and drunk drivers as well as in familial interventions.[423]

Additionally, the political focus on aiding alcoholics who could pay for treatment once these services were made available and were covered by insurance policies influenced how the arena of treatment developed throughout the 1970s. Ten years after the passing of the Hughes Act, a massive infusion of federal funds had led to an explosion of "counsellors, scientists, think-tank personnel, administrators, government funding agencies, lobbyists, associations, consultants, evaluators and technical assistants" getting involved in alcoholism rehabilitation and research.[424] But these services were not universally accessible or affordable. At the same time that rehabilitation programs targeting homeless alcoholics were being consistently underfunded and under constant attack for being ineffective, treatment services for alcoholics of higher socioeconomic statuses were flourishing. By the 1980s, a rehabilitation industry funded in part

[423] Constance Weisner and Robin Room, "Financing and Ideology in Alcohol Treatment," *Social Problems* 32, no. 2 (December 1984): 177.
[424] The rise of this "treatment industry" even disturbed Senator Hughes who remarked: "We have, in effect, a new civilian army that has now become institutionalized. The alcohol and drug industrial complex is not as powerful as its military-industrial counterpart, but nonetheless there are some striking similarities." Carolyn L. Wiener, *The Politics of Alcoholism: Building an Arena Around a Social Problem* (New Brunswick: Transaction Books, 1981), 3; Allison McKim, *Addicted to Rehab: Race, Gender, and Drugs in the Era of Mass Incarceration* (New Brunswick: Rutgers University Press, 2017), 26.

by public dollars had been created that catered to alcoholics who had the means to pay for help and left the indigent and uninsured with different, substandard treatment options.

CHAPTER 5

“We Cannot Afford to Be Colorblind:”

Meeting the Treatment Needs of “Special Population” Alcoholics

A white construction worker wearing a hard hat. A Black man holding up a briefcase. A white woman answering an office phone. These were a few of the individuals featured in a late 1970s informational poster with the headline: “Alcoholism is an Equal Opportunity Disease.”[425] The message promoted by the poster was a common one that was often repeated by those involved in the modern alcoholism movement or who were members of Alcoholics Anonymous. AA pamphlets consistently highlighted that “anyone [could] be an alcoholic” since the disease was “no respecter of age, sex, creed, race, wealth, occupation, or education.”[426] This universalist approach to alcoholism informed the comprehensive alcoholism legislation passed at the end of 1970. Indeed, as Senator Hughes repeatedly explained, alcoholism’s ability to “cut across all sectors- rich and poor, young and old, liberal and conservative” was what made it an essential problem for the federal government to tackle. The fact that Americans of all demographics were susceptible to the disease meant that alcoholism had reached “epidemic” proportions in the country and therefore required public investment.[427]

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[425] Performance Resource Press, *Alcoholism is an Equal Opportunity Disease,* Still Image, http://resource.nlm.nih.gov/101438609. Within their public education campaigns about alcoholism, the NIAAA and later iterations of the department within the National Institutes of Health consistently discussed the disease as one that was far-reaching and impacting individuals of all demographics. In the early 1990s, for example, the NIH distributed a poster entitled “The Typical Alcoholic American.” Under a series of pictures with people of varying race, age, and gender, the poster explained: “There’s no such thing as typical. We have all kinds. 10 million Americans are alcoholic. It’s our number one drug problem.” NIH, *The Typical Alcoholic American,* Still Image, 1991, http://resource.nlm.nih.gov/101450055.

[426] Quoted in Trysh Travis, *The Language of the Heart: A Cultural History of the Recovery Movement from Alcoholics Anonymous to Oprah Winfery* (Chapel Hill: University of North Carolina Press, 2010), 90-91.

[427] The Impact of Alcoholism, *Hearings Before the Special Subcommittee on Alcoholism and Narcotics of the Committee on Labor and Public Welfare- Senate,* 91st Cong., 1st Sess., July 1969, 3; “Alcohol Still Remains the Biggest Addiction, *The Boston Globe,* November 1, 1970, 26.

Cultural historian Trysh Travis has termed this conceptualization "alcoholic equalitarianism"- the idea that the "alcoholic condition" is universalizing and equalizing.[428] Take Marty Mann's *Primer on Alcoholism* as an example: "Background, environment, race, sex, social status- these make no appreciable difference once the disease takes hold of the individual. For all intents and purposes, he might just as well then be labeled with a number. He has become just another victim of alcoholism."[429] As with most developments in alcoholism knowledge throughout the twentieth century, arguing that anyone could be an alcoholic was a deliberate way to advance the disease concept of alcoholism. According to historian Michelle McClellan, understanding alcoholism in this way had "the greatest potential to reduce stigma for all" as it emphasized the "uniformity of the condition rather than the characteristics of the sufferer."[430]

While emphasizing the equalizing aspects of alcoholism might have helped to get the Hughes Act passed in 1970, this approach also resulted in significant blind spots being built into the legislation. Rather than thinking through how racial or economic differences might impact one's experience with substance abuse, the Hughes Act invested in a one-size-fits-all approach to alcoholism research and treatment. These services were modeled off what policymakers considered to be the "average" alcoholic. This alcoholic was not visible on Skid Row. Instead, he most likely was white, male, and employed. Essential healthcare services for alcoholics based on these individuals included detoxification in a general hospital, help staying on the job, and access to short- and long-term rehabilitation covered by insurance policies.

Within the first few years after the passing of the Hughes Act, it became clear that these advancements in alcoholism treatment services were not benefitting everyone equally.

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[428] Travis, *The Language of the Heart,* 86.
[429] Quoted in Michelle McClellan, *Lady Lushes: Gender, Alcoholism and Medicine in Modern American* (New Brunswick: Rutgers University Press, 2017), 114.
[430] Ibid., 109.

Researchers, treatment providers, and activists representing racial minority groups and women increasingly called into question the federal government's reliance on a universalized category of "alcoholic" throughout the 1970s. These challenges were in part inspired by the American Indian, Black Power, and feminism movements that were connecting racial and gender identity to health outcomes.[431] This rhetoric carried over into political conversations around substance use disorders. Advocates argued that gendered and racialized assumptions about who the "average" alcoholic was had made alcoholics who were not white and male "invisible" in alcoholism policy discussions and resulted in an inequitable treatment environment.[432] Black and Indian citizens in particular pointed to how "white control over policy" and the "budgeting of alcoholism treatment" had often meant that healthcare services were less accessible and of lower quality for alcoholics of color.[433] Feminists and female alcoholism researchers argued that this was a similar issue for women of all racial and socioeconomic backgrounds. Many were barred from receiving medical help whether this was in a general hospital, a detox facility, or halfway house because these were "male oriented and male dominated."[434]

Alcoholism might have been an "equal opportunity disease" in the sense that no individual or demographic was immune from becoming an alcoholic. But by the late 1970s, activists and researchers had clearly demonstrated that not all alcoholics experienced the disease

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[431] Julie L. Davis, *Survival Schools: The American Indian Movement and Community Education in the Twin Cities* (Minneapolis: University of Minnesota Press, 2013); Alondra Nelson, *Body and Soul: The Blank Panther Party and the Fight Against Medical Discrimination* (Minneapolis: University of Minnesota Press, 2011); Wendy Kline, *Bodies of Knowledge: Sexuality, Reproduction, and Women's Health in the Second Wave* (Chicago: The University of Chicago Press, 2010).
[432] Marian Sandmaier, *The Invisible Alcoholics: Women and Alcohol Abuse in America* (New York: McGraw-Hill, 1981).
[433] Frederick D. Harper, *Alcoholism Treatment and Black Americans* (Washington, D.C.: US Government Printing Offices, 1979), 22.
[434] Female alcoholics were often only admitted into these spaces if there was a designated number of beds specifically set aside for women. Alcohol Abuse Among Women: Special Problems and Unmet Needs, 1976, *Hearing Before the Subcommittee on Alcoholism and Narcotics of the Committee on Labor and public Welfare-Senate,* 94th Cong., 2nd Sess., September 1976, 1.

in the same way. While treatment options had expanded in the wake of the Hughes Act, the services had been tailored to meet the needs of a primarily white and male clientele. These care opportunities were not necessarily effective at treating alcoholics coming from different racial and gender backgrounds. More studies illustrated that race and gender (and the ways in which these factors intersected with class) significantly influenced the possible underlying causes for excessive drinking. Advocates argued that experiences like racism, sexism, poverty, and unemployment could not be divorced from an individual's alcoholism. For treatment to genuinely be successful, these issues had to be seriously taken into account to help someone find long-term sobriety. In other words, treatment could not "afford to be colorblind" and had to be "culturally sensitive" to differences amongst alcoholic patients in ways not possible in settings that had been intentionally designed for the "average" alcoholic.[435]

This chapter will examine the political effort to diversify the category of the "alcoholic" and to extend treatment opportunities to alcoholics of varying demographics. The federal organization newly created to handle alcoholism problems, the National Institute on Alcohol Abuse and Alcoholism (NIAAA), referred to these individuals as "special populations." Alcoholic "subpopulations" were defined as those requiring "special consideration" because unique "sociocultural factors [influenced] where, how much, and why a person [drank]."[436] These same groups were also those who had historically been "relatively ignored in treatment program planning" and therefore merited "more intensive study to create appropriate programs for them."[437] The first of such programs targeted Native Americans and began soon after the

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[435] Gary W. Lawson and Ann W. Lawson, *Alcoholism and Substance Abuse in Special Populations* (Rockville: Aspen Publishers, 1989), 126; Arleen Rogan, "Recovery from Alcoholism: Issues for Black and native American Alcoholics," *Alcohol health and Research World* 11, no. 1 (Fall 1986): 44.
[436] National Institute on Alcohol Abuse and Alcoholism, *Alcohol and Health: Third Special Report to the U.S. Congress* (Washington D.C.: US Government Printing Office, 1978), 23.
[437] National Institute on Alcohol Abuse and Alcoholism, *Alcohol and Health: Second Special Report to the U.S. Congress* (Washington D.C.: US Government Printing Office, 1974), 112.

NIAAA was established. By 1974, the NIAAA extended this focus to "Spanish-Speaking Americans" and "young black men." Four years later, the NIAAA's added women, teenagers, and the elderly to their list of special populations.[438]

Those who identified themselves as part of one or more of these populations defined their uniqueness in a slightly different manner than the official language published by the NIAAA throughout the 1970s. They instead contended that they were "special" because they were owed and entitled to targeted governmental services. This viewpoint was particularly strong amongst Black and Native alcoholics who argued that they "deserved special Federal effort because of a history of deprivation and racial discrimination" and the fact minority "problem drinkers [tended] to not be included in the general healthcare system."[439]

In tracing the efforts of two of these groups- Native American and Black Americans- this chapter will analyze how advocates sought to illuminate the limits to what a purely medicalized approach could achieve for alcoholics of different race and class backgrounds. Within the politics of alcoholism, factoring race more fully into treatment raised the importance of broader socioeconomic issues or what would be referred to today as social determinants of health. These were problems like community disinvestment, chronic unemployment, and generational poverty that could not be solved solely by medical means. Those involved in treating alcoholics of color made more expansive rights claims throughout the 1970s and 1980s, arguing that the "right to get well" had to include treatment that addressed more than just the physical or psychological symptoms of alcoholism. But these substantive rights claims collided with rising skepticism about the effectiveness of state-sponsored programs and the slashing of funds directed towards health and welfare services. While advocates were successful in expanding the category of the

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[438] NIAAA, *Third Special Report,* 23.
[439] Harper, *Alcoholism Treatment and Black Americans,* 114.

alcoholic, they were less effective at having federal policymakers tackle the larger structural social and economic dynamics that might be leading to high rates of alcoholism in minority communities.

"We are the Landlords, and the Rent is Due:" Treating Native Alcoholics

Beginning in 1972, the NIAAA created an "Indian Desk" within the federal agency's newly designated Special Projects Branch. Native Americans were the first "special population" group to which the NIAAA turned its focus.[440] This attention was partially due to the fact that alcoholism rates in Indian communities were estimated to be double the national average and deaths associated with alcoholic psychosis and liver cirrhosis were 6.5 times higher than the general population[441] But the creation of the "Indian Desk" was also a formal recognition that the federal government had been failing to live up to its responsibility of delivering adequate medical care to Native Americans by allowing alcoholism within Indian communities to go unchecked and untreated. The Indian Health Service (IHS), the agency specifically charged with "promoting the health of all American Indians" and providing them with free healthcare, did not prioritize the problem of alcoholism until 1969 despite a long recognition of the epidemic proportions of Indian alcohol abuse.[442]

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[440] National Institute on Alcohol Abuse and Alcoholism, *First Special Report to the U.S. Congress on Alcohol and Health (*Washington D.C.: US Government Printing Office, 1971), viii.
[441] Indian Health Service Task Force on Alcoholism, *Alcoholism: A High Priority Health Problem* (Washington, D.C.: US Department of Health, Education, and Welfare, 1969), 1; "Department of the Interior and Related Agencies Appropriations for 1972," *Hearings Before a Subcommittee of the Committee on Appropriations- House, 92nd Cong., 1st Sess.,* (Washington D.C.: US Government Printing Office, 1971), 982.
[442] William Boyum, "Health Care; An Overview of the Indian Health Service," *American Indian Law Review* 14, no. 2 (1988): 241; Alan L. Sorkin, *The Urban American Indian* (Lexington: Lexington Books, 1978), 47; "Self-Help Programs for Indians and Native Alaskans," *Alcohol Health and Research World* (Summer 1974): 12.
Federal concern about alcohol abuse and Indians had a long history, with laws prohibiting the sale of liquor to Indians remaining on the books between 1832 and 1953. This prohibition was a measure undertaken "at the request of Indian people." But it also resulted in blatantly discriminatory practices, with Native Americans being the only American citizens unable to legally purchase alcohol on reservations even after the national repeal of Prohibition in the 1930s. "Self-Help Programs," 11; IHS Task Force, *Alcoholism,* 3.

With the launch of a newly targeted program, the NIAAA attempted to wage a more concerted attack that was believed to be necessary to combat the prevalence of alcoholism within Native communities. While this effort helped raise visibility for the unique problems facing Indians struggling with alcoholism, it also resulted in a push and pull between state administrators and indigenous citizens, who tended to disagree over the roots causes of and necessary solutions for alcoholism. State agencies like the IHS and the NIAAA tended to promote the idea that alcoholism rates in Indian communities were so high because alcohol was still "a fairly recent addition to the experience of the American Indian people" who supposedly had not yet had the "time to establish and regulate the use of the substance."[443] But in advocating this claim, the IHS overlooked a long tradition of indigenous treatment movements and the work to combat alcoholism that had been initiated by tribes across the country throughout the 1960s.[444]

The first attempts by tribal governments to address alcoholism administratively and in partnership with the state arose during the War on Poverty. As historian Christopher Riggs has documented, rather than pursuing past policies that aimed to "assimilate Indians into the white mainstream," policymakers in the 1960s sought to "facilitate economic betterment in Indian country" by "providing Native Americans with greater opportunities to govern themselves and to maintain a distinct cultural identity."[445] This move reflected the maximum feasible participation policy undergirding the War on Poverty, but it also was a response to Indian demands to be more involved in the decisions affecting their lives and futures. From the inception of this new anti-poverty politics, tribes established community action programs aimed at bettering the health and

[443] Ibid., 2; 6.
[444] Don L. Coyhis and William L. White, *Alcohol Problems in Native America: The Untold Story of Resistance and Recovery- The Truth about the Lie* (Colorado Springs: White Bison Inc, 2006), 145.
[445] Christopher Riggs, "Indians, Liberalism, and Lyndon Johnson's Great Society, 1963-1969," ProQuest Dissertations Publishing, 1997, 1.

economic well-being of their own members. And as seen in the priorities enumerated in grant applications to the Office of Economic Opportunity, one of the most pressing issues that Native Americans wanted to address was alcoholism which they identified as being the "number one health problem" on reservations.[446]

Indians framed their political approach to alcoholism as a key component of their citizenship rights as well as their unique relationship to the federal government. According to the American Indian Policy Review Commission, the federal government had long recognized their formal "responsibility toward the health and general well-being of the Indian people" as seen in the creation of IHS. But these services reached only "approximately half of the estimated total number of Indians in the United States" since they were primarily directed towards Indians living on reservations.[447] While these services were an essential obligation of the federal government, they had also allowed for state and local officials to abdicate any responsibility toward Native citizens. This dereliction especially affected individuals living off reservations and in urban areas, where they did not receive the same kind of access to health and welfare services as non-Indians.[448]

In the field of alcoholism, state allocations for treatment efforts were not directed towards Indian programs under the notion that these were already being handled by the federal

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[446] The Blackfeet Tribe Resolution, 1968, Records of the National Council on Indian Opportunity, 1968-1974, Part 1: Alcoholism Files, ProQuest History Vault, Folder 102668-006-0001. For all the OEO funded alcoholism programs, see: Self-Determination: A Program of Accomplishments, May 1971, Records of the National Council on Indian Opportunity, 1968-1974, Part 4: Indian Self-Determination, ProQuest History Vault, Folder 102674-001-0635.
[447] Task Force Eleven, *Report on Alcohol and Drug Abuse: Final Report to the American Indian Policy Review Commission* (Washington D.C.: US Government Printing Office, 1976), 11; Robert A. Fairbanks, "The Cheyenne-Arapaho and Alcoholism: Does the Tribe Have a Legal Right to a Medical Remedy?" *American Indian Law Review* 1 (1983): 63.
[448] Barbara Isenberg, "Red Man's Plight- Urban Indians, Driven to Cities by Poverty, Find Harsh Existence," *Wall Street Journal,* March 9, 1970, 1; William Mullen, "Alcoholism is Indians' Worst Health Problem," *Chicago Tribune,* September 16, 1976, 1.

government. Additionally general hospitals often refused to help Indian patients, "directing them to go to 'their own' hospitals" even if this meant traveling 100 miles to get to an IHS facility. Native Americans framed this inequity over healthcare access which included the treatment of substance abuse through the language of citizenship. "The Indian people are citizens of the United States," the American Indian Policy Review commission wrote, "and therefore are eligible for whatever services or benefits any other citizen is eligible for."[449] Claiming their own space in the politics of alcoholism, activists advocated that Indians had the same right to care as all other citizens struggling with the disease and fought against the notion that they would be denied access to such help just because of their racial identity or their special relationship with the federal government.

While demanding acceptance into all medical spaces, tribal leaders concerned about problem drinking remained wary of relying on federal health agencies that had been ineffective at helping alcoholics within their communities. Even in hospitals run by the IHS which were specifically established to service Native Americans, patients felt that many white doctors were "not sensitive to Indian health needs."[450] Advocates pointed to high death rates of Indians who had been hospitalized as proof that state-run healthcare services were failing Indian people.[451] For Native Americans struggling with alcoholism, their experiences with IHS hospitals and other governmental medical facilities were additionally affected by stereotypes and biases. Activists argued that the myth of the "drunken Indian"- the idea that Native Americans had "an inherent inability to cope with alcohol"- resulted in medical professionals treating indigenous alcoholics

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[449] Task Force Eleven, Report on Alcohol and Drug Abuse, 12.
[450] Phoenix Indian Center Narrative, 1972, Records of the National Council on Indian Opportunity, 1968-1974, Part 3: Phoenix Indian Center Files, ProQuest History Vault, Folder 102672-020-0001.
[451] Proceedings of American Indian/Alaskan Native/ NIAAA Seminar, February 1973, Records of the National Council on Indian Opportunity, 1968-1974, Part 3: Mescalero Reservation and Apache Tribe Files, ProQuest History Vault, Folder 102672-008-0533.

with “indifference” or “callousness and impatience” rather than with genuine care.[452] Because of this, many claimed that healthcare services especially those that were designed to treat problems of excessive drinking had to be run for and by Indians themselves. With funding help from the OEO, tribal governments were able to initiate their own programs and had established almost 40 Indian-led alcoholism treatment services by the end of 1970.

According to activists, these programs had proven far more successful at treating Native alcoholics than the few services run primarily by white healthcare professionals. Indian leaders reported that Native alcoholics did not feel comfortable in treatment spaces where the majority of clients were white. Identifying and sharing with fellow alcoholics was seen as a vital step in the recovery process and this was something that could not happen as easily in white dominated facilities. In the Phoenix area, for example, managers of the local halfway house requested that local courts and welfare agencies stop referring Indians to the facility because the “Indian alcoholic [felt] out of place among non-Indians and with very few exceptions [would] not stay beyond a day or two.”[453] Furthermore, in agencies where all staff members were white, Indian alcoholics had “no one with whom to identify” or to “trust” in the vulnerable process of establishing sobriety.”[454] Finally, advocates argued that traditional treatment structures and resources could not meet the needs of Indian alcoholics because their definition of “rehabilitation” was “based on a white middle-class society’s concept of what was valuable.” Key to the kind of treatment resources that were now being supported and promoted by governmental agencies like the NIAAA was the idea that patients would be motivated to get

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[452] IHS, *Alcoholism,* 2; Donald Lee Fixico, *The Urban Indian Experience in America* (Albuquerque: University of New Mexico Press, 2000), 89.
[453] Phoenix Indian Center Half-way House Proposal, 1972, Records of the National Council on Indian Opportunity, 1968-1974, Part 3: Phoenix Indian Center Files, ProQuest History Vault, Folder 102672-020-0001.
[454] Cherokee Alcoholism Services, North Carolina, August 1973, Records of the National Council on Indian Opportunity, 1968-1974, Part 1: Alcoholism Files, ProQuest History Vault, Folder 102668-006-0336.

sober in order to “have a nice home, a nice car, a and a good-paying job.”[455] These factors were not necessarily motivating for Indian people coming from a culture with a different relationship to both materialism and individualism.

Rehabilitation programs like those established under the banner of the War on Poverty helped to alleviate some of these issues. Alcoholism services run by Indians, especially those who were also in recovery, demonstrated the possibility and effectiveness of “Indian solutions for Indian problems.”[456] Whether on reservations or in urban areas, these programs that included individual counseling, group therapy, and vocational training offered Native alcoholics the comfort and safety of a fellowship amongst those who shared similar experiences. Additionally, Indian counselors could directly address the underlying reasons for a patient’s drinking behavior that might be tied to their racial identity in ways that white healthcare professionals could not. As one Sioux treatment provider claimed, an Indian drank because of a feeling that he didn’t “fit into society” and had to live “a phony life just to survive.”[457] The frustration and loneliness stemming from this sense of not belonging at least partially explained why so many turned to alcohol. Such issues could be shared and treated openly in spaces where these feelings were understood mutually by clients and staff. According to tribal leaders, these resources had proven far more effective as seen in how many more patients were willing to complete a program or agree to follow-up care than those who had entered into predominately white facilities.

The creation of the Indian Desk within the NIAAA in 1972 represented a possible threat to the progress that Native Americans themselves had made with these OEO-funded treatment

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[455] American Indian Commission on Alcoholism and Drug Abuse Understand Indian Alcoholism Report, 1971, Records of the National Council on Indian Opportunity, 1968-1974, Part 1: Alcoholism Files, ProQuest History Vault, Folder 102668-006-0001.
[456] “Group Tries to Erase Drunken Indian Image,” *Los Angeles Times,* January 1, 1970, A5.
[457] “OEO Helps Indian Fight Alcoholism,” *Hartford Courant,* September 1, 1971, 15D

programs. In this new branch, government workers were supposed to be guided by the self-determination agenda that President Nixon announced in 1970 to dictate the relationship between the state and Indian citizens. Nixon commanded that all federal policies and practices regarding the “Indian future” needed to be “determined by Indians acts and Indian decisions.”[458] While the federal government would increase the level of expenditures being directed towards Native communities, how these funds were to be used would be determined by Indian folks themselves.

On the surface, the Indian Desk within the NIAAA was a clear area where this policy could be successfully executed since Indian-led alcoholism programs that were state funded had already been undertaken in a variety of areas for almost five years. As one report from a group of Arizona tribes claimed, the War on Poverty had resulted in Native Americans claiming “their right to ascertain their own needs and problems; to design and develop the programs and solutions to meet these needs… and to manage and administer federal, state, private and tribal resources and funds.”[459] Despite this, several leaders involved in indigenous alcoholism efforts felt that they had been overlooked in the creation of the Indian Desk. In a meeting with the NIAAA, tribal authorities asserted that that the desk has been created and staffed “without consultation from inter-tribal or national Indian organizations” and was not “responsive to suggestions which might [have allowed] for indigenous Indian input concerning administration

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[458] President Richard Nixon, “Special Message to the Congress on Indian Affairs- July 8, 1970,” in *Public Papers of the President of the United States: Richard M. Nixon, 1970* (Washington D.C: U.S. Government Printing Office, 1970), 564- 565. While this announcement was covered as a new policy direction for the federal government, it was in effect a continuation of the kinds of partnerships developed between state agencies and tribal governments during the War on Poverty. Thomas Foley, “Nixon Urges More Aid, Bigger Role for Indians,” *Boston Globe,* July 9, 1970, 1; Ken W. Clawson, “Nixon Asks New Indian Policy,” *The Washington Post,* July 9, 1970; “A Pledge to Indians of a New and Better Deal,” *The New York Times,* July 12, 1970.
[459] Self-Determination: A Program of Accomplishments, May 1971, Records of the National Council on Indian Opportunity, 1968-1974, Part 4: Indian Self-Determination, ProQuest History Vault, Folder 102674-001-0635.

and funding policy."[460] By doing so, activists argued that the NIAAA had squandered an opportunity to genuinely implement President Nixon's "self-determination message."[461]

With these arguments, Indian leaders fought to make alcoholism policy and politics more attuned to the needs of their communities. The Hughes Act was based on the foundation that citizens struggling with alcoholism possessed the "right to care" and that it was the role of the federal government to protect this right by ensuring alcoholics had access to adequate treatment resources. However, the definition over what counted as "quality care" remained an open question. This determination became even more important when the NIAAA turned its attention toward "special population" alcoholics in the early 1970s. Though Native Americans involved in the alcoholism treatment field welcomed the new influx of funds that the NIAAA focus portended, they were also wary that this funding would require the enforcement of certain treatment protocols and standards that were not based on the needs of Indian alcoholics.

Alcoholism as defined by the NIAAA had been based on "'white' research, 'white' criteria, 'white' program goals, and 'white' nomenclature" and thus "the expertise and treatment-response based on such knowledge" was not necessarily appropriate for Indians.[462] Yet the NIAAA utilized these "white" standards to evaluate the effectiveness of treatment programs and to decide whether or not they should continue receiving funding. In a meeting with the NIAAA, representatives from the American Indian Movement fought against this evaluation being done by "white research organizations and consultants" who did not "have rapport to do research on

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[460] The NIAAA had hired Bert Eder, a member of the Sioux tribe from Montana, to direct the Indian desk. But many leaders felt that they should have been more directly involved in the process of choosing who would control this new department.
USET Standing Committee on Alcoholism- Resolution No. 8A72, June 1972, Records of the National Council on Indian Opportunity, 1968-1974, Part 1: Alcoholism Files, ProQuest History Vault, Folder 102668-006-0336.
[461] AIM Telegram to NIAAA, 1972, Records of the National Council on Indian Opportunity, 1968-1974, Part 1: Alcoholism Files, ProQuest History Vault, Folder 102668-006-0336.
[462] Task Force Eleven, *Report on Alcohol and Drug Abuse,* xvi.

Indian alcoholism programs."[463] Particularly, activists feared that assessment of Indian programs being done by non-Indian bureaucrats would discount the importance of having "traditional heritage and culture" integrated into their treatment programming.[464] Since the loss of indigenous customs was seen as contributing to Native alcoholism, emphasizing the value of these in a treatment setting was believed to be essential in helping Indians get sober. These efforts resulted in the NIAAA changing their evaluation standards towards Native alcoholism treatment programs.[465] Indians involved in the alcoholism movement thus succeeded in defining "care" on their own terms and in asserting their right to receive publicly subsidized treatment that more closely aligned with the specific needs of minority alcoholics.

Indian leaders also shifted the dynamic of an equation that had been at the heart of the politics of alcoholism since the 1960s. From the beginning of the decriminalization effort, there had been an ongoing debate about the relationship between a person's socioeconomic status and the disease of alcoholism. Was poverty the cause or the effect of alcohol abuse? As previous chapters have illustrated, decriminalization advocates and social scientists tended to land on latter side of the calculation. Alcoholism was the main reason why so many individuals were impoverished and homeless on Skid Row. Once their drinking behavior was resolved, they would be capable of being reintegrated into American society by finding a steady job and permanent shelter.

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[463] Proceedings of American Indian/Alaskan Native/ NIAAA Seminar.

[464] Task Force, *Report on Alcohol and Drug Abuse,* 6.

[465] Weighted criteria for assessing Indian alcoholism programs included points for demonstrating "Indian community initiative and Indian control over the administration and operation of the program" and "demonstration that Indian community and cultural values" were part of the program. Applicants for Special Demonstration Projects Grants for Indian Alcoholism Programs, 1973, Records of the National Council on Indian Opportunity, 1968-1974, Part 1: Alcoholism Files, ProQuest History Vault, Folder 102668-006-0336.

For representatives speaking on behalf of Native alcoholics, this approach made no sense for those who had been "historical victims of systematic economic exploitation."[466] Poverty, discrimination, an extreme lack of socioeconomic and educational opportunities were the reasons for, not the effect of, high rates of alcoholism. Like one individual testifying before the civil rights commission explained, "Alcohol in itself is not the problem. It's the symptom of the lack of social acceptance, not being able to adjust. If the Indian were accepted socially, economically, or fully into the community, I don't think alcohol would be such a problem."[467] In discussing alcoholism in these terms, Indians demanded more from those involved in the political response to substance use disorders. If the point of expanding treatment opportunities for alcoholics was to help "restore" them to citizenship and reintegrate them into society, then at least for Native Americans who were alcoholics this required more than just detoxification and therapy but an actual alleviation of poverty, racial discrimination, and unemployment.

In doing so, Native Americans sought to demonstrate the limits to what a purely medicalized approach could accomplish. Indian activists accepted the premise of the broader alcoholism movement that alcoholics were sick people who needed and were entitled to medical treatment. However, the proposed solutions offered from this medicalized approach (detoxification, inpatient and outpatient services, and halfway houses) were not sufficient for individuals whose alcoholism could not be separated from their racial identity and class. Race significantly influenced one's access to socioeconomic opportunities and also affected their experiences with substance abuse. One grant application summarized this view: "It is our contention that to treat the alcoholic solely as a disease does not provide a sufficient solution to

[466] Jack Slater, "Urban Indians: Fighting for Identity," *Los Angeles Times,* February 29, 1976, 11.
[467] Minnesota Advisory Committee to the US Commission on Civil Rights, *Bridging the Gap: The Twin Cities Native American Community* (Washington D.C.: US Government Printing Office, 1975), 82.

the Indian alcoholic. Basically, without a job and the dignity and self-respect which derives from being a constructive force in the community, the problem of alcoholism cannot be overcome."[468] In the eyes of Native Americans involved in the alcoholism field, the medicalization solutions that the state was offering in the wake of the Hughes Act with a federal alcoholism program accounted for little more than "drying out" patients and failed to put individuals on a real path to recovery. For Indians struggling with alcoholism, treatment needed to lead to the "full rehabilitation of the alcoholic" in which long-term sobriety was coupled with "economic viability and independence."[469] With these claims, Indians challenged what white lawmakers had outlined as being the state's obligations to citizens who were alcoholics. When race and class were more fully considered, alcoholics were entitled to not just healthcare services but comprehensive help that tackled broader socioeconomic forces that could not be solved by medical aid alone.

After almost a decade of Indian-led treatment efforts, activists representing Native communities became more vocal about the need to tie the disease of alcoholism to its social determinants in the mid-1970s. Jose Rey Toledo, a Pueblo Indian summarized this outlook to the United States Commission on Civil Rights: "I have often felt that health problems [like alcoholism] can't be examined in a vacuum. They are related to many things including unemployment, lack of vocational skills, inadequate education, [and] cultural conflicts."[470] In particular, alcoholism among Native Americans could not be separated from their lack of financial resources and access to employment opportunities. As Doug Sky, the tribal chairman of

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[468] Summary of Project- Indian Alcoholism Counselor Training Program, 1972, Records of the National Council on Indian Opportunity, 1968-1974, Part 1: Alcoholism Files, ProQuest History Vault, Folder 102668-006-0336.
[469] USET Telegram to NIAAA, 1972, Records of the National Council on Indian Opportunity, 1968-1974, Part 1: Alcoholism Files, ProQuest History Vault, Folder 102668-006-0336.
[470] United States Commission on Civil Rights, *Hearing before the US Commission on Civil Rights: Albuquerque, NM November 1972* (Washington, D.C.: US Government Printing Office, 1974), 36.

the Standing Rock Sioux explained, “It’s tough to counsel sobriety to somebody with an empty belly, dirt floor, and dirt roof. Such persons… are apt to feel a lot better drunk.”[471] By demanding that alcoholism be recognized as both a health and economic problem, Indians fought against the individualistic reasons offered to explain the disease of alcoholism (i.e. genetic predisposition towards alcohol abuse or lack of will power) that tended to find fault in individuals’ lifestyles, culture, or behavior. Instead, they emphasized the larger structural explanations (large-scale unemployment, poverty, and forced relocation) for the prevalence of alcoholism within indigenous populations.

By framing alcoholism in this way, Native Americans often challenged federal agencies to provide them with more than government officials were willing to give. Throughout the 1970s, the NIAAA continued to fund alcoholism programs run by and for Indians that offered detoxification, culturally sensitive counseling, halfway houses, and vocational training.[472] But this funding only dealt with the mitigation of alcoholism rather than prevention of the disease, offering nowhere near the kind of investment that would be needed to address the structural socioeconomic issues that advocates believed to be at the heart of high alcoholism rates in Native communities.

Like in all programs set up by NIAAA grants, funding for Indian treatment was given on a provisional basis. NIAAA programs were designed to be temporary with the intention that services could be subsumed within mainstream healthcare operations and funded by local and state governments after their need had been demonstrated. The same could not be said for Indian programs, with tribes unable to take on the funding burden for alcoholism services without consistent help from the federal government. As the American Indian Policy Review

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[471] AICADA Understand Indian Alcoholism Report.
[472] “Indian Alcohol Abuse Subject of U.S. Concern,” *NIAAA/IFS Special Report,* August 23, 1974, 3.

Commission explained in 1976, "Short term funding and verbal commitments, however well intentioned, lead to false hopes and frustrations… A long range commitment by both the Indian people and the federal government to combat the adverse effects of alcohol and drug use is the only way they can be alleviated."[473] Native Americans framed this need for an enduring funding source for alcoholism treatment as being tied to their special relationship with the federal government. Will Basque, the head of the Boston Indian Council stated this idea most poignantly: "Indian programs should be exempt from cuts… These programs aren't welfare. We have a unique situation. We are not immigrants. We are the landlords, and the rent is due."[474]

Despite these arguments, the fate of Indian healthcare services and alcoholism treatment efforts remained tied to the whims of different administrations. Under Presidents Ford and Carter, for example, Congress passed the Indian Healthcare Improvement Act. This law outlined the kinds of obligations that Native Americans had been fighting for in relationship to health and welfare programs. The act stated that due to the federal government's "responsibility to the American Indian people," it was up to the United States to "provide the quantity and quality of health services which will permit the health status of Indians to be raised to their highest possible level and to encourage the maximum participation of Indians in the planning and management of those services."[475] Included in this law was a significant increase in the amount of money being expended towards alcoholism treatment for Indians. But the willingness to invest heavily in Indian healthcare had waned significantly only a few years later. As one journalist put it, "white sympathy and guilt over the treatment of Indians seem to be fading before a new mood of fiscal

[473] Task Force Eleven, Report on Alcohol and Drug Abuse, 21.
[474] Mitchell Berger, "NE Indians go to Washington to Fight Funding Cuts," *The Boston Globe,* August 18, 1975, 3.
[475] Indian Health Care Improvement Act, Public Law 94-437, 90 Stat. 1400, September 30, 1976, 1.

austerity"- a tide that crescendoed by the 1980s.[476] The view of the federal government's obligations towards Native Americans under the Reagan administration was summed up by the Secretary of Interior James Watt who claimed that Indian reservations with high alcoholism and unemployment rates were an "example of the failures of socialism."[477] Although policies continued to require the state to provide for Indian health needs, certain administrations included funds for these services within a wave of broad cuts to social welfare programming which gutted treatment for alcoholism.

Even within administrations that committed significant monies towards Indian alcoholism programs, they remained limited in impact precisely because they failed to meet the demands consistently made by Native advocates to see alcoholism as a disease that required more than medical services. Certain governmental bodies gave credence to the social determinist view of alcoholism. The United States Commission on Civil Rights, for example, declared in their comprehensive study on Indian health: "It is also important to keep in mind that the health status of American Indians cannot be isolated from other life experiences. Until American Indians receive equal opportunities in other areas- housing, sanitation, jobs, education, income, etc. – it is likely that their health status will remain inferior to that of the majority population."[478]

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[476] Howell Raines, "American Indians Struggling for Power and Identity," *The New York Times,* February 11, 1979, Sm6.

[477] According to Watt, reservations had the "highest drug rate, highest alcoholism rate, highest unemployment rate… because the people [had] been trained… to look to the government as the creator, as the provider, as the suppliers and they [had] not been trained to use the initiative to integrate into the American system." The statement, made on a conservative radio show, caused a storm of controversy within Native communities with leaders calling out the hypocrisy of a statement coming from someone within an administration removing the very resources needed to combat the problems Watt was describing. "Watt's Remarks Create Furor and Demands for His Resignation," *Navajo Area Newsletter* 12, no. 6 (February 1983): 1; William Raspberry, "Watt's Indian Problem," *The Washington Post,* January 24, 1983; Christopher Sullivan, "Urban Indians Say Their Problems Mount as US Funds Are Cut," *The Washington Post,* February 2, 1983, 3.

[478] U.S. Commission on Civil Rights, *The Southwest Indian Report* (Washington D.C.: U.S. Government Printing Office, 1973), 32.

A similar sentiment was even put forth by Indian Health Service officials who felt that "the treatment of alcoholism among Indian [would] never be totally effective until the underlying social, economic and cultural causes [were] remedied, over which the IHS [had] little or no control." Boyum, "Health Care," 249.

But these statements never truly corresponded with the necessary investment to tackle all of these problems together. The state was willing to fund medical services (albeit on an unequal and inconsistent basis) to treat the physical and psychological symptoms of alcoholism but rarely any more than that.

However, the Indian approach to alcoholism did have significant contributions in the broader alcoholism movement and in the political dialogues around the disease. Indians were the first to point out the limitations in viewing the "alcoholic" as a universal category, which would inspire other groups throughout the 1970s. This work illustrated the importance of recognizing how differences in race and culture impacted the experience of the disease of alcoholism. By illustrating the double burden of being both an Indian and an alcoholic, Native Americans advocated for the need to differentiate alcoholism treatment to accommodate for the specific needs of minority groups. Indian alcoholism programs also questioned what counted as quality care for individuals who were not white and economically well-off. Their calls to see structural socioeconomic issues as inherently interconnected with substance abuse would reverberate into other conversations in the last decades of the twentieth century around the interactions among poverty, homelessness, and alcoholism.

The "Unseen Crisis:" Helping Black Alcoholics

Prior to the 1970s, race was only discussed as a metaphor in political conversations about alcoholism. Alcoholics had historically been treated *like* members of racial minority groups in the sense that they had been discriminated against and stigmatized. As one article stated, alcoholics had been treated "like many minority group members" in how they were "refused admission to hospitals for treatment" or received "only cursory attention." Likewise, the political

effort to expand treatment access was "similar to blacks and Chicanos forming movements to seek justice to improve their lot."[479] With statements like these, individuals involved in the alcoholism movement failed to think through the experiences of those who were in both of these marginalized groups and how that might impact a person's ability to get help. The efforts of Native Americans to make treatment resources more accountable for those who were not white led to a focus on other racial minority groups, especially African Americans. Similar to the arguments given for Indian programs, advocates argued that Black alcoholics were entitled to government-subsidized services that were racially sensitive and fully accounted for the specific needs of Black patients. Activists also pushed for a broader definition of "treatment" that encompassed other major issues – unemployment especially- that were seen as contributing factors leading to alcoholism among Black Americans.

In 1977, the NIAAA published a report entitled "The Unseen Crisis: Blacks and Alcohol." According to the study, alcoholism amongst African Americans had gone largely "unseen" because it had been "ignored" by not only white researchers, policy makers, and treatment providers but also by Black community leaders and activists.[480] By overlooking alcoholism as a significant problem, it had reached "crisis" levels which was measured by how much more severe the consequences of the disease were for Black citizens. Alcoholism was far worse in individuals with high blood pressure and diabetes, health issues that were high among African Americans. Black alcoholics were thus more likely to die from the disease. One governmental report found that "rates of acute and chronic alcohol-related diseases" such as liver cirrhosis, heart disease, and cancers of the mouth or esophagus "which at one time were lower

[479] William Madsen, "Alcoholics Anonymous as a Crisis Cult," *Alcohol Health and Research World* (Spring 1974): 7.
[480] Frederick D. Harper and Marvin R. Dawkins, "Alcohol Abuse in the Black Community," *The Black Scholar* 8, no. 6 (1977): 24.

than or similar to those for whites" had "increased to almost epidemic proportions" among African Americans in the later decades of the twentieth century.[481] But, like the "Unseen Crisis" report highlighted, Black alcoholism had traditionally not received anywhere near the kind of attention commensurate with these consequences.

This lack of consideration for racial difference was seen most clearly in the colorblindness of alcoholism research. In the 1970s, as more African American professionals got involved in areas of mental health and alcoholism services, they increasingly pointed out the shortage of studies that discussed Black alcoholics in any substantial way.[482] Frederick Harper, a Howard University professor, was one of the main leaders involved in diversifying alcoholism research and corresponding treatment measures. In one literature review, he found that fewer than 100 articles on alcoholism included any discussion about race and fewer than 15 dealt with "Black alcohol use as the major topic or Black alcoholics as the major research group."[483] Even within these few studies that included race as a factor, they perpetuated prejudicial understandings to explain alcoholism amongst African Americans. White researchers tended to consider Black alcoholism through the lens of "white middle-class values" and in doing so labeled excessive drinking behavior as deviance or "evidence of abnormality" in non-white individuals.[484] By pointing out these limitations and biases, advocates contended that policies and treatment resources which had been based on studies unreflective of non-white experiences would never be effective for Black Americans.

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[481] Laura Ronan, "Alcohol-Related Risks Among Black Americans: Highlights of the Secretary's Task Force Report on Black and Minority Health," *Alcohol Health and Research World* 11, no. 2 (Winter 1986): 38.
[482] William Harvey, "Alcohol Abuse and the Black Community," *Journal of Drug Issues* (Winter 1985): 85.
[483] Frederick D. Harper, "Research and Treatment with Black Alcoholics," *Alcohol Health and Research World* 4, no. 4 (Summer 1980): 12-13.
[484] Fred T. Davis JR, "Alcoholism Among American Blacks," *Addictions* (1974): 14.

Advocates also argued that the issue of alcoholism had been similarly ignored in Black communities. Jesse Jackson, for example, wrote that alcoholism represented “a far more severe crisis than [was] generally recognized by the black community.”[485] The lack of awareness was exemplified in the fact that Black journals and magazines had only published 8 articles on the topic of alcoholism.[486] In attempting to explain why alcoholism did not seem to garner the appropriate level of attention, leaders posited that Black Americans were more likely to view alcoholism as a “moral issue” where individuals could stop drinking if they wanted. This moralism allowed people to “dissociate [from] the need for any involvement” in helping alcoholics recover.[487]

Furthermore, the disease concept itself was seen as a white-washed idea. As one researcher argued, alcoholism was an illness “for white folks” and “blacks just drink a lot of liquor.”[488] But perhaps the biggest problem was the notion that alcoholism treatment had been intentionally designed only for white people. There was a “perception” in the “Black community that the official white response to alcohol abuse [was] different for blacks than whites.” In particular, they felt that “white abusers [were] treated by the establishment as sick” while Black alcoholics were treated “as being criminal.”[489]According to Black professionals, the white-dominated nature of the alcoholism field had made individuals in the Black community feel that this was not their problem. Additionally, the failure of white researchers to truly understand the

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[485] National Institute on Alcohol Abuse and Alcoholism, *The Unseen Crisis: Blacks and Alcohol* (Washington D.C.: US Government Printing Office, 1977), 3.
[486] Harper, “Research and Treatment,” 13.
[487] Ibid., 6.
[488] Harper and Dawkins, “Alcohol Abuse,” 28.
[489] Harvey, “Alcohol Abuse and the Black Community,” 82; H. Eugene Hodges and George D. Lowe, “Race and Changes in Rates of Treatment and Deaths due to Alcoholism in a Southern State: 1970-1974,” *Phylon* 38, no. 2 (1977): 152.

unique experiences of minority groups had made African Americans wary of treatment resources stemming from these studies and policies.

The efforts by racial justice advocates to tackle all areas of inequity throughout the 1970s, including those concerning healthcare, put a sharper focus on how the disease of alcoholism impacted Black Americans. For activists, an issue that had long been ignored from all corners required specific resources devoted to raising awareness about alcoholism both within the Black community and among white policy makers and treatment providers. These concerns were illustrated in the creation of advocacy groups like the National Black Council on Alcoholism as well as the Black Alcoholism program within the NIAAA's Special Projects division in 1974.[490] Individuals working in these spaces aimed to analyze the unique needs of Black alcoholics. Advocates contended that racism could not be separated from how Black Americans approached alcohol and other substances. Many believed that Black Americans used alcohol "as a means of forgetting," of "tuning out the psychological and physical pain" associated with living in a racist society.[491] For those interested in Black alcoholism, these experiences associated with one's racial identity had to be adequately confronted and understood for rehabilitation to be successful.

But the largest issue that advocates interested in aiding Black alcoholics identified was the inequity of the treatment field. Because of legal segregation and other forms of racial discrimination, Black alcoholics had often been denied treatment in hospitals, AA groups, and community alcoholism programs. This denial of help resulted in severe consequences with Black

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[490] "Black Alcohol Personnel Create Advocacy Group," *NIAAA Information and Feature Service* 6 (1974): 3.
[491] The prevalence of liquor stores in Black communities was another reason often cited for distinct drinking patterns among African Americans. The hyper-availability of alcohol made it an easy avenue of escape that could quickly slip into abuse. Harper and Dawkins, "Alcohol Abuse," 27; Creigs Beverly, "Toward A Model for Counseling Black Alcoholics," *Journal of Non-White Concerns in Personnel and Guidance* 3, no. 4 (1975): 171.

Americans more likely to "die alcohol-related deaths because they [received] little to no health care service" for their illness.[492] Even in the 1970s when official forms of racial discrimination in healthcare had been prohibited, Black Americans still lacked access to quality medical help. In the alcoholism field, facilities targeting "middle-class alcoholics [had] expanded rapidly" in the wake of the Hughes Act.[493] Black alcoholics, especially those lacking in financial resources, did not have the same kind of access to these services. Instead, they had to rely on public hospitals and clinics which tended to be overcrowded and underfunded. Even for those who had access to mainstream treatment resources, a number of studies found that African Americans of all class backgrounds often did not "feel welcome by the alcoholism treatment world."[494] Since the programming of these services had been designed by and for white individuals, Black alcoholics did not necessarily identify with others in spaces dominated by white staff and white clients.

The failure to reach Black patients in mainstream treatment facilities was also in part due to how the system had been set up to get patients in the door. As the previous chapter discussed, the services that had been established under the Hughes Act relied on "constructive coercion" by employers, family members, or physicians to get alcoholics into treatment. African Americans were rarely "given an opportunity to seek treatment" by these same players.[495] Judges were the only ones sending Black alcoholics into the treatment system at which point they were already in the more progressive stages of the disease.[496] African Americans also tended to not seek out help for themselves. According to one study, as a coping mechanism against a history of oppression, Black Americans had developed a "higher threshold for emotional pain" and therefore would

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[492] Frederick D. Harper, *Alcoholism Treatment and Black Americans* (Washington, D.C.: US Government Printing Offices, 1979), 32.
[493] "Prevention of Alcohol Abuse Among Black Americans," *Alcohol Health and Research World* 11, no. 2 *(Winter 1986):* 40; George Getze, "Black Alcoholics Require Separate Aid," *The Los Angeles Times,* June 5, 1975, A9.
[494] Harper, *Alcoholism Treatment and Black Americans,* 32.
[495] *The Unseen Crisis,* 10.
[496] "Perspectives: Interview Feature," *Alcohol Health and Research World* 4, no. 4 (Summer 1980): 27.

only seek aid in the most extreme of situations.[497] Black patients' decision to seek help was also influenced by the historical relationship between African Americans and the general healthcare apparatus, especially facilities associated with mental health services. Many understood predominant "helping institutions" as reflecting "racist character" and operating "out of a racist framework."[498] Because of this, Black alcoholics did not necessarily view mainstream treatment facilities as a place in which they could get help for their drinking problem.

Similar to Indian leaders, advocates pointing out the inequities of the alcoholism treatment field and the particular needs of Black alcoholics challenged the federal government and the NIAAA especially to be diversify the "alcoholic" category and to broaden the scope of "treatment" and "prevention" to adequately help alcoholics of all backgrounds. In demanding more quality care for Black alcoholics, advocates argued for the necessity of racially sensitive treatment programming. In a series of workshops held by the NIAAA in 1976, service providers reported that they had often not been successful in rehabilitating minority alcoholics who entered into treatment. Black researchers argued that African-American alcoholics did not respond to the therapeutic methods offered in most treatment facilities because those methods understood the disease too individualistically. For Black patients, therapy and counseling needed to be linked "to broader social processes" like "economic and social adversity" as these were the main reasons why African Americans abused alcohol.[499] Additionally, fostering a positive racial

[497] "MIBCA Sponsored Conference- Groundwork for Future Action," *Alcohol Health and Research World* 11, no. 2 (Winter 1986): 24. A similar report argued that it was almost impossible to gauge the "general health status of Black Americans" because many "regardless of pain and disease" did not seek medical help. Harper, "Alcoholism Treatment," 8; Harrold W Neighbors, "The Help-Seeking Behavior of Black Americans," *Journal of the National Medical Association* 80, no. 9 (1988):1009.
[498] Beverly, "Toward a Model," 170. It was for this same reason that Black communities might thwart "intervention into the lives" of alcoholics, especially by "white officials" including social workers, law enforcement officers, and public health nurses. Black folks were found to be more willing than white people to "tolerate certain levels of undesirable behavior" associated with alcoholism "in order to prevent sanctions and confinement being imposed on the offending community member by the ruling group." Harvey, "Alcohol Abuse," 83.
[499] Davis, "Alcoholism Among American Blacks," 14.

identity was seen as being essential for Black alcoholism treatment. Culturally sensitive programming had to include promoting blackness as a way to "foster a sense of self pride that [would] assist individuals on a long-term sobriety journey."[500] Fighting against the notion that alcoholism was a colorblind or universal disease, activists instead demonstrated the necessity of individualizing rehab programming to fit the unique needs of nonwhite alcoholics.

Activists also argued that effective treatment had to include programming that dealt directly with the larger socioeconomic issues Black Americans were facing. In answering the question over whether poverty was a cause or an effect of alcoholism, those involved in the Black alcoholism field argued that it was a mix of both. The problem of "unemployment, underemployment, and unstable employment" caused by "racism and racial discrimination" created a "sense of powerlessness that [lent] itself easily to drinking as a means of escape."[501] Especially for those living in inner-city areas wrecked by deindustrialization and disinvestment, there was no question that alcoholism among Black residents was at least in part caused by living in a seemingly hopeless economic situation.[502] But, according to researchers, alcoholism as well as drug addiction made these conditions even worse. Peter Bell, the head of the Minnesota Institute on Black Chemical Abuse explained it this way: "Black Americans are less able than other Americans to isolate themselves from the ravages of chemical abuse. Partly because our economic status is more temporary and our educational status is problematic, the alcohol and drug abuse problems in our community and in our family have a more devasting impact on black Americans than they tend to have on white Americans." Because of this, efforts to tackle

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[500] Arleen Rogan, "Recovery from Alcoholism: Issues for Black and Native American Alcoholics," *Alcohol health and Research World* 11, no. 1 (Fall 1986): 44.
[501] Harper, "Research and Treatment," 12.
[502] "Staggering Black Unemployment," *Atlanta Daily World,* September 22, 1977, 4; Jim Davis, "Institutional Racism- Cause of Skyrocketing Black Unemployment," *Philadelphia Tribune,* March 21, 1978, 8; Charles Belle, "Rising Black Unemployment," *Philadelphia Tribune,* October 8, 1977, 8.

alcoholism had to be undertaken alongside the larger “black agenda” that focused on “housing, health care, education, crime and economic development.”[503] The fact that Black Americans did not have the same opportunities in all of these areas explained why alcoholism was an issue in the Black community. But any progress made in these sectors could not be realized by individuals who remained chemically dependent. Those involved in Black alcoholism programs and studies thus pushed to have alcoholism be viewed as both a disease and a social problem tied to broader questions around economic security.

In the political arena, African Americans utilized the language of rights and citizenship to demand that the state fulfill the obligations it had established after the passing of the Hughes Act. Within the first few years after the enactment of this legislation, it was clear that Black Americans were not being reached by new treatment resources. For activists, this failure to help non-white alcoholics was a dereliction of the state’s established commitment to citizens struggling with the disease. It was therefore the “responsibility of state, local, and federal institutions” to initiate additional programs to meet the needs of this special population.”[504]

Inspired by the rhetoric employed by Native Americans, advocates argued that Black alcoholics were also uniquely entitled to services and help from the federal government. These services included racially sensitive treatment opportunities in which Black patients could find programs staffed by Black counselors, group counseling that had fellow alcoholics of color, and open discussion about racial identity As Frederick Harper wrote, “Blacks’ alcohol problems deserve a special federal effort because of a history of deprivation and racial discrimination, the isolation of black communities from mainstream America, and the fact that black problem

[503] “MIBCA-Sponsored Conference,” 24.
[504] Davis, “Alcoholism Among American Blacks,” 14.

drinkers tend to not be included in the general health care system."[505] Furthermore, Black alcoholics possessed the right as citizens to receive this recognition and aid. As participants in a workshop told the NIAAA, "Black alcoholics should have as much right as white alcoholics to at least 4 conditions for effective treatment: 1) alcoholism services within their own community, 2) alcoholism professionals who understand their cultural background and needs, 3) professionals who are interpersonally effective… and 4) professionals who are competent in skills, knowledge, and motivation."[506] Within these claims, African Americans slightly expanded the "right to quality care" notion that was fundamental to the Hughes Act and the larger alcoholism movement. At the most basic level, Black alcoholics were entitled to the right to be seen as sick people deserving of help. But they also had the right to define for themselves what kind of treatment best fit their community's needs and the right to have these services be funded as an essential form of healthcare.

While predominately white policymakers were willing to fund racially sensitive treatment programs, they were far less interested in addressing the socioeconomic components of alcoholism. Just as was the case with Native Americans, supporters argued that that Black alcoholism required more than medicalization and the removal of barriers to healthcare facilities. According to Black scholars like Thomas Watts and Roosevelt Wright, the state needed to "go even beyond the public health approach to a large-scale ecological, environmental, systems-oriented approach" to combat alcoholism. For a "large-scale Black substance abuse prevention policy" to be successful, it had to "look at a much larger horizon than simply 'substance abuse' itself" and "look at education policies, unemployment policies, and much more."[507]

[505] Harper, *Alcoholism Treatment,* 114.
[506] Ibid., 113.
[507] "Prevention of Alcohol Abuse," 41.

In concrete terms, researchers proposed that funds from the NIAAA should be used to cover not only medical services like detoxification and psychological counseling but also a direct stipend system to Black alcoholic clients. These individuals were far less likely to stay sober if they returned to a life without financial opportunity. Stipends as well as vocational training programs, offering part time jobs, and securing full time work were offered as being key components of Black alcoholism treatment in which the goal of sobriety was couple with the aim of helping clients "meet their basic needs."[508] But supporters were not often successful in getting the level of public aid needed to implement these ideas. Even in advocating for this expansive vision of comprehensive rehabilitation, participants in this conversation understood that the funding landscape for these kinds of programs was "bleak" in an era of "zero-based budgets." Additionally, the required certification and licensing needed to fund programs were "based on white-oriented criteria" and did "not favor black programs."[509] As more attention was being paid to the problems of minority alcoholics in the late 1970s and 1980s, the will for substantial governmental investment in health and welfare services and combatting racial disparities had waned.

The discrepancy between advocates' views on alcoholism and those of governmental officials was epitomized in the state's first major study into the health status of minority Americans in 1985. Commissioned by President Reagan's Secretary of Health and Human Services Margaret Heckler, the task force behind the study aimed to understand why health disparities continued to persist among individuals of different racial backgrounds despite the advancements that had been made in medicine. Their work, compiled in what would become known as the Heckler Report, found six health areas with major disparities: cancer,

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[508] Harper, *Alcoholism Treatment,* 41-42.
[509] Ibid., 47.

cardiovascular disease and stroke, diabetes, homicide and accidents, infant mortality, and chemical dependency. While the authors of the report acknowledged that many of these areas were related to social determinants like unemployment and poverty, their analysis primarily offered an explanation that centered on the behaviors and choices of sick people themselves.[510] This viewpoint was particularly true in the section on chemical dependency. According to the report, "the misuse of alcohol and drugs" was one of the major health problems facing minority Americans that was "amenable to health education efforts."[511] The report thus argued that education was the most effective defense in the fight against chemical dependency since individuals could be taught to make different lifestyle choices- i.e. deciding not to drink or do drugs.[512]

This proposal was in direct opposition to what activists representing Black alcoholics had been demanding for almost a decade by the time the report was published in 1985. It turned alcoholism into a disease rooted in individual behavior rather than one's socioeconomic circumstances. Edith Irby Jones, the president of the National Medical Association, spoke on behalf of minority doctors in her criticism of trying to treat alcohol abuse through health education rather than what was really needed- "better nutrition…, better housing, and more and better jobs."[513] As seen in the arguments put forth by the Heckler Report, the effort to institutionalize this social determinist view on alcoholism within the federal government had largely failed.

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[510] Arleen Tuchman, "One Size Does Not Fit All: An Historian's Perspective on Precision Diabetes Medicine," 2021.
[511] U.S. Department of Health and /human Services, *Report of the Secretary's Task Force on Black and Minority Health* (Washington D.C.: US Government Printing Office, 1985), 41.
[512] The education approach to substance use was epitomized in Nancy Reagan's "Just Say No" campaign which was supported by the National Institute on Drug Abuse. Department of Health and Human Services, "Just Say No Clubs Resource Paper," (Rockville: Public Health Service, 1986).
[513] E.I. Jones, "Closing the Health Status Gap for Blacks and Other Minorites," *Journal of the National Medical Association* 78, no. 6 (June 1986): 486.

But Native and Black Americans did succeed in making the unique problems of non-white alcoholics visible to decision-makers, community members, and the broader public by the 1980s. They were effective at illustrating the limitations built into the Hughes Act and were successful at fighting to make minority alcoholics seen as being just as deserving and worthy of help from the state. This work led to tangible advancements, breaking down more barriers to treatment in the general healthcare setting by making treatment providers, doctors, and therapists more cognizant of the special needs of alcoholics coming from varying backgrounds. Additionally, these efforts led to the creation of more racially sensitive programming, the training of more Indian and Black alcoholism counselors, and the formation of treatment mechanisms that viewed racial identity and knowledge as sources of strength rather than deviance. Perhaps most significantly, the claims that Black and Native alcoholics made as individuals dealing with the legacy of government-sponsored oppression extended the concept of what citizens struggling with alcoholism were entitled to from the state. Though they were not often successful in their demands for alcoholism to be combatted as more than just a medical or mental health problem, their tying of substance use disorders to the need for broader structural changes planted seeds for these same ideas to be taken up by other generations of lawmakers and activists.

CONCLUSION

In the early 1990s, Betty Ford made a rare appearance in Washington D.C. to criticize the leaders of her own party for their stance on drugs and alcohol. Her condemnation was twofold. The Reagan and Bush administrations' War on Drugs focused far too much on "cocaine and crack to the extent of ignoring alcohol, the No.1 drug of addiction." But even more significantly, the government's punitive approaches to alcohol and drug abuse had allowed for a "regression to an addiction-as-crime mind-set" that was detrimentally affecting the lives of alcoholics and addicts across the country.[514] Speaking a little over 12 years after she broke barriers by publicly discussing her own bout with alcoholism, Betty Ford outlined how the return to punitive politics was denying individuals suffering from substance use disorders needed avenues of help.[515] Additionally, by re-criminalizing drug use, the federal government was once again stigmatizing people who were sick.

Although a "War on Drugs" had been undertaken initially by President Nixon in the early 1970s, the drug war in the 1980s and 1990s was markedly different. While Nixon's administration put the bulk of their focus on therapeutics like methadone maintenance, the policy agenda established first under Ronald Reagan and carried on by subsequent administrations (conservative and liberal alike) centered around hyper-punitive practices like mandatory minimums as well as other draconian and racially discriminatory sentencing measures. It has been well-documented in recent years that this system of punishment was a failure on multiple

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[514] Barbara Gamarekian, "Mrs. Ford Criticizes Neglect of Alcohol in U.S. Drug Efforts," *The New York Times,* March 26, 1991, A19.

[515] At this point, the Bush Administration was directing two-thirds of its budget towards illegal drug control and only one-third for treatment and prevention. Mrs. Ford was particularly critical of how these War on Drugs priorities were giving insurance companies an easy excuse to remove coverage for stays in treatment facilities. Ibid. "Betty Ford Admits to Alcoholism," *The Hartford Courant,* April 22, 1978, 1A; Anne Lariviere, "Betty Ford's Candidness on Alcoholism has Brought Her Some Grief," *Los Angeles Times,* April 1, 1982, Se2.

fronts- failing to curb drug sale and use, devastating communities of color, and creating a system of mass incarceration.[516] But as Mrs. Ford's statement in the early 1990s illustrates, the War on Drugs was also harmful for how it undermined the progress that the reformers described throughout these chapters had established. Federal policymakers were no longer being guided by the understanding that substance abuse was a disease requiring treatment. And by losing sight of this disease concept, lawmakers were now threatening to destroy the advancements that had been made because of individuals involved in the modern alcoholism and decriminalization movements.

This dissertation has aimed to show that even when the central ideas undergirding both of these efforts were gaining traction, there never was a total consensus around what was the best political approach to citizens with substance use issues especially those visible to the public eye. The politics of alcoholism and addiction more generally has always been on a spectrum between viewing these problems as crimes or diseases, as matters of individual welfare or public safety, as something requiring mandatory confinement or voluntary treatment, as something rooted in individual behavior or, in the case of African American and Native Americans, set in larger economic structures. Throughout the 1960s and 1970s, the pendulum between these variables swung in favor of advocates fighting for alcoholics of all backgrounds to be considered sick individuals deserving of help and protection from undue punishment or discrimination. But, as was epitomized by the *Powell* decision in 1968, the idea that alcoholics were just willfully misbehaving was never fully repudiated even at the height of the alcoholism reform movements. Therefore, to describe the punitive turn in the 1980s as a "backlash" is not necessarily an apt

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[516] Dan Baum, *Smoke and Mirrors: The War on Drugs and the Politics of Failure* (Waltham: Little, Brown and Co, 1996); Michelle Alexander, *The New Jim Crow: Mass Incarceration in the Age of Colorblindness* (New York: The New Press, 2012); Alfred W. McCoy, "The War on Drugs is 50 Years Old, July 7, 2021, https://www.thenation.com/article/politics/anniversary-war-on-drugs/.

descriptor of alcoholism politics towards the end of the twentieth century.[517] Instead, there was a resurgence of practices and ideologies that reformers had been working against in the post-Prohibition era.

"Broken Windows" vs. "Victimless Crimes:" Alcoholism and Homelessness

In 1982, two scholars wrote an article in *The Atlantic* that altered the course of policing practices in urban neighborhoods. James Wilson and George Kelling posited that police officers had been neglecting a serious source of concern for city residents – "the fear of being bothered by disorderly people." These individuals were not violent and not even "necessarily criminals," but were "disreputable or obstreperous or unpredictable people: panhandlers, drunks, addicts, rowdy teenagers, prostitutes, loiterers, the mentally disturbed." According to their article, the blight that these people caused to a sense of public order needed to be handled as seriously as those engaging in "real" crimes. To illustrate that public disorder and crime were fundamentally connected, Wilson and Kelling utilized the imagery of windows. "If a window in a building is broken and is left unrepaired, all the rest of the windows will soon be broken," they argued, "an unrepaired broken window is a signal that no one cares, and so breaking more windows costs nothing."[518]

This "broken windows" theory gained significant traction among criminologists and law enforcement departments throughout the 1980s. Leaders in Chicago, Baltimore, New York City, and elsewhere instituted new programs that put officers back on the beat. Policemen were once

[517] William White described the 1980s as a "backlash" in his history of treatment. William L. White, *Slaying the Dragon: The History of Addiction Treatment and Recovery in America* (Bloomington: Chestnut Health Systems, 1998), 284.
[518] George L. Kelling and James Q. Wilson, "Broken Windows: The Police and Neighborhood Safety," *The Atlantic,* March 1982.

again patrolling neighborhoods for signs of public drinking, drug using, panhandling, and other signs of social disorder. These efforts were undertaken on the basis that such behavior while perhaps not criminal on its own set the stage for more serious crimes and therefore required police intervention.[519]

The acceptance of the "broken windows" theory countered the "victimless crime" concept that buttressed the decriminalization effort of the 1960s. As legal scholars like Herbert Packer and Norval Morris had claimed, the law should not be used against individuals engaging in behavior like gambling, prostitution, or public intoxication precisely because these actions posed no real threat to anyone else. In between the 1960s and 1970s, this argument was supported by conservative and liberal administrations alike with both Attorney Generals serving under Presidents Johnson and Nixon agreeing that such "victimless" actions should be decriminalized and handled through non-penal methods. Public drunkenness was the first "victimless" behavior to be partially decriminalized, with statutes penalizing public intoxication being taken off the books in a number of states after the passing of the Uniform Act in 1971.[520]

But a little over ten years later, Wilson and Kelling laid their case for reverting back to traditional methods for dealing with these behaviors. They contended that legal charges like public drunkenness needed to be brought back "not because society wants judges to punish vagrants or drunks but because it wants an officer to have the legal tools to remove undesirable persons from a neighborhood."[521] While in some ways agreeing with the notion that these individuals did not deserve to be punished, Wilson and Kelling also claimed that it was the role

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[519] "Broken Windows or Broken Promises?," *The New York Times,* May 12, 2002, CY13; Roger B. Parks, "Broken Windows and Broken Windows Policing," *Criminology and Public Policy* 7 (May 2008)L 159- 162.
[520] Bernard E. Harcourt, "The Collapse of the Harm Principle," *The Journal of Criminal Law and Criminology* 90, no. 1 (Autumn 1999): 149-154; Tom Goldstein, "Rethinking 'Victimless' Crimes," *The New York Times,* February 6, 1977, E5.
[521] Kelling and Wilson, "Broken Windows;" George F. Will, "Beggars: Does Society Have the Right to Protect Public Spaces," *The Hartford Courant,* February 1, 1990, C15C.

of the law to remove them from public view. In essence, certain rights of people like "vagrants or drunks" might need to be violated for the sake of collective order and safety.

The terminology that broken window theorists relied on to support their ideas was particularly telling and reflective of how far the debate had shifted away from decriminalization advocates. Refuting the "victimless crimes" premise, Wilson and Kelling wrote: "This wish to 'decriminalize' disreputable behavior that 'harms no one'….is a mistake. Arresting a single drunk or a single vagrant who has harmed no identifiable person seems unjust, and in a sense it is. But failing to do anything about a score of drunks or a hundred vagrants may destroy an entire community."[522] In this framing, there were no alcoholics. There were no sick, non-threatening people in need of help and understanding. Individuals exhibiting excessive drinking behavior in public were back to being regarded as "drunks," a stigmatizing label stripped of any connection to medicalization or the disease concept. This change in language was meaningful, signaling a renewed engagement with moralistic views of alcoholism and other forms of addiction. "Drunks" rather than "alcoholics" did not necessarily have rights that either the police or the community were obligated to respect. Just by existing in public, these individuals were a threat to a sense of safety and therefore could be arrested or forcibly dealt with by the law.

These calls for a more penal approach to those visibly intoxicated perhaps gained fast support because the problems of homelessness, mental illness, and substance abuse seemed be spinning out of control in the 1980s. A number of factors coalesced to produce what media outlets referred to as "crisis" levels of homelessness throughout American cities.[523] The rise in

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[522] Ibid.

[523] For example: Charles Pizzi, "Proposals to Ease City's Homeless Crisis," *Philadelphia Tribune,* September 5, 1988, 9A; Rita Malmund, "Frist Step is Offered in Homeless Crisis," *The New York Times,* May 1, 1988, WC32; Sylvia Easton, "Homeless Crisis," *Los Angeles Times,* December 31, 1986, B4; Deirdre Carmody, "New York if Facing Crisis on Vagrants," *The New York Times,* June 28, 1981, 1.

populations who were unhoused was in part due to unintended outcomes of liberal reforms. Urban renewal projects undertaken between the 1950s and 1970s led to the "destruction" of "Skid Rows" in many American cities. Most of these projects were marketed as a solution to the homelessness problem, implying as the historian Ella Howard has documented that the presence of a Skid Row area "somehow created [its] occupants" rather than being created by "dire poverty."[524] A lack of adequate relocation programs for Skid Row residents meant that the homeless population was not removed like city planners had intended, but instead were dispersed throughout the city. This shift made the homeless issue a widespread issue that was no longer quarantined to a distinct neighborhood by the 1980s.

These changes in urban space were further compounded by the unexpected consequences of another major attempt at reform in the arena of mental health. In between the 1940s and 1960s, several works exposed the prevalence of abuse and mistreatment of patients happening in state-run mental health hospitals. Advocates for the mentally ill pushed for lawmakers to support deinstitutionalization, replacing these large facilities with community-based mental health centers that could provide individualized treatment primarily on an outpatient basis. While this move was seen as a more humane way to care for persons dealing with mental illnesses, it also turned out be a rather shortsighted decision with dire consequences for those who were supposed to be helped. As the historian Gerald Grob has illuminated, the "promised integrated and coordinated community systems of mental health care to replace hospitals" never materialized.[525] Instead, those formerly housed in mental hospitals were left without a strong system of support

[524] Ella Howard, *Homeless: Poverty and Place in Urban America* (Philadelphia: University of Pennsylvania Press, 2013), 120-127, 189, 221; Todd DePastino, *Citizen Hobo: How a Century of Homelessness Shaped America* (Chicago, University of Chicago Press, 2003), 243; Barbara Basler, "With Skid Row Fading, Change Sweeps the Bowery," *The New York Times,* July 29, 1986, B1.
[525] Gerald Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University Press, 1991), 75, 239, 254-257.

and often wound up in nursing homes, jails, shelters, or on the street. Deinstitutionalization policy, as one journalist put it, "conceived in the optimism of the 1950s" was now being "reevaluated in the disillusionment of the 1980s." Similar to the "drunks and vagrants," the freedom of those with mental illness was secondary to the desires of the public under the broken windows view. Even mental health experts, including the head of the American Psychological Association, began calling for a return to "involuntary asylums" to prevent patients from "dying [in the street] with their rights on" in the eighties.[526] Cities and states instituted new policies that effectively supported forced confinement, with police in areas like New York City for example being permitted by the mayor to handcuff and forcibly remove individuals to psychiatric hospitals or city shelters.[527] Legal arguments about the injustice of locking up citizens against their will were outmatched by the fears over this seemingly unpredictable presence of homeless individuals with mental health problems.

The consequences of deinstitutionalization and urban renewal projects also coalesced with deindustrialization and a significantly reduced welfare state to change the demographic make-up of the homeless population. Because of these economic changes and a fraying social safety net, those without permanent shelter were more likely to be younger, female, people of color, and to have a mental illness in the 1980s. Press reports referred to these individuals as "the new homeless"-- people who were not stereotypical "bag ladies or skid row alcoholics."[528] However, the focus on substance abuse within the homeless community remained prominent

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[526] "Deinstitutionalization Reexamined," *The Washington Post,* May 14, 1985, A11; Cristine Russell, "Effort to Vacate Psychiatric Wards Fails Needs of Mentally Ill, Study Says," *The Washington Post,* September 13, 1984.
[527] Josh Barbanel, "Saving Homeless from Themselves: A New Policy Creates New Disputes," *The New York Times,* December 7, 1985, 29.
[528] Paul Bass, "Homeless: No Longer a Stereotype," *The New York Times,* August 5, 1984, CN1; Jean Dietz, "Report on Homeless: Study Challenges Beliefs on Homeless," *The Boston Globe,* March 1, 1984, 1; Joye Brown, "Challenge to America: Helping 'New Homeless,'" *Chicago Tribune,* January 16, 1983, 1.

even as more attention was paid to the economic conditions exacerbating the problem.[529] Both drinking and other kinds of drug use (heroin and crack in particular) were seen as a major factor that had to be considered in any policy response to homelessness. For those who had long been involved in discussions around decriminalization and the health needs of the "public inebriate," there was a new willingness at this time period to look beyond an individuals' drinking behavior to explain their housing situation. Regarding the increasingly diverse group making up the "new homeless," experts could no longer say that alcoholism was the only thing keeping people on the street. Individuals now faced "multi-risk factors" including "poverty, malnutrition, unemployment, physical and mental illness, and narcotics abuse."[530]

It can of course be argued that these conditions had always been there amongst those that had been labeled "Skid Row alcoholics," but those involved in studying and caring for the homeless in the 1980s were now considering the importance of these conditions in a different light. Even amongst those still focused on studying and treating the "synonymous" problems of "alcoholism and homelessness," medical rehabilitation alone was not enough to help this population. As one study questioned, what was the point of rehabilitation where "men were almost always discharged back to their Skid Row habitats and back to the homelessness-alcoholism cycle?"[531] Beyond questioning the limits of medicalization for impoverished alcoholics, others were also beginning to rethink the idea central to the decriminalization movement that sobriety had to come first. According to one scholar, "The alcohol problems of

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[529] Sandra Evans Teeley, "Hard Times Breed New Homeless," *The Washington Post,* January 23, 1983, A1; Judith Cummings, "Surge of Homeless People in Nation Tests Cities' Will and Ability to Cope," *The New York Times,* May 3, 1982, B13; Gina Kolata, "Twins of the Streets: Homelessness and Addiction," *The New York Times,* May 22, 1989, A1.
[530] Barbara Lubran, "Alcohol-Related Problems Among the Homeless- NIAAA's Response," *Alcohol Health and Research World* 11, no. 3 (Spring 1987): 4.
[531] Gerald R. Garrett, "Alcohol Problems and Homelessness: History and Research," *Contemporary Drug Problems* 16 (1989): 324

the public inebriate cannot be cured without coming to grips with the causes of homelessness. It is extremely difficult for an individual to stay sober without a stable economic support system [or] without a place to live."[532] Experts were finally coming around to the idea that Skid Row alcoholics themselves had been articulating for decades: that a person's basic socioeconomic needs had to be met before dealing with a drinking problem. While starting in earnest in the late 1980s, the "housing first versus treatment first" debate is one that continues to this day.[533]

But the voices of those offering up these kinds of welfarist solutions to the overlapping issues of homelessness, substance abuse, and mental illness were drowned out by those demanding more strong-handed approaches in between the eighties and nineties. As chapter 3 demonstrated, the move to prioritize the public order over the rights of individual homeless alcoholics was already underway in the 1970s. Additionally, more treatment providers were arguing that some of these "hard-core" problem drinkers might be past the point of help and that directing limited resources towards them was a "relatively fruitless" endeavor.[534] However, the calls to reinstate a carceral approach to those exhibiting symptoms of substance abuse in public either through arrest or involuntary commitment to a health facility gained new momentum in the 1980s. This trend was justified by a strengthening of moralistic sentiments towards substance abuse in general. While this viewpoint had consequences for addicts and alcoholics of all backgrounds, it particularly had negative consequence for those who were visibly sick. Though the work to have homeless alcoholics be seen as citizens deserving and worthy of help was

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[532] Louisa Stark, "A Century of Alcohol and Homelessness: Demographics and Stereotypes," *Alcohol Health and Research World* 11, no. 3 (Spring 1987): 12-13.

[533] Deborah Padgett el. Al, "Substance Use Outcomes Among Homeless Clients with Serious Mental Illness: Comparing Housing First with Treatment First Programs," *Community Mental Health Journal* 47 (2011): 227-232; CNBC, "Why the U.S. Can't Solve Homelessness," January 2022, https://www.youtube.com/watch?v=VMjTKbUTaMs.

[534] "Philadelphia's Center House: Inpatient Treatment for the Pre-Skid Row Man," *Alcohol Health and Research World* 1, no. 1. (Spring 1973): 8.

always a strained one, the effort buckled under the weight of eighties punitive politics and left these individuals once again stripped of both sympathetic understanding and access to real quality care.

"Willful Misconduct:" Eroding Legal Protections for Alcoholics

In 1987, the Supreme Court heard the case of two soldiers who had been denied benefits on account of their alcoholism. The Veterans Administration alleged that alcoholism was a reason to not extend benefits to these men because it constituted "willful misconduct" under the agency's "applicable statues and regulations." Lawyers for the men countered that this action violated the rights of the soldiers under the Rehabilitation Act of 1973 which afforded protections including G.I. Bill benefits to all "handicapped" persons.[535] And as alcoholics, these men should officially be considered by the VA as "handicapped" in the same way as they would with a physical disability. With the case of *Traynor v. Turnage*, the Supreme Court was once again called upon to make a determination over the exact nature of alcoholism and how it should be considered under the law. Was alcoholism a disease with associative involuntary behaviors that should be officially considered a handicap? Or was alcoholism a series of personal choices that did not constitute any kind of formal protections? The Supreme Court ultimately sided with the VA, agreeing that alcoholics did engage in "willful misconduct" and therefore to withdraw benefits was not a violation of their legal rights.

This decision was another in a series of setbacks to gaining legal and policy recognition for the disease concept in the 1980s. Selectively citing different pieces of medical and scientific studies, the court argued that even experts contested "the proposition that alcoholism is a disease,

[535] *Traynor v. Turnage,* 485 U.S. 535 (1988).

much less that it is a disease for which the victims bear no responsibility."[536] By doing so, the Court sided with the contrarian voices that had been building in the years leading up to the *Traynor* case. Historian William White has written that "it is perhaps ironic that the very vehicle that the pioneers of the modern alcoholism movement used to launch the movement in the 1940s- science [and professional debate]- gave birth to the most serious challenges to that movement's most basic declarations about alcoholism."[537] After the creation of the NIAAA and the enlargement of the treatment field, more scholars from a variety of different fields got involved in studying and evaluating alcoholism. As White pointed out, this increase in the number of those focused on alcoholism ironically led to a questioning of the disease concept. The most publicized of this viewpoint came from the philosopher Herbert Fingarette. Ever since the *Powell* case had raised the prospect of decriminalization of alcoholism on a national level, Fingarette had been vocal about opposing the legal implications of the disease concept. "The idea that alcoholism is a disease is a myth," Fingarette wrote, "and a harmful myth at that."[538] The disease concept was particularly dangerous in its implications for criminal law and personal responsibility. In essence, people were being let off the hook for criminal behavior because of a "myth" that they were sick and were not making conscious choices for which they could be held responsible.

This outlook found favor among conservative scholars and fed into the political conservatism of the eighties. Starting first with alcoholism, America according to scholars like social psychologist Stanton Peele had been "sold" the idea that "larges areas of our behavior are

[536] J. Larry Goff, "Alcoholism: Disease or Willful Misconduct- A Look at the Veterans Administration Position in Traynor v. Turnage," *Journal of Psychiatry and the Law* 59 (1990): 69.
[537] White, *Slaying the Dragon,* 284.
[538] Herbert Fingarette, "Alcoholism: The Mythical Disease," *The Public Interest* 91 (Spring 1988): 3; Hebert Fingarette, *Heavy Drinking: The Myth of Alcoholism as a Disease* (Berkley: University of California Press, 1988); Herbert Fingarette, "Addiction and Criminal Responsibility," *Yale Law Journal* 84 (January 1975): 413-444.

diseases that are out of control."[539] Medicalizing social problems like drug or alcohol use had given people excuses for immoral behavior that should not be tolerated nor treated as acceptable. At the governmental level, this ideology fit into the attack the Reagan administration and other conservative politicians were waging against liberal reforms and welfare in particular. Both Ronald and Nancy Reagan's approach to substance abuse was based not on science or medicine but on the idea that drug use was a matter of "individual and immoral choices."[540] Especially with the "Just Say No" campaign, the Reagans put their weight behind the idea that alcoholics and addicts did not need help or treatment. They just needed to learn how to make better choices for themselves and their communities.

When it came to alcohol, President Reagan also lent his support to the Mothers Against Drunk Driving campaign. MADD was a grassroots effort made up of women who did not have any professional ties to alcoholism. These volunteers tended to have a personal connection with a drunk driving incident, often having lost a loved one in an accident. For these mothers, the behavior of problem drinking was viewed differently than the activists who had been involved in both the decriminalization and modern alcoholism movements. They argued that society had not been caring about the "real" victims of excessive drinking behavior: innocent people killed or maimed as a result of intoxicated drivers. Within this framing, any decision to get behind the wheel while drunk was a conscious choice no matter if one had the "disease" of alcoholism or not. MADD thus called on policymakers to reevaluate the lenient approach to drinkers, demanding harsh criminal penalties for those who willingly decided to drink and drive. Though opposed by the leaders of the NIAAA, the Reagan administration endorsed this law and-order-

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[539] Stephen Barr, "Addiction and the 'Disease Mythology,'" *The New York Times,* March 18, 1990, NJ3; Stanton Peele, *Diseasing of America: Addiction Treatment Out of Control* (Lexington: Lexington Books, 1989).
[540] Carl Erik Fischer, *The Urge: Our History of Addiction* (New York: Penguin Press, 2022), 255.

approach championed by MADD. Calling the "lax" law enforcement approach to drunk driving a national "travesty, Reagan demanded stricter arrest guidelines and carceral time for "drunks on the highways" including those who were who were "first-timers."[541] As the historian Barron Lerner has argued, the penalization demanded by the MADD campaign most likely would not have garnered such support only a decade earlier. But by the 1980s, MADD was operating in a "political and cultural climate conducive to the angry, moralistic, and media-driven campaign."[542] Just as was the case with homeless individuals who were visibly intoxicated in public, those advocating for jailtime for drunk drivers relied upon the idea that substance use and abuse was a decision that deserved punishment rather than treatment.

The hardline ideology around addiction and alcoholism that undergirded the MADD campaign, the broken windows theory, and the "willful misconduct" arguments before the Supreme Court affected alcoholics who were not targeted by any of these efforts. The treatment system that had been funded by the Hughes Act and expanded under its subsequent amendments now largely got its clients from those convicted of drunk driving or other criminal charges associated with drinking. As the physician Carl Erik Fischer has recently illuminated, this "massive arrest-to-treatment pipeline" affected the philosophy and practices of the entire treatment system. Whether patients checked themselves into treatment or were referred by their families, all alcoholics now faced a system that revolved around "much harsher confrontation" and "threats and punishments" than had been originally intended by the reformers fighting for a comprehensive treatment system in the 1960s.[543] Additionally, between the 1980s and 1990s, the

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[541] Ronald Reagan, "Radio Address to the Nation on Drunk Driving," December 17, 1983, https://www.reaganlibrary.gov/archives/speech/radio-address-nation-drunk-driving.
[542] Barron H. Lerner, *One for the Road: Drunk Driving Since 1900* (Baltimore: Johns Hopkins University Press, 2011), 64.
[543] Fischer, *The Urge,* 260; Weisner and Room, "Financing and Ideology," 167-184.

cost for entry into these programs skyrocketed. Like Betty Ford predicted, under the protection of these new punitive political winds, insurance companies increasingly removed coverage for rehabilitation and cut off access to treatment even for working- and middle-class alcoholics.[544]

Reformers interested in destigmatizing alcoholism were well aware of the significant intersections between politics and ideology and between policy and societal attitudes. There is no question that the resurgence of the view that alcoholics were willfully delinquent rather than ill had concrete and enduring effects on the lives of citizens across the country. The fact that treatment became inordinately expensive crippled one of the notions that had been at the heart of modern alcoholism reform: that all sick people had a right to receive appropriate and accessible care. Furthermore, more policymakers, legal scholars, employers, and insurance companies were now willing to fight against alcoholism being considered a legitimate disability. No longer ensured job security or access to benefits, it is natural that alcoholics would be wary of openly asking for help and would revert back to concealing the problem.[545] The eroding of the rights and protections of alcoholism under the punitive politics and ideology of the 1980s are a significant reason for why alcoholism and other forms of addiction remain stigmatizing conditions today.

The Legacy of the Decriminalization and Modern Alcoholism Movements

A significant amount of scholarly attention has been paid to the rise of this punitive politics in the eighties, especially in the areas of illicit drugs. Far less time has been given to the

[544] Sari Horwitz, "Mandatory Health Benefits Debates: Key Issue is Coverage of Treatment for Drug, Alcohol Abuse, and Mental Illness," *The Washington Post,* August 19, 1985, WB1; Milt Freudenheim, "Employers Winning Right to Cut Back Medical Insurance," *The New York Times,* March 29, 1992, 1; Beth Botts, "Cost of Treatment for Alcoholics Scrutinized," *Los Angeles Times,* June 17, 1985, D1; Claire D. Clarke, *The Recovery Revolution: The Battle over Addiction Treatment in the United States* (New York: Columbia University Press, 2017).
[545] "Groups Waging Last-Ditch Battle for Rights of Addicts and Alcoholics," *Alcoholism and Drug Abuse Week* 1 (1989): 1.
It is estimated that fewer than 5% of those with substance use disorders today ever seek treatment. Fischer, *The Urge,* 4.

moments of promise that occurred in the preceding decades. This deficit might be attributed to the notion that the policy approaches epitomized by the Reagan-era War on Drugs negated the reforms that had been implemented in the sixties and seventies. But the belief that alcoholics were sick individuals who possessed the right as American citizens to compassion and care was never fully eradicated even at the height of the punitive approach in the eighties and nineties. Instead, these differing views- one of disease and rights, the other of willful misbehaviors and punishment- were now in competition with each other. This can be seen in how the medicalized view of substance use disorders has been reemerging in recent years. Thus, any history covering the politics of substance abuse is incomplete without contending with the ideas of the decriminalization and modern alcoholism movements.

It is important to fully understand the mixed legacy of both of these efforts, to be clear-eyed about the ways in which they succeeded and failed. As Carl Fischer has written, the United States fifty years ago was "on the cusp of a new therapeutic approach to addiction, one that would have abandoned punitive approaches for a kind and compassionate attempt at care. Then, right on the threshold, the country started to lose patience of the idea of rehabilitation altogether, and it began down a path toward prohibitionist responses."[546] This is true. But this shift can only partially be explained by a general rise in conservative and moralistic views towards addicts and alcoholics. The move towards penalization is also tied to the flaws built into the therapeutic policies initiated in the sixties and seventies. Especially for homeless alcoholics, the goals of reformers failed to align with the reality of the situation the target population was facing. Rather than contending with the problems of rehabilitative programs that only sought to solve Skid Row alcoholics' drinking behavior and not their socioeconomic circumstances, treatment providers as

[546] Fischer, *The Urge,* 239.

well as policymakers began to question whether these individuals were capable of being helped and worth public investment. For the less publicly visible alcoholics, the chosen therapeutic approaches were also limited with large blind spots concerning women and people of color. Additionally, relying on "constructive coercion" to get people into treatment ensured that elements of force became part of a newly expanding rehabilitation field that could easily be manipulated as calls for punishment increased in later decades.

The pandemic and the opioid crisis have renewed attention to many of the problems that the historical actors examined throughout this dissertation attempted to solve.[547] What does a medicalized handling of a substance abuse epidemic look like? Are there certain elements of substance use disorders that cannot be resolved by medicalization alone? How do we ensure that those who are addicted to alcohol or other drugs receive the help that they need? Can treatment be administered voluntarily and outside the confines of the criminal justice system? And how can rehabilitation options be made affordable, especially for those who are uninsured? As many reformers of today offer remarkably similar solutions to those described in the pages above, I think it is necessary to fully understand the successes and failures of the therapeutic policies attempted half a century ago. This history illustrates how rehabilitative approaches to addiction

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[547] For a small snapshot of the pandemic's effects on those with substance use disorders: Anahad O'Connor, "Alcohol Abuse is On the Rise, but Doctors Too Often Fail to Treat It," *The New York Times,* July 12, 2021, https://www.nytimes.com/2021/07/12/well/live/alcohol-abuse-drinking-treatment.html; Roni Caryn Rabin, "Alcohol-Related Deaths Spiked During the Pandemic, a Study Shows," *The New York Times,* March 22, 2022, https://www.nytimes.com/2022/03/22/health/alcohol-deaths-covid.html; Emma Goldberg, "Relapsing Left and Right: Trying to Overcome Addiction in a Pandemic," *The New York Times,* January 4, 2021, https://www.nytimes.com/2021/01/04/nyregion/addiction-treatment-coronavirus-new-york-new-jersey.html. Regarding efforts to medicalize responses to the ongoing opioid crisis: American Medical Association, "Issue Brief: Nation's Drug-Related Overdose and Death Epidemic Continue to Worsen," May 12, 2022, https://www.ama-assn.org/system/files/issue-brief-increases-in-opioid-related-overdose.pdf; Howard Koh "Community Approaches to the Opioid Crisis," *Journal of American Medical Association* (2015): 1437-1438; Jason Doctor and Michael Menchine, "Tackling the Opioid Crisis with Compassion, New Ways to Reduce Use and Treatment," *Brooks Schaeffer on Health Policy,* March 20, 2017, https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2017/03/20/tackling-the-opioid-crisis-with-compassion-new-ways-to-reduce-use-and-treatment/.

can only be effective if treatment is equitable, responsive to social determinants, and accessible to individuals without financial resources.

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